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NAME _____ DATE _____

MOOD QUESTIONNAIRE

PLEASE RATE HOW YOU FEEL ON THE SCALE UNDER EACH STATEMENT

1. I FEEL SAD OR EMPTY MOST OF THE DAY OR MORE DAYS THAN NOT

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

2. MY INTEREST IN DAILY ACTIVITY, SEX, OR LIFE IN GENERAL, ESPECIALLY THE THINGS I USED TO ENJOY IS LESS

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

3. I HAVE LOST OR GAINED A SIGNIFICANT AMOUNT OF WEIGHT

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

4. I HAVE TROUBLE SLEEPING AT NIGHT OR I AM SLEEPING MORE

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

5. I FEEL RESTLESS OR I FEEL AS IF I AM SLOWING DOWN

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

6. I AM FREQUENTLY FATIGUED AND HAVE LESS ENERGY

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

7. I HAVE FEELINGS OF WORTHLESSNESS OR GUILT

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

8. I HAVE TROUBLE CONCENTRATING; I AM INDECISIVE

0 1 2 3 4 5 6 7 8 9 10
LESS MORE

9. I THINK ABOUT DEATH A LOT

0 1 2 3 4 5 6 7 8 9 10
LESS MORE