Client ID# ___________ Date: ___/___/___

# CES-D Short Form Depression Screening Questionnaire

**Below is a list of ways you might have felt or behaved.**
**Please indicate how often you have felt this way DURING THE LAST WEEK.**

| | | CIRCLE ONE NUMBER ON EACH LINE | | | |
|---|---|---|---|---|---|
| **Main Questions** | | **Rarely** | **Some of the time** | **Occasionally** | **All of the time** |
| 1. | I was bothered by things that don't usually bother me. | 0 | 1 | 2 | 3 |
| 2. | I had trouble keeping my mind on what I was doing. | 0 | 1 | 2 | 3 |
| 3. | I felt depressed. | 0 | 1 | 2 | 3 |
| 4. | I felt everything I did was an effort. | 0 | 1 | 2 | 3 |
| 5. | I felt hopeful about the future.** | 0 | 1 | 2 | 3 |
| 6. | I felt fearful. | 0 | 1 | 2 | 3 |
| 7. | My sleep was restless. | 0 | 1 | 2 | 3 |
| 8. | I was happy.** | 0 | 1 | 2 | 3 |
| 9. | I felt lonely. | 0 | 1 | 2 | 3 |
| 10. | I could not get going. | 0 | 1 | 2 | 3 |
| **Additional Questions** | | | | | |
| | I feel like everyone is against me. | 0 | 1 | 2 | 3 |
| | I feel very angry or irritable. | 0 | 1 | 2 | 3 |
| | I feel like giving up. | 0 | 1 | 2 | 3 |
| | I'm worried that something might happen to myself or my baby | 0 | 1 | 2 | 3 |
| | I feel like I hurting myself, my pregnancy, (or my baby), or others. | 0 | 1 | 2 | 3 |
| ** Items 5 and 8 are reversed before adding them to the total score. | | | | | |

**For Nurse To Complete:**

1. Is this client prenatal? If yes, number of weeks: ______

2. Is this client postpartum? If yes, how many weeks: ______