



PATIENT NAME _____

DATE _____

Please check a response for each of the 20 items.	None OR a Little of the Time	Some of the Time	Good Part of the Time	Most OR All of the Time
1. I FEEL DOWNHEARTED, SAD AND BLUE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. MORNING IS WHEN I FEEL THE BEST	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I HAVE CRYING SPELLS OR FEEL LIKE IT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I HAVE TROUBLE SLEEPING THROUGH THE NIGHT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I EAT AS MUCH AS I USED TO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I ENJOY LOOKING AT, TALKING TO, AND BEING WITH ATTRACTIVE WOMEN/MEN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I NOTICE THAT I AM LOSING WEIGHT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I HAVE TROUBLE WITH CONSTIPATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. MY HEART BEATS FASTER THAN USUAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I GET TIRED FOR NO REASON	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. MY MIND IS AS CLEAR AS IT USED TO BE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I FIND IT EASY TO DO THE THINGS I USED TO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. I AM RESTLESS AND CAN'T KEEP STILL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. I FEEL HOPEFUL ABOUT THE FUTURE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. I AM MORE IRRITABLE THAN USUAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. I FIND IT EASY TO MAKE DECISIONS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. I FEEL THAT I AM USEFUL AND NEEDED	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. MY LIFE IS PRETTY FULL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. I FEEL THAT OTHERS WOULD BE BETTER OFF IF I WERE DEAD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. I STILL ENJOY THE THINGS I USED TO	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

INSTRUCTIONS

Read each sentence carefully. For each statement, check the circle in the column that best corresponds to how often you have felt that way during the past two weeks.

For statements 5 and 7, if you are on a diet, answer as if you were not.