

Number: _____

Patient Name: _____ Gender: _____

Permanent Address: _____ Age: _____

S. NO.	VARIABLE	QUERY	(None) 0	(Little) 1	(Some) 2	(Much) 3	(Most) 4
1.	Acute Sadness	How often are you feeling down, depressed, irritable, sad or hopeless?					
2.	Loss of Concentration	How often do you have little interest or pleasure in doing normal things?					
3.	Abnormal Sleep	How often are you having trouble falling asleep or sleeping too much?					
4.	Abnormal Appetite	How often do you have a poor appetite, or you overeat?					
5.	Loss of Energy	How often have you been feeling tired, or having little energy or feel lifeless?					
6.	Feel of Guilt	How often have you been feeling bad about yourself or feeling that you are a failure, or that you have let yourself or your family down?					
7.	Abnormal Social Behavior	How often have you been moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual and is noticeable?					
8.	Suicidal thoughts	How often have you been bothered by thoughts that you would be better off dead, or of hurting yourself in some way?					
9.	Persistent Pains	How often do you feel aches or cramps without a clear cause?					
10.	Emotional activity	Have you been more easily tearful or crying more than usual?					

S. NO.	VARIABLE	QUERY	(YES) 1	(NO) 0
1.	Overall functioning disturbed	Do you feel that this has affected your overall life process?		
2.	Weight loss	Have you lost weight?		
3.	Relationship functioning disturbed	Is your relationship with your spouse or family affected by this?		

4.	Social support	Did you get any kind of social support from your family and relatives?		
5.	Prior work competence	Did you do well academically or work well prior this?		
6.	Effort to do simple things	Do you need great effort to do simple things/is it difficult for you?		
7.	Decision Making	Are you able to make decisions?		
8.	Acute Social Anxiety	Do you feel that people judge you negatively which leads to humiliation, embarrassment?		
9.	Loss of Enjoyment	Loss of enjoyment in things that were once pleasurable/pleasure gone in life?		
10.	Family History of psychiatric illness	Is anyone from your family suffering from psychiatric disorder?		
11.	Pessimism	Have you been feeling more pessimistic or negative than usual?		
12.	Addiction	Do you have any kind of addiction(say cigarettes, drugs etc)?		
13.	Marital Status	Are you married?		
14.	Unemployment	Are you unemployed?		
15.	Prior Illness	Did you have any life threatening illness?		
16.	Religious activity	Did you offer prayers or were involved in any religious activity prior to this?		
17.	Religious effect	Does offering prayer help you now/support you now?		
18.	Death of close relative	Has any of your close relative died?		
19.	Killing of a close relative	Is there any of your close relative murdered/martyred by enemies?		
20.	Tortured or beaten	Have you anytime been beaten up or tortured by forces?		
21.	Witnessed Others in peril	Did you witness any threatened situation happened with other people?		
22.	Torture of a close relative	Has any of your close relative been tortured ruthlessly by enemies?		
23.	Witnessing arrests	Did you witness any arrests of your relative by the forces?		
24.	Eye contact	Lack of eye contact.		
25.	Hand Positioning	Pacing, hand wringing, and pulling on hair.		
26.	Appearance	Psychomotor retardation or agitation, such as slowed speech, sighs, and long pauses.		