

**BEHAVIORAL HEALTH PARTNERS (BHP)**

Date: \_\_/\_\_/\_\_\_\_

Name: \_\_\_\_\_

This survey will take approximately 10 minutes to complete. It contains questions about your emotional health over the past two weeks. Please give this completed survey to your BHP clinician who will talk with you about your responses to the survey. You may skip any questions that you do not wish to answer. Thank you so much for taking the time to complete this survey.

**Over the past two weeks, how often have you been bothered by any of the following problems?**

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead, or hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?			<input type="checkbox"/>	Not difficult at all
			<input type="checkbox"/>	Somewhat difficult
			<input type="checkbox"/>	Very difficult
			<input type="checkbox"/>	Extremely difficult

