QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)
(QIDS-SR)

NAME: _____ TODAY'S DATE _____

Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep:

   0 I never take longer than 30 minutes to fall asleep.
   1 I take at least 30 minutes to fall asleep, less than half the time.
   2 I take at least 30 minutes to fall asleep, more than half the time.
   3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night:

   0 I do not wake up at night.
   1 I have a restless, light sleep with a few brief awakenings each night.
   2 I wake up at least once a night, but I go back to sleep easily.
   3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking Up Too Early:

   0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   1 More than half the time, I awaken more than 30 minutes before I need to get up.
   2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:

   0 I sleep no longer than 7-8 hours/night, without napping during the day.
   1 I sleep no longer than 10 hours in a 24-hour period including naps.
   2 I sleep no longer than 12 hours in a 24-hour period including naps.
   3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling Sad:

   0 I do not feel sad
   1 I feel sad less than half the time.
   2 I feel sad more than half the time.
   3 I feel sad nearly all of the time.

6. Decreased Appetite:

   0 There is no change in my usual appetite.
   1 I eat somewhat less often or lesser amounts of food than usual.
   2 I eat much less than usual and only with personal effort.
   3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. Increased Appetite:

   0 There is no change from my usual appetite.
   1 I feel a need to eat more frequently than usual.
   2 I regularly eat more often and/or greater amounts of food than usual.
   3 I feel driven to overeat both at mealtime and between meals.

8. Decreased Weight (Within the Last Two Weeks):

   0 I have not had a change in my weight.
   1 I feel as if I've had a slight weight loss.
   2 I have lost 2 pounds or more.
   3 I have lost 5 pounds or more.

9. Increased Weight (Within the Last Two Weeks):

   0 I have not had a change in my weight.
   1 I feel as if I've had a slight weight gain.
   2 I have gained 2 pounds or more.
   3 I have gained 5 pounds or more.

10. Concentration/Decision Making:

    0 There is no change in my usual capacity to concentrate or make decisions.
    1 I occasionally feel indecisive or find that my attention wanders.
    2 Most of the time, I struggle to focus my attention or to make decisions.
    3 I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of Myself:

    0 I see myself as equally worthwhile and deserving as other people.
    1 I am more self-blaming than usual.
    2 I largely believe that I cause problems for others.
    3 I think almost constantly about major and minor defects in myself.

12. Thoughts of Death or Suicide:

    0 I do not think of suicide or death.
    1 I feel that life is empty or wonder if it's worth living.
    2 I think of suicide or death several times a week for several minutes.
    3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General Interest:

    0 There is no change from usual in how interested I am in other people or activities.
    1 I notice that I am less interested in people or activities.
    2 I find I have interest in only one or two of my formerly pursued activities.
    3 I have virtually no interest in formerly pursued activities.

14. Energy Level:

    0 There is no change in my usual level of energy.
    1 I get tired more easily than usual.
    2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
    3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

    0 I think, speak, and move at my usual rate of speed.
    1 I find that my thinking is slowed down or my voice sounds dull or flat.
    2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
    3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

    0 I do not feel restless.
    1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
    2 I have impulses to move about and am quite restless.
    3 At times, I am unable to stay seated and need to pace around.

<u>To Score</u>:

1. Enter the highest score on any 1 of the 4 sleep items (1-4) ____
2. Item 5 ____
3. Enter the highest score on any 1 appetite/weight item (6-9) ____
4. Item 10 ____
5. Item 11 ____
6. Item 12 ____
7. Item 13 ____
8. Item 14 ____
9. Enter the highest score on either of the 2 psychomotor items (15 and 16) ____

TOTAL SCORE (Range 0-27) ____

Scoring Criteria	
0–5	Normal
6–10	Mild
11–15	Moderate
16–20	Severe
≥21	Very Severe

Revised 5/1/00

Patient Health Questionnaire – PHQ-9 (www.depression-primarycare.org)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	❒	❒	❒	❒
b. Feeling down, depressed, or hopeless.	❒	❒	❒	❒
c. Trouble falling/staying asleep, sleeping too much.	❒	❒	❒	❒
d. Feeling tired or having little energy.	❒	❒	❒	❒
e. Poor appetite or overeating.	❒	❒	❒	❒
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	❒	❒	❒	❒
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	❒	❒	❒	❒
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	❒	❒	❒	❒
i. Thoughts that you would be better off dead or of hurting yourself in some way.	❒	❒	❒	❒

2. If you checked off any problem on this questionnaire so far, 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

TOTAL SCORE _____

***PHQ-9* score**	***Severity***
0 - 4	Minimal
5 - 9	Mild
10 - 14	Moderate
15 - 19	Moderately severe
20 - 27	Severe

PHQ-9 is adapted from PRIME MD TODAY

Generalized Anxiety Disorder 7-item (GAD-7) Scale

Please circle the best response based on your experiences during the past 2 weeks.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge.	0	1	2	3
Not being able to stop or control worrying.	0	1	2	3
Worrying too much about different things.	0	1	2	3
Trouble relaxing.	0	1	2	3
Being so restless that it's hard to sit still.	0	1	2	3
Becoming easily annoyed or irritable.	0	1	2	3
Feeling afraid as if something awful might happen.	0	1	2	3
Add the score in each column:				

TOTAL SCORE: _____

If you checked off any problems, 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

Score	
0-4	Normal
5-9	Mild
10-14	Moderate
15-21	Severe

GAD-7 developed by PRIME-MD/Pfizer Inc.; in the public domain.

Perceived Deficits Questionnaire – Depression (PDQ-D) 5-item

The following questions describe problems people may have with their memory, attention or concentration. Please circle the best response based on your experiences during the past 7 days.

During the past 7 days, how often did you…	**Never in the past 7 days**	**Rarely (once or twice)**	**Sometimes (3 to 5 times)**	**Often (about once a day)**	**Very often (more than once a day)**
Have trouble getting things organized?	0	1	2	3	4
Have trouble concentrating on what you were reading?	0	1	2	3	4
Forget the date unless you looked it up?	0	1	2	3	4
Forget what you talked about after a telephone conversation?	0	1	2	3	4
Feel like your mind went totally blank?	0	1	2	3	4
Add the score in each column:					

TOTAL SCORE: _____

Total Score	**Cognitive Problems**
0-5	None or minimal problem
6-10	Mild problems
11-15	Moderate problems
16-20	Severe problems

BC-CCI – E

Name _____ Date _____

Please rate your problems with concentration, memory, and thinking skills during the past 7 days.

Use this scale: 0 = Not at all 1 = Some 2 = Quite a bit 3 = Very much

Past 7 Days

Forgetfulness / Memory Problems ..... _____

Poor concentration ..... _____

Trouble expressing my thoughts ..... _____

Trouble finding the right word ..... _____

Slow thinking speed ..... _____

Trouble figuring things out or solving problems ..... _____

Please answer the questions below regarding how you feel in the **past 7 days**. Circle your response.

1. The symptoms I noted above make it difficult for me to do my job (if not working, answer based on your last job).

   False, Not at all True Slightly True Mainly True Very True

2. The symptoms I noted above make it difficult for me to have good relationships with my family and friends.

   False, Not at all True Slightly True Mainly True Very True

3. The symptoms I noted above make it difficult for me to enjoy social activities, recreational activities, or hobbies.

   False, Not at all True Slightly True Mainly True Very True

Lam Employment Absence and Productivity Scale (LEAPS)

Name: _____ Date: _____

Although all forms of work including house work, child care, and others are important, the next questions are about the employed or self-employed paid work that you may do. Please do not include house work, volunteer work, or school work.

1. What kind of paid work do you do? _____

2. **Over the past 2 weeks**, how many hours were you scheduled or expected to work? _____

3. **Over the past 2 weeks**, how many hours of work did you miss because of the way you were feeling? _____

4. **Over the past 2 weeks,** how often at work were you bothered by any of the following problems? Please limit your answers to the time when you were at work. Please circle your ratings.

	None of the time (0%)	Some of the time (25%)	Half the time (50%)	Most of the time (75%)	All of the time (100%)
a) Low energy or motivation.	0	1	2	3	4
b) Poor concentration or memory.	0	1	2	3	4
c) Anxiety or irritability.	0	1	2	3	4
d) Getting less work done.	0	1	2	3	4
e) Doing poor quality work.	0	1	2	3	4
f) Making more mistakes.	0	1	2	3	4
g) Having trouble getting along with people, or avoiding them.	0	1	2	3	4
Add up score in each column:					

Total Score (0-28) = _____

Score	Work Impairment
0-5	None to minimal
6-10	Mild
11-16	Moderate
17-22	Severe
23-28	Very severe

Lam RW et al. A new clinical rating scale for work absence and productivity. BMC Psychiatry 2009; 9:78.

FIBSER Scale

Please choose and circle your response based on side effects that you believe are caused by medications for depression **IN THE PAST WEEK**.

Do **NOT** rate side effects if you believe they are caused by medications for medical conditions other than depression.

1. IN THE PAST WEEK, how **much of the time** did you experience side effects caused by medications for depression?

0	1	2	3	4	5	6
None of the time (no side effects)	10% of the time	25% of the time	50% of the time	75% of the time	90% of the time	All the time

2. IN THE PAST WEEK, how **severe** were the side effects to your medications for depression?

0	1	2	3	4	5	6
None (no side effects)	Minimal severity	Mild severity	Moderate severity	Marked severity	Severe severity	Intolerable severity

3. IN THE PAST WEEK, how much have the side effects to your medications for depression **interfered** with your day-to-day activities?

0	1	2	3	4	5	6
No interference with activities	Minimal interference with activities	Mild interference with activities	Moderate interference with activities	Marked interference with activities	Severe interference with activities	Unable to function

Clinical Relevance: Question 3	
0 – 2	No changes needed.
3 – 4	Side effect should be addressed.
5 – 6	Change treatment.

Adapted by Dr. Raymond W. Lam, with permission from Wisniewski SR et al, J Psychiatr Prac 2006;12:71-9.

MDC Scales Summary Form

Enter all scores for each visit date

Date ➔									
QIDS-SR **or** **PHQ-9** **(subtract 1 point per category)**	Severe; Very (16-20; ≥21)								
	Moderate (11-15)								
	Mild (6-10)								
	None/Minimal (0-5)								
GAD-7	Severe (15-21)								
	Moderate (10-14)								
	Mild (5-9)								
	None/Minimal (0-4)								
PDQ-5	Severe (16-20)								
	Moderate (11-15)								
	Mild (6-10)								
	None/Minimal (0-5)								
SDS	Extreme (30)								
	Marked (14-27)								
	Moderate (12-16)								
	None/Mild (0-9)								
LEAPS	Severe; Very (17-22; 23-28)								
	Moderate (11-16)								
	Mild (6-10)								
	None/Minimal (0-5)								
FIBSER	Marked/Severe (4-6)								
	Mild/Moderate (2-3)								
	None/Minimal (1-2)								