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Name_____ Date_____

PLEASE COMPLETE THIS CHECKLIST:

Have you in the past, especially within the last two (2) months or so, experienced any of the following?

1.	Distinct period of unpleasant mood or continuous loss of interest or pleasure that is a major part of your problem and relatively persistent?	( )yes	( )no
2.	Felt sad, blue, down in the dumps?	( )yes	( )no
3.	Feelings of worthlessness?	( )yes	( )no
4.	Feelings of hopelessness?	( )yes	( )no
5.	Loss of interest in usual activities?	( )yes	( )no
6.	Loss of interest in sex?	( )yes	( )no
7.	Excessive feelings of self-reproach or guilt?	( )yes	( )no
8.	Loss of ability to enjoy usual activities?	( )yes	( )no
9.	Troubled by diminished concentration?	( )yes	( )no
10.	Preoccupied by thoughts of death or dying?	( )yes	( )no
11.	Preoccupied by suicidal thoughts or ideas?	( )yes	( )no
12.	Crying spells or feeling on the verge of tears?	( )yes	( )no
13.	Poor appetite or weight loss?	( )yes	( )no
14.	Increased appetite or weight gain?	( )yes	( )no
15.	Felt restless, fidgety or unable to sit still?	( )yes	( )no
16.	Feeling better in the evening?	( )yes	( )no
17.	Sleep difficulty:		
	a) trouble falling asleep?	( )yes	( )no
	b) trouble staying asleep (sleep broken up)?	( )yes	( )no
	c) unable to go back to sleep after awakening too early?	( )yes	( )no
18.	Sleeping more than usual?	( )yes	( )no
19.	Loss of energy, fatigue, tiredness?	( )yes	( )no
20.	Felt slowed down, sluggish, lying around a lot?	( )yes	( )no