

Depression Symptom Questionnaire

Use for depression treatment visits or when low mood, loss of interest, energy, motivation, guilt, or hopelessness are concerns.

Patient name:	_____	Date of birth:	_____
Date completed:	_____	Appointment date:	_____

During the past 2 weeks, how often have you experienced the following? *Select the response that best reflects your experience.*

Symptom or experience	Not at all	Several days	More than half	Nearly every day
Little interest or pleasure in activities	☐	☐	☐	☐
Feeling sad, depressed, empty, or hopeless	☐	☐	☐	☐
Sleep difficulty or sleeping much more than usual	☐	☐	☐	☐
Low energy or fatigue	☐	☐	☐	☐
Poor appetite, overeating, or weight change	☐	☐	☐	☐
Feeling worthless, guilty, or like a failure	☐	☐	☐	☐
Difficulty concentrating, reading, or making decisions	☐	☐	☐	☐
Moving or speaking unusually slowly, or feeling unusually restless	☐	☐	☐	☐
Thoughts that you would be better off dead, suicide thoughts, or self-harm urges	☐	☐	☐	☐

How difficult have these symptoms made work, school, home responsibilities, or relationships?

☐ Not difficult ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

What situations, losses, medical issues, medications, or life changes may be contributing?

Clinical safety question	No	Yes	Unsure
Have you ever had a period of unusually elevated or irritable mood with much less need for sleep?	☐	☐	☐
Have you had psychotic symptoms, severe confusion, or inability to care for yourself?	☐	☐	☐

Clinical safety question	No	Yes	Unsure
Are you currently having suicide thoughts, a plan, intent, or recent preparatory behavior?	☐	☐	☐
Can you stay safe until you are evaluated?	☐	☐	☐

What has helped, even a little?
