MAJOR DEPRESSION SCREENING –DSM-IV

Patient's Name : _____ Date: _____

A. Have any of the following symptoms been present in your child for greater than 2 weeks and have been a change in the way your child normally functions. (Please mark any that apply.)

____ depressed mood most of the day (feels sad, empty, or tearful)
____ irritable mood
____ diminished interest in all (or almost all) activities
____ significant weight loss or weight gain
____ poor appetite or overeating
____ insomnia or excessive sleeping
____ restlessness
____ appearing slowed down/ flat emotions
____ fatigue or loss of energy
____ feelings of worthlessness or excessive guilt (low self esteem)
____ feelings of hopelessness
____ poor concentration or difficulty making decisions
____ recurrent thoughts of death or suicide
____ suicide attempted or planned

A1. How long has your child had these symptoms? _____
Do these symptoms occur more often than not? _____

B. Are any of the symptoms above ever mixed with periods of increased energy, hyperactivity, excessive activity with little sleep, aggressiveness, or extreme mood changes? _____

C. Does your child's symptoms cause problems at home, with friends or with performance at school? (If yes, please explain.) _____
_____
_____

D. Does your child have any medical conditions (e.g., hyperthyroidism)? (Please list)
_____
Does your child take any medicine regularly? (If yes, please list.)
_____

Does you child use illegal drugs or alcohol or do you suspect this? _____

E. Did any of the above symptoms occur after the death of a loved one or after a stressful event in your child's life? _____
F. Has your child ever had hallucinations or unusual delusions? _____