Patient Name: DOB:

Depression Self-Rating Test

Instructions: Please circle the one response to each item that best describes you for the past seven days.

1. Falling asleep:

0. I never take longer than 30 minutes to fall asleep.
1. I take at least 30 minutes to fell asleep, less than half the time.
2. I take at least 30 minutes to fell asleep, more than half the time.
3. I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep during the night:

0. I do not wake up at night.
1. I have a restless, light sleep with a few brief awakenings each night.
2. I wake up at least once a night, but I go back to sleep easily
3. I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking up too early:

0. Most of the time. I awaken no more than 30 minutes before I need to get up.
1. More than half the time. I awaken more than 30 minutes before I need to get up.
2. I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually
3. I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping too much:

0. I sleep no longer than 7-8 hours night, without napping during the day.
1. I sleep no longer than 10 hours in a 24-hour period including naps.
2. I sleep no longer than 12 hours in a 24-hour period including naps.
3. I sleep longer than 12 hours in a 24-hour period including naps.

Enter the highest score for items 1-4 _____

5. Feeling sad:

0. I do not feel sad.
1. I feel sad less than half the time.
2. I feel sad more than half the time.
3. I feel sad nearly all of the time.

6. Decreased appetite:

0. There is no change in my usual appetite.
1. I eat somewhat less often or lesser amounts of food than usual.
2. I eat much less than usual and only with personal effort.
3. I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. Increased appetite:

0. There is no change from my usual appetite.
1. I feel a need to eat more frequently than usual.
2. I regularly eat more often and or greater amounts of food than usual.
3. I feel driven to overeat both at mealtime and between meals.

8. Decreased weight (within the last two weeks):

0. I have not had a change in my weight.
1. I feel as if I've had a slight weight loss.
2. I have lost 2 pounds or more.
3. I have lost 5 pounds or more.

9. Increased weight (within the last two weeks):

0. I have not had a change in my weight
1. I feel as if I've had a slight weight gain.
2. I have gained 2 pounds or more.
3. I have gained 5 pounds or more.

Enter the highest score for items 6-9 _____

Patient Name: DOB:

10. Concentration Decision making:

0. There is no change in my usual capacity to concentrate or make decisions.
1. I occasionally feel indecisive or find that my attention wanders.
2. Most of the time. I struggle to focus my attention or to make decisions.
3. I cannot concentrate well enough to read or cannot make even minor decisions

11. View of myself:

0. I see myself as equally worthwhile and deserving as other people
1. I am more self-blaming than usual.
2. I largely believe that I cause problems for others
3. I think almost constantly about major and minor defects in myself

12. Thoughts of death or suicide:

0. I do not think of suicide or death.
1. I feel that life is empty or wonder if it's worth living.
2. I think of suicide or death several times a week for several minutes.
3. I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General interest:

0. There is no change from usual in how interested I am in other people or activities.
1. I notice that I am less interested in people or activities.
2. I find I have interest in only one or two of my formerly pursued activities.
3. I have virtually no interest in formerly pursued activities

14. Energy level:

0. There is no change in my usual level of energy.
1. I get tired more easily than usual.
2. I have to make a big effort to start or finish my usual daily activities (for example: shopping homework, cooking, or going to work).
3. I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

0. I think, speak, and move at my usual rate of speed.
1. I find that my thinking is slowed down or my voice sounds dull or flat.
2. It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.
3. I am often unable to respond to questions without extreme effort.

16. Feeling restless:

0. I do not feel restless.
1. I'm often fidgety, wringing my hands, or need to shift how I am sitting.
2. I have impulses to move about and am quite restless.
3. At times. I am unable to stay seated and need to pace around.

Enter the highest score for items 15 or 16 _____

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1-4	_____
5	_____
6-9	_____
10	_____
11	_____
12	_____
13	_____
14	_____
15-16	_____
Total	_____

Patient Name: DOB:

Anxiety Screener

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom

	Not at all	Mildly but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely - it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____.

Patient Name: DOB:

Epworth Sleepiness Scale

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations.

Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze or fall asleep in that situation.

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you.

Use this scale to choose the most appropriate number for each situation:
0= would never doze, 1 = slight chance of dozing, 2 = moderate chance of dozing, 3 = high chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

Situation	Chance of dozing (0-3)			
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place — for example, a theater or meeting	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
In a car, while stopped in traffic	0	1	2	3
	Total Score:			