K-10+

Patient or Client Identifier:
|___|___|___|___|___|___|___|___|___|___|
Surname:
Other names:
Date of Birth: Gender:
___ ___ / ___ ___ / ___ ___ ___ ___ Male ☐1 Female ☐2 Other ☐3
Address:

Date completed: _ _ / _ _ / _ _ _ _

Instructions

The following ten questions ask about how you have been feeling in the **last four weeks**. For each question, mark the circle under the option that best describes the amount of time you felt that way.

		None of the time	A little of the time	Some of the time	Most of the time	All of the time
1.	In the last four weeks, about how often did you feel tired out for no good reason?	O	O	O	O	O
2.	In the last four weeks, about how often did you feel nervous?	O	O	O	O	O
3.	In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	O	O	O	O	O
4.	In the last four weeks, about how often did you feel hopeless?	O	O	O	O	O
5.	In the last four weeks, about how often did you feel restless or fidgety?	O	O	O	O	O
6.	In the last four weeks, about how often did you feel so restless you could not sit still?	O	O	O	O	O
7.	In the last four weeks, about how often did you feel depressed?	O	O	O	O	O
8.	In the last four weeks, about how often did you feel that everything was an effort?	O	O	O	O	O
9.	In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	O	O	O	O	O
10.	In the last four weeks, about how often did you feel worthless?	O	O	O	O	O

Please turn over – there are a few more questions on the other side

The next few questions are about how these feelings may have affected you in the **last four weeks.** You need not answer these questions if you answered 'None of the time' to all of the ten questions about your feelings

11.	In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?	_____ (Number of days)
12.	[Aside from those days], in the last 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?	_____ (Number of days)
13.	In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings?	_____ (Number of consultations)
14.	In the last 4 weeks, how often have physical health problems been the main cause of these feelings?	
	None of the time	O
	A little of the time	O
	Some of the time	O
	Most of the time	O
	All of the time	O

Thank you for completing this questionnaire.

Please return it to the staff member who asked you to complete it.