THE MOOD SCREENER

Name: …….…….. **Date:** …… [Patient ID: …….] *Office use only*

	A. Lifetime		B. Current	
	Have you ever had two weeks or more when nearly every day you…	**Check if any "Yes" in each Section**	**Have you had this problem nearly every day in the last two weeks?**	**Check if any "Yes" in each section**
❶ Felt sad, blue, or depressed most of the day nearly every day?	☐ Yes ☐ No	1 ☐	☐ Yes ☐ No	1 ☐
❷ Lost all interest or pleasure in things you usually cared about or enjoyed?	☐ Yes ☐ No	2 ☐	☐ Yes ☐ No	2 ☐
❸ **a.** Lost or increased your appetite nearly every day?	☐ Yes ☐ No		☐ Yes ☐ No	
b. Lost weight without trying to? (*Over 2 lbs. per week*)	☐ Yes ☐ No	3 ☐	☐ Yes ☐ No	3 ☐
c. Gained weight without trying to?	☐ Yes ☐ No		☐ Yes ☐ No	
❹ **a.** Had trouble falling sleep, staying sleep, or waking up too early?	☐ Yes ☐ No	4 ☐	☐ Yes ☐ No	4 ☐
b. Been sleeping too much nearly every day?	☐ Yes ☐ No		☐ Yes ☐ No	
❺ **a.** Talked or moved more slowly than is normal for you?	☐ Yes ☐ No	5 ☐	☐ Yes ☐ No	5 ☐
b. Had to be moving all the time, that is, couldn't sit still and paced up or down?	☐ Yes ☐ No		☐ Yes ☐ No	
❻ **a.** Felt tired or without energy all the time?	☐ Yes ☐ No	6 ☐	☐ Yes ☐ No	6 ☐
❼ **a.** Felt worthless, sinful, or guilty nearly every day?	☐ Yes ☐ No	7 ☐	☐ Yes ☐ No	7 ☐
❽ **a.** Had a lot more trouble concentrating or making decisions than is normal for you?	☐ Yes ☐ No	8 ☐	☐ Yes ☐ No	8 ☐
b. Noticed that your thoughts came much slower than usual or seemed mixed up nearly every day?	☐ Yes ☐ No		☐ Yes ☐ No	
❾ **a.** Thought a lot about death—either your own, someone else's, or death in general?	☐ Yes ☐ No		☐ Yes ☐ No	
b. Wanted to die?	☐ Yes ☐ No	9 ☐	☐ Yes ☐ No	9 ☐
c. Felt so low you thought about committing suicide?	☐ Yes ☐ No		☐ Yes ☐ No	
d. Attempted suicide?	☐ Yes ☐ No		☐ Yes ☐ No	
		Number of boxes checked: = _____		**Number of boxes checked:** = _____
Did these problems interfere with your life or activities a lot?	☐ Yes ☐ No	☐	☐ Yes ☐ No	☐