Name	Birthdate Do		ctor T		oday's Date	
A	Survey from Yo	our Healthcare	e Provider			
Part of routine screening Instructions: How often h past two weeks? For each describes how you have	ave you been bothe h symptom put an "	ered by each of th	e following s	ymptoms du	ring the	
a southeather a st		(0)	(1)	(2)	(3)	
		Not At All	Several Days	More Than Half the Days	Nearly Every Day	
Feeling down, depressed, i	rritable or hopeless?					
Little interest or pleasure in	doing things?					
Trouble falling or staying as	sleep or sleeping too	much?				
Poor appetite, weight loss,	or overeating?					
Feeling tired or having little	energy?					
Feeling bad about yourself failure, or have let yourself	•	ire a				
Trouble concentrating on the reading or watching TV?	ings, like school work	ς,				
Moving or speaking so slow have noticed? Or the opposite – being so were moving around a lot n	fidgety or restless tha					
Thoughts that you would be hurting yourself in some wa		f				
In the <i>past year</i> have you follow the second of the secon	of the problems on the	nis form, how difficu	ult have these			
☐ Not difficult at all	☐ Somewhat difficul	t □ Very difficult	□ Extreme	ly difficult		
Has there been a time in th about ending your life?	e past month when y	ou have had seriou	s thoughts	ΞY	′es □ No	
Have you ever, in your who	ole life, tried to kill yo	urself or made a รเ	uicide attempt?	Υ	′es □ No	
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