DEPRESSION SCALE ASSESSMENT

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ARK INTEGRATIVE MEDICINE

PATIENT NAME _____ TREATMENT # _____ DATE _____

During the past week, including today…	Not At All 0	Rarely 1	Some-times 2	Often 3	Almost Always 4
1. Little interest or pleasure in doing things……	☐	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless……	☐	☐	☐	☐	☐
3. Trouble falling or staying asleep or sleeping too much……..	☐	☐	☐	☐	☐
4. Feeling tired or having little energy……	☐	☐	☐	☐	☐
5. Poor appetite or overeating……	☐	☐	☐	☐	☐
6. Feeling bad about yourself- or that you are a failure or have let yourself family down ……	☐	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television ……	☐	☐	☐	☐	☐
8. Moving or speakin g so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual ……	☐	☐	☐	☐	☐
9. Thought that you would be better off dead, or of hurting yourself ……	☐	☐	☐	☐	☐

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