MORE ABOUT YOU SCREENING PANEL

Patient Name: _____

Date: _____

Rate the following as they apply to you. Circle the number which best applies to you, with 1 being NEVER and 4 being EVERYDAY

SYMPTOM	NEVER	OFTEN	MORE THAN HALF	EVERYDAY
Little interest or pleasure in doing things	1	2	3	4
Feeling down, depressed or hopeless	1	2	3	4
Trouble falling or staying asleep, or sleeping too much	1	2	3	4
Feeling tired or having little energy	1	2	3	4
Poor appetite or overeating	1	2	3	4
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	1	2	3	4
Trouble concentrating on things, such as reading the newspaper or watching television	1	2	3	4
Moving or speaking so slowly that other people could have noticed	1	2	3	4
Thoughts that you would be better off dead, or hurting yourself	1	2	3	4
If you've had any days with issues above, how difficult have these problems made it for you at work, home, school or with other people	1	2	3	4