DEPRESSION SELF-REPORT SCALE

Patient's Name: _____Date: _____

Filled out by:_____

Circle the number that applies to each question: 0=not at all, 1=a little bit, 2=moderately, 3=quite a bit, 4=extremely.

Instruction to patient: Below is a list of problems and complaints that patients sometimes experience. Please read each one carefully, circle the number to indicate how much you have been concerned by that problem in the last 2 weeks.

1.	Do you feel sad, "blue", down, or depressed?	0	1	2	3	4
2.	Do you think about death or committing suicide?	0	1	2	3	4
3.	Do you feel discouraged about your future?	0	1	2	3	4
4.	Do you feel like a failure?	0	1	2	3	4
5.	Do you think you are a burden to others?	0	1	2	3	4
6.	Do you feel dissatisfied or disappointed with your life?	0	1	2	3	4
7.	Do you have feelings of guilt?	0	1	2	3	4
8.	Do you feel like you are being punished?	0	1	2	3	4
9.	Do you feel detached or withdrawn from others?	0	1	2	3	4
10.	Do you feel like crying more than normal?	0	1	2	3	4
11.	Are you more irritable than normal?	0	1	2	3	4
12.	Have you been feeling nervous, tense, worried, fearful, or stressed?	0	1	2	3	4
13.	Have you lost interest or pleasure in activities or people that you used to enjoy?	0	1	2	3	4
14.	Have you lost interest in sex?	0	1	2	3	4
15.	Have you been feeling overly sensitive to the opinions or criticisms of others?	0	1	2	3	4
16.	Are you having difficulty making decisions or difficulty staying motivated?	0	1	2	3	4
17.	Are you having problems concentrating?	0	1	2	3	4
18.	Are you having sleep problems, insomnia, or sleeping too much?	0	1	2	3	4
19.	Has your appetite changed? Increased/decreased (circle AND rate)	0	1	2	3	4
20.	Has your weight changed? Increased/decreased (circle AND rate)	0	1	2	3	4
21.	Are you worried or unhappy about your appearance?	0	1	2	3	4
22.	Are you worried about medical, physical, or health problems?	0	1	2	3	4
23.	Are you feeling tired or fatigued?	0	1	2	3	4
24.	Have you been experiencing physical pain or discomfort?	0	1	2	3	4
25.	Are you experiencing external thoughts, perceptions, or voices that make you feel worse?	0	1	2	3	4
	TOTALS:					

Score: _____ Do you currently have any weapons or firearms at home? _____

Patient signature: _____