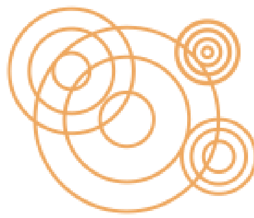

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Rating Scale of Recent Experience

DATE ______________________

NAME ____ **SEX** _____ **AGE** _____

Over the past 2 weeks how often have you been bothered by any of the following?
Circle a number to indicate your response.

FEELINGS	Not at all (0)	Sometimes (1)	Often (2)	Almost always (3)
1. Little interest or pleasure in enjoyable activities	0	1	2	3
2. Feeling down, depressed, or discouraged	0	1	2	3
3. Difficulty with sleep (too much or too little)	0	1	2	3
4. Feeling tired and low on energy	0	1	2	3
5. Loss of appetite or overeating	0	1	2	3
6. Feeling bad about yourself	0	1	2	3
7. Trouble concentrating	0	1	2	3
8. Feeling agitated	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
10. Feeling inadequate or inferior to others	0	1	2	3
11. Feeling lonely	0	1	2	3
12. Feeling anxious, nervous, worried, or fearful	0	1	2	3
13. Sudden unexpected panic spells	0	1	2	3
14. Feeling apprehensive	0	1	2	3
15. Feeling tense, stressed, "uptight" or on edge	0	1	2	3
16. Feeling easily frustrated or irritated	0	1	2	3
17. Feeling overwhelmed	0	1	2	3
18. Having difficulty completing tasks	0	1	2	3
19. Having difficulty sustaining attention	0	1	2	3
20. Having temper outbursts	0	1	2	3
Total Scores	0			

Sum of Total Scores:____________