



Patient or Client Identifier	
Surname	MOLE
Other names	KARYN JOY
Date of Birth	10 04 1971
Gender	Male <input type="radio"/> Female <input checked="" type="radio"/> Other <input type="radio"/>
Address	4 DEIRDRE DRIVE RIVERSTONE
Date completed: _/ _/ _	

Instructions

The following ten questions ask about how you have been feeling in the **past four weeks**. For each question, mark the circle under the option that best describes the amount of time you felt that way.

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
1.	In the past four weeks, about how often did you feel tired out for no good reason?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2.	In the past four weeks, about how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
3.	In the past four weeks, about how often did you feel so nervous that nothing could calm you down?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.	In the past four weeks, about how often did you feel hopeless?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5.	In the past four weeks, about how often did you feel restless or fidgety?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6.	In the past four weeks, about how often did you feel so restless you could not sit still?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7.	In the past four weeks, about how often did you feel depressed?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8.	In the past four weeks, about how often did you feel that everything was an effort?	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9.	In the past four weeks, about how often did you feel so sad that nothing could cheer you up?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10.	In the past four weeks, about how often did you feel worthiness?	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please turn over – there are a few more questions on the other side

The next few questions are about how these feelings may have affected you in the **past four weeks**. You need not answer these questions if you answered 'None of the time' to all of the ten questions about your feelings

11.	In the past four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?	0	(Number of days)
12.	[Aside from those days], in the past 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?	0	(Number of days)
13.	In the past 4 weeks, how many times have you seen a doctor or any other health professional about these feelings?	2	(Number of consultations)
14.	In the past 4 weeks, how often have physical health problems been the main cause of these feelings?	<input checked="" type="radio"/> None of the time <input type="radio"/> A little of the time <input type="radio"/> Some of the time <input type="radio"/> Most of the time <input type="radio"/> All of the time	

Thankyou for completing this questionnaire.

Please return it to the staff member who asked you to complete it.

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