Patient Evaluation Form

Patient Name: _____ **Date**: _____

INSTRUCTIONS: Please decide on *one answer to each question* that most closely represents your feelings and put a check mark in the space. Also, please try to be completely honest in your responses so that your physician will be best able to assess your needs. Note that there is room at the end for additional comments you might have.

		No/Rarely or Never	A Little/ Sometimes	A good Deal/ Often	A Lot/ Almost Always
1	How often do you feel Depressed (sad, hopeless, worthless, and/or weepy?)				
2	Do you tend to feel guilty and/or worthless?				
3	Do you feel that you're bad or evil?				
4	Do you have trouble falling asleep at bedtime?				
5	Do you have trouble sleeping in the middle of the night?				
6	Do you wake-up before you want to?				
7	Are you spending less time on your work, your social life, and other activities?				
8	Do you find it harder to concentrate?				
9	Do you tend to feel anxious and restless?				
10	Do you tend to feel irritable and worried?				

		No/Rarely or Never	A Little/ Sometimes	A good Deal/ Often	A Lot/ Almost Always
11	Do physical problems bother you (such as, "butterflies", indigestion, diarrhea, headaches, trouble catching you breath, or a frequent need to urinate?				
12	Have you experienced loss of appetite?				
13	How often do you feel tired?				
14	Have you lost interest in sex?				
15	Do you feel there is something wrong with your body?				
16	Are your problems and difficulties caused by circumstances beyond your control?				
17	Have you lost weight recently?				
18	Do you ever feel that life isn't worth living?				
19	Have you ever considered suicide?				
20	Have you ever tried to kill yourself?				

Comments:

_____

_____

On the reverse side, draw each person in your immediate family doing an activity, include yourself. Please do not use stick figures.