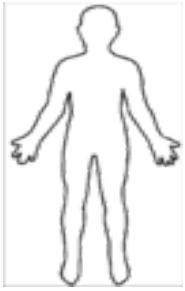
NAME: DATE:

OVER THE LAST 2 WEEKS, how often have you been bothered by the following?

1) Physical ailments (please specify what you are experiencing such as headaches, stomachs, muscle tension) and where on your body you feel the pain.



- □ 0 – Not at all
- □ **1**– Several Days
- □ 2 – More than half the days
- □ 3 – Nearly everyday

2) Feeling nervous, anxious or on edge

- □ 0 – Not at all
- □ 1 – Several Days
- □ 2 – More than half the days
- □ 3 – Nearly everyday

3) Not being able to stop or control worrying

- □ 0 – Not at all
- □ 1 – Several Days
- □ 2 – More than half the days
- □ 3 – Nearly everyday

4) Little interest or pleasure in doing things

- □ 0 – Not at all
- □ 1 – Several Days
- □ 2 – More than half the days
- □ 3 – Nearly everyday

5) Feeling down, depressed or hopeless

- □ 0 – Not at all
- □ 1 – Several Days
- □ 2 – More than half the days
- □ 3 – Nearly everyday

5) Thoughts you would be better off dead or hurting yourself in some way.

- □ 0 – Not at all
- □ 1 – Several Days
- □ 2 – More than half the days
- □ 3 – Nearly everyday