

Signs and Symptoms

Name _____ Date _____

Please tick the most appropriate box								
During the last month, have you:	(a) Almost never	Points	(b) Some times	Points	(c) Most of the time	Points	(d) Almost all the time	Points
1. Been easily irritated by people or trivial events?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
2. Felt impatient?	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
3. Felt unable to cope?	<input type="checkbox"/>	0	<input type="checkbox"/>	10	<input type="checkbox"/>	20	<input type="checkbox"/>	30
4. Felt a failure?	<input type="checkbox"/>	0	<input type="checkbox"/>	10	<input type="checkbox"/>	20	<input type="checkbox"/>	30
5. Found it difficult to make decisions?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
6. Lost interest in other people?	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
7. Felt you had no one to confide in or talk to about your problems?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
8. Found it difficult to concentrate?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
9. Failed to finish tasks/jobs before moving onto the next, leaving jobs incomplete?	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
10. Felt neglected in any way?	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
11. Tried to do too many things at once?	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
12. Felt anxious or depressed?	<input type="checkbox"/>	0	<input type="checkbox"/>	10	<input type="checkbox"/>	20	<input type="checkbox"/>	30
13. Been uncharacteristically aggressive?	<input type="checkbox"/>	0	<input type="checkbox"/>	10	<input type="checkbox"/>	20	<input type="checkbox"/>	30
14. Felt bored?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
15. Changed your patterns of drinking, smoking or eating?	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
16. Changed your level of sexual activity?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
17. Cried or had the desire to cry?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
18. Felt tired most of the time?	<input type="checkbox"/>	0	<input type="checkbox"/>	2	<input type="checkbox"/>	4	<input type="checkbox"/>	6
19. Suffered from any of the following more frequently? back and neck pain, headaches, muscular aches and pains, muscular spasms and cramps, constipation, diarrhea, loss of appetite, heartburn, indigestion and nausea	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
20. Do two or more of the following apply to you? bite your nails, clench your fists, drum your fingers, grind your teeth, hunch your shoulders, tap your feet, have trouble falling or staying asleep	<input type="checkbox"/>	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3
Your scores								
Your total score								

Evaluation

If your score is over 30 then you are most likely to be suffering from distress. The higher you score towards the maximum of 192 the more distress you are suffering. Scores of over 60 are a cause for concern and indicate that you should discuss your lifestyle with your doctor.