

33 (2) VERSION DIAGNOSTIC CRITERIA FOR DEPRESSION

1. a. Participant's Name: (4) _____
 b. SHEP ID: (3) 22 23 - 24 25 26 27 - 28 29 (5)
 c. Acrostic: 41 42 43 44 45 46 (6)
 2. Date of Clinic Visit: 36 37 38 39 34 35 (7) 3. Sequence #: 47 48 (8)
 Month Day Year
 4. Date of SHORTCARE Evaluation: 51 52 53 54 49 50 (9)
 Month Day Year

For each of the following criteria for depression taken from DSM III, please indicate if the criterion is present or not. If present, please indicate on what basis the judgment is made.

Criterion (DSM III)	Present?	Basis of Judgment
5. Dysphoric mood or loss of interest or pleasure in all or almost all usual activities and past times (10) 55 a. Mood is characterized by symptoms such as depression, sad, blue, hopeless, low, down in the dumps, irritable (11) 56 b. Mood disturbance is prominent and relatively persistent (12) 57	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	
6. At least four of the following symptoms have <u>each</u> been present nearly every day for a period of at least two weeks a. Poor appetite with weight loss or increased appetite with weight gain (13) 58 b. Insomnia or hypersomnia (14) 59 c. Psychomotor agitation or retardation (15) 60 d. Loss of interest or pleasure in sexual activities or decrease in sexual drive (16) 61 e. Loss of energy or fatigue (17) 62 f. Feelings of worthlessness, self-reproach or excessive or inappropriate guilt (18) 63	Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	

Criterion (DSM III)	Present?	Basis of Judgment
g. Complaints or evidence of diminished ability to think or concentrate	64 19 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	
h. Recurrent thoughts of death, suicidal indication, wishes to be dead or suicide attempt	65 20 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	
7. Neither of the following dominate the clinical picture when an affective syndrome is not present		
a. Preoccupation with a mood, delusion or hallucination	66 21 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	
b. Bizarre behavior	67 22 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	
8. Not superimposed upon either schizophrenia, schizophreniform, or paranoid disorder	68 23 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	
9. Not due to any organic mental disorder or uncomplicated bereavement	69 24 Yes <input type="checkbox"/> 1 No <input type="checkbox"/> 2	

10. In your opinion, does this participant have depression? Yes 1 No 2
70 25

11. Signature: _____

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71 72
Code

RECORD TYPE 27 73

DATE RECEIVED 28 74-79

UPDATE NUMBER 29 80-82

DATE LAST PROCESSED 30 83-88

PAPER COPY 31 89

32 Cross-Forms Edit Status

3-8 514 BATCH DATE

11-16 515 DATE MODIFIED

17-20 516 TIME MODIFIED

21 517 EDIT STATUS