

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

Use “ ” to indicate your answer.

	Not at all	Several Days	More than half the days	Nearly Every Day
1. Little Interest of pleasure doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Troubling falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling Tired or having little energy	0	1	2	3
5. Poor Appetite or overeating	0	1	2	3
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble Concentrating on things such as reading the newspaper or watching television	0	1	2	3
8. 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 a lot more than usual?	0	1	2	3
9. Thoughts that you'd have been better off dead or of hurting yourself in some way	0	1	2	3

For Office Coding

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

1.) Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly Every Day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble Relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or Irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

For Office Coding

Total Score= _____

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

1. Has there been a period in time when you were not your usual self and...	Yes	No
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
... you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
... you felt so much more self confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... you got much less sleep than usual and found you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
... you were much more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
... you had much more energy or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
... you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	<input type="checkbox"/>	<input type="checkbox"/>
... spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>
2. If you have checked YES to more than one of the above, have several of these every happened during the same period of time?	<input type="checkbox"/>	<input type="checkbox"/>
3. How much of a problem did any of these cause you- like being unable to work; having money or legal troubles; getting into arguments or fights?		
<input type="checkbox"/> No Problem <input type="checkbox"/> Minor Problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>