Patient Depression Intake Questionnaire

** indicates a required field*

Over the last 2 weeks, how often have you been bothered by any of the following symptoms?

Please answer each question by selecting the one answer that best describes you.

* Little interest or pleasure in doing things?

- ◯ Not at all
- ◯ Several days
- ◯ More than half days
- ◯ Nearly every day

* Feeling down, depressed, or hopeless?

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

* Trouble falling or staying asleep, or sleeping too much?

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

*** Feeling tired or having little energy?**

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

*** Poor appetite or overeating?**

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

*** Feeling bad about yourself - or that you are a failure or have let yourself or your family down?**

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

*** 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

*** Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual?**

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

*** Thoughts that you would be better off dead, or of hurting yourself in some way?**

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

Patient :

* **Signature :** _____

I consent to sharing information provided here.

*** Print Name :**

*** Date :**