



Please affix patient label here

Family Name

URN

Given Names

Date of Birth

Sex  M  F

Choose the best answer (YES or NO) for how you felt over the **past week, including today.**

- |                                                                               | YES | NO | Score |
|-------------------------------------------------------------------------------|-----|----|-------|
| 1. Are you basically satisfied with your life?                                |     |    |       |
| 2. Have you dropped many of your activities and interests?                    |     |    |       |
| 3. Do you feel that your life is empty?                                       |     |    |       |
| 4. Do you often get bored?                                                    |     |    |       |
| 5. Are you in good spirits most of the time?                                  |     |    |       |
| 6. Are you afraid that something bad is going to happen to you?               |     |    |       |
| 7. Do you feel happy most of the time?                                        |     |    |       |
| 8. Do you often feel helpless?                                                |     |    |       |
| 9. Do you prefer to stay at home, rather than going out and doing new things? |     |    |       |
| 10. Do you feel you have more problems with memory than most?                 |     |    |       |
| 11. Do you think it is wonderful to be alive now?                             |     |    |       |
| 12. Do you feel pretty worthless the way you are now?                         |     |    |       |
| 13. Do you feel full of energy?                                               |     |    |       |
| 14. Do you feel that your situation is hopeless?                              |     |    |       |
| 15. Do you think that most people are better off than you are?                |     |    |       |

**TOTAL**

Interviewer Name: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Scoring instructions:

Either hold this page up to the light and assign one point to any response that appears shaded; or assign one point for each of these answers:

- |        |         |        |         |        |         |         |        |
|--------|---------|--------|---------|--------|---------|---------|--------|
| 1. No  | 2. Yes  | 3. Yes | 4. Yes  | 5. No  | 6. Yes  | 7. No   | 8. Yes |
| 9. Yes | 10. Yes | 11. No | 12. Yes | 13. No | 14. Yes | 15. Yes |        |

A score >5 suggests possible depression.

GERIATRIC DEPRESSION SCALE (SHORT FORM)

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

