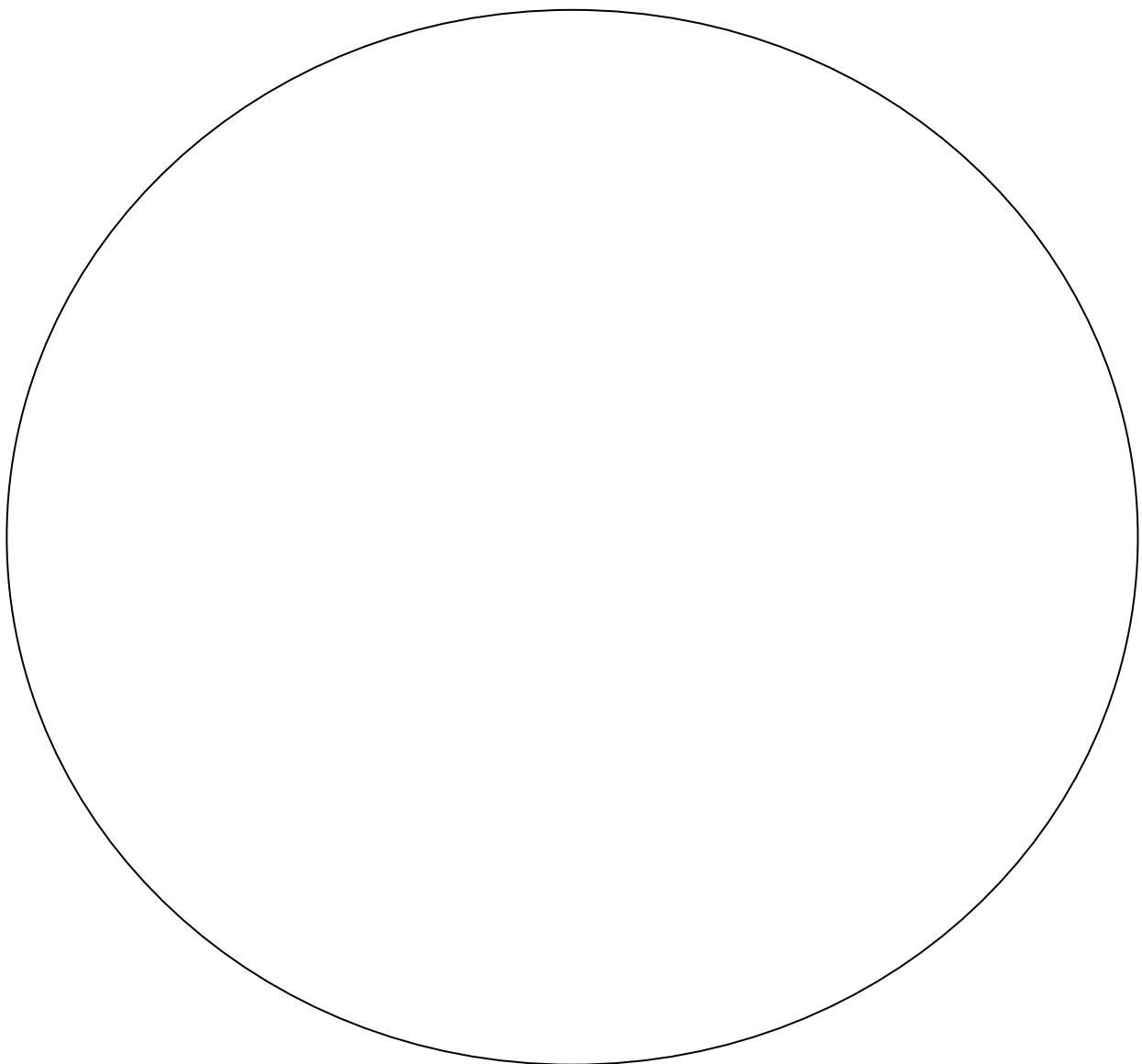


Name	Date
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Please draw a clock, including the numbers and hands, showing time 10 minutes after 11



Name	Date
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Over the past two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thoughts that you would be better off dead or of hurting yourself in some way.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you checked off the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
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Name	Date
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1. What is your age? _____

2. In general, compared to other people your age, would you say that your health is:

- Poor
- Fair
- Good
- Very Good
- Excellent

3. How much difficulty, on average, do you have with the following physical activities:

	No Difficulty	A little Difficulty	Some Difficulty	A lot of Difficulty	Unable to do
Stooping, crouching or kneeling?	<input type="checkbox"/>				
Lifting or carrying objects as heavy as 10 pounds?	<input type="checkbox"/>				
Reaching or extending arms above shoulder level?	<input type="checkbox"/>				
Writing, or handling and grasping small objects?	<input type="checkbox"/>				
Walking a quarter of a mile?	<input type="checkbox"/>				
Heavy housework such as scrubbing floors or washing windows?	<input type="checkbox"/>				

Name	Date
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4. Because of your health or a physical condition, do you have any difficulty:

a) Shopping for personal items (like toiletries or medicines)?

- YES → Do you get help with shopping? Yes No
 NO
 DON'T DO → Is it because of your health? Yes No

b) Managing money (like keeping track of expenses or paying bills)?

- YES → Do you get help with managing money? Yes No
 NO
 DON'T DO → Is that because of your health? Yes No

c) Walking across the room? USE OF CANE OR WALKER IS OK.

- YES → Do you get help with walking? Yes No
 NO
 DON'T DO → Is that because of your health? Yes No

d) Doing light housework (like washing dishes, straightening up, or light cleaning)?

- YES → Do you get help with light housework? Yes No
 NO
 DON'T DO → Is that because of your health? Yes No

e) Bathing or showering?

- YES → Do you get help with bathing or showering? Yes No
 NO
 DON'T DO → Is that because of your health? Yes No