



TEEN MOOD SCREENING QUESTIONNAIRE

(For patient to complete)

Name: _____ DOB: _____

Over the last two weeks, how often have you been bothered by the following problems?

Low Mood	Not at all	Several days	More than half the days	Nearly every day or every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/staying asleep, sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as school work, reading, or watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being restless more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3

Anxiety	Not at all	Several days	More than half the days	Nearly every day or every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

	Not at all difficult	Somewhat difficult	Very difficult	Extremely difficult
How difficult have these problems made it for you to do your schoolwork, participate in any chores or extracurricular activities, or get along with other people?	0	1	2	3