

Name _____

Date of birth _____

Date completed _____

**Columbia Depression Scale (Ages 11 and over)
Present State (last 4 weeks)
TO BE COMPLETED BY TEEN**

If the answer to the question is "No," check the box beneath "No"; if it is "Yes", check the box below "Yes". Please answer the following questions as honestly as possible.

- | In the last four weeks... | No | Yes |
|--|--------------------------|--------------------------|
| 1. Have you often felt sad or depressed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you felt like nothing is fun for you and you just aren't interested in anything? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you often felt grouchy or irritable and often in a bad mood, when even little things would make you mad? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you lost weight, more than just a few pounds? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you lost your appetite or often felt less like eating? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you gained a lot of weight, more than just a few pounds? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you felt much hungrier than usual or eaten a lot more than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you had trouble sleeping, that is, trouble falling asleep, staying asleep, or waking up too early? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you slept more during the day than you usually do? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you often felt slowed down...like you walked or talked much slower than you usually do? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you often felt restless...like you had to keep walking around? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you had less energy than you usually do? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Has doing even little things made you feel really tired? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you often blamed yourself for bad things that happened? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you felt you couldn't do anything well or that you weren't as good-looking or as smart as other people? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has it seemed like you couldn't think as clearly or as fast as usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you often had trouble keeping your mind on your [schoolwork / work] or other things? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has it often been hard for you to make up your mind or to make decisions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you often thought about death or about people who had died or about being dead yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you thought seriously about killing yourself? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you tried to kill yourself in the last four weeks? | <input type="checkbox"/> | <input type="checkbox"/> |