South Shore
Medical Center

Patient
Label

Adult Patient Questionnaire Addendum

The following questions are a screening for symptoms of depression. Please read each question carefully, then select the answer that indicates how much you have been bothered by that problem in the last 2 weeks.

Patient's Name:	**Date of Birth:**		**Date of Visit:**	

Question	**Response**			
1. Over the last two weeks, have you had little interest or pleasure in doing things?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
2. Over the last two weeks, have you felt "down", depressed, or hopeless?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
3. Over the last two weeks, how often have you had trouble falling or staying asleep, or sleeping too much?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
4. Over the last two weeks, how often have you felt tired or had little energy?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
5. Over the last two weeks, how often did you have a poor appetite or overeat?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
6. Over the last two weeks, have you felt bad about yourself – or felt that you are a failure and have let yourself or your family down?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
7. Over the last two weeks, have you had trouble concentrating on things such as reading the newspaper or watching television?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
8. Over the last two weeks, have you moved or spoken so slowly that other people could have noticed? Or the opposite – have you been so fidgety or restless that you have moved around a lot more than usual?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
9. Over the last two weeks, have you had thoughts that you would be better off dead or of hurting yourself?	☐ Not at all	☐ Several days	☐ More than half the days	☐ Nearly every day
10. Over the last two weeks, how difficult has it been for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

Patient Signature:
X

Date: