

Life Script Counseling Services

"Helping You Reclaim Your Life"

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Depression Severity Screening

Name: _____

Date: _____

Answer each question with regard to how you have felt over the last two weeks. Circle the appropriate answer.

Topic	Not at all	Several Days	More than half the	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about your self, that you are a failure	0	1	2	3
Trouble concentrating on tasks or activities	0	1	2	3
Moving or speaking slowly, or being fidgety & restless	0	1	2	3
Thoughts that you would be better off dead or of hurting	0	1	2	3

Add up each Column: TOTALS:

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If you checked any of the problems, how difficult have they made it for you to work, take care of things at home or get along with others?

Not Difficult

Some-what Difficult

Very Difficult

Extremely Difficult

Do Not Write In This Section!

Total : _____

Ratings:

0 – 5 none 6 – 12 gray zone 13 – 18 mild to moderate 19 – 27 severe