

K10+



For all questions, please fill in the appropriate box to indicate your answer.

The maximum score is 50, indicating severe distress.

The minimum score is 10, indicating no distress.

Name:

Date:

In the past 4 weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1 About how often did you feel tired out for no good reason?	☐	☐	☐	☐	☐
2 About how often did you feel nervous?	☐	☐	☐	☐	☐
3 About how often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐
4 About how often did you feel hopeless?	☐	☐	☐	☐	☐
5 About how often did you feel restless or fidgety?	☐	☐	☐	☐	☐
6 About how often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐
7 About how often did you feel depressed?	☐	☐	☐	☐	☐
8 About how often did you feel that everything was an effort?	☐	☐	☐	☐	☐
9 About how often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐
10 About how often did you feel worthless?	☐	☐	☐	☐	☐

(More questions over-page)

The next few questions are about how these feelings may have affected you in the last four weeks.

You don't need to answer these questions if you answered 'None of the time' to all of the ten questions about your feelings.

11 In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings?

(No. of days)

12 (Aside from those days), in the last 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings?

(No. of days)

13 In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings?

(No. of consultations)

14 In the last 4 weeks, how often have physical health problems been the main cause of these feelings?

None of the time:

☐

A little of the time:

☐

Some of the time:

☐

Most of the time:

☐

All of the time:

☐

Thank you for completing!

Please return to the staff member who asked you to complete this form.