Name _____ Birthdate_____ Doctor _____ Today's Date _____

A Survey from Your Healthcare Provider

Part of routine screening for your health includes considering mood and emotional concerns. Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
Feeling down, depressed, irritable or hopeless?				
Little interest or pleasure in doing things?				
Trouble falling or staying asleep or sleeping too much?				
Poor appetite, weight loss, or overeating?				
Feeling tired or having little energy?				
Feeling bad about yourself --or feeling that you are a failure, or have let yourself or your family down?				
Trouble concentrating on things, like school work, reading or watching TV?				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the ***past year*** have you felt depressed or sad most days, even if you felt OK sometimes? ☐ Yes ☐ No

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

Have you ***ever***, in your ***whole life***, tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

For Office Use Only: Score _____

Center for Epidemiological Studies Depression Scale for Children (CES-DC)

Number _____

Score _____

INSTRUCTIONS

Below is a list of the ways you might have felt or acted. Please check how *much* you have felt this way during the *past week*.

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
1. I was bothered by things that usually don't bother me.	___	___	___	___
2. I did not feel like eating, I wasn't very hungry.	___	___	___	___
3. I wasn't able to feel happy, even when my family or friends tried to help me feel better.	___	___	___	___
4. I felt like I was just as good as other kids.	___	___	___	___
5. I felt like I couldn't pay attention to what I was doing.	___	___	___	___

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
6. I felt down and unhappy.	___	___	___	___
7. I felt like I was too tired to do things.	___	___	___	___
8. I felt like something good was going to happen.	___	___	___	___
9. I felt like things I did before didn't work out right.	___	___	___	___
10. I felt scared.	___	___	___	___

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
11. I didn't sleep as well as I usually sleep.	___	___	___	___
12. I was happy.	___	___	___	___
13. I was more quiet than usual.	___	___	___	___
14. I felt lonely, like I didn't have any friends.	___	___	___	___
15. I felt like kids I know were not friendly or that they didn't want to be with me.	___	___	___	___

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
16. I had a good time.	___	___	___	___
17. I felt like crying.	___	___	___	___
18. I felt sad.	___	___	___	___
19. I felt people didn't like me.	___	___	___	___
20. It was hard to get started doing things.	___	___	___	___