



## Adult Symptom Battery

Client Name \_\_\_\_\_ Date \_\_\_\_\_ Pre-test ☐ Post-test ☐

**Over the last two weeks how often have you been bothered by these problems?**

<i>Circle only one answer for each statement</i>	Not at all	Several Days	More than half the days	Nearly Every Day	Always
Little interest or pleasure in doing things	0	1	2	3	4
Feeling down, depressed or hopeless	0	1	2	3	4
Trouble falling asleep, staying asleep, or too much sleep	0	1	2	3	4
Feeling tired or having little energy	0	1	2	3	4
Feeling bad about yourself or that you are a failure, or you have let someone down	0	1	2	3	4
Trouble concentrating on things, or ability to focus on reading or watching TV	0	1	2	3	4
Being more fidgety or restless than usual	0	1	2	3	4
Thoughts you would be better off dead or hurting yourself	0	1	2	3	4
Feeling nervous, anxious or on edge	0	1	2	3	4
Not being able to stop or control worrying	0	1	2	3	4
Worrying too much or about things you would not normally worry about?	0	1	2	3	4
Trouble relaxing or sitting still	0	1	2	3	4
Becoming easily annoyed or more irritable lately	0	1	2	3	4
<i>Column Totals</i>					
<i>Total Score</i>					