

Depression questionnaire

Please indicate if any of the following symptoms or characteristics apply to you.

Score 3 – for those that always or frequently apply

Score 2 – for those that often apply

Score 1 - for those that occasionally apply

Nausea or constipation <input type="checkbox"/>	Ideas of grandeur <input type="checkbox"/>	Anxiety, extreme fears or paranoia <input type="checkbox"/>
White spots on fingernails <input type="checkbox"/>	Feeling 'unreal' <input type="checkbox"/>	Phobias <input type="checkbox"/>
Pale skin which burns easily <input type="checkbox"/>	Hearing your own thoughts <input type="checkbox"/>	Poor concentration or confusion <input type="checkbox"/>
Frequent colds and infections <input type="checkbox"/>	Anxiety and inner tension <input type="checkbox"/>	Poor memory <input type="checkbox"/>
Stretch marks <input type="checkbox"/>	Inability to think straight <input type="checkbox"/>	Angry or aggressive feelings <input type="checkbox"/>
Irregular menstruation <input type="checkbox"/>	Learning difficulties or dyslexia <input type="checkbox"/>	Hyperactivity <input type="checkbox"/>
Impotency <input type="checkbox"/>	Suspicious of people <input type="checkbox"/>	Emotional ups and downs <input type="checkbox"/>
Crowded upper front teeth <input type="checkbox"/>	Good pain tolerance <input type="checkbox"/>	Headaches or migraines <input type="checkbox"/>
Poor tolerance of alcohol or drugs <input type="checkbox"/>	Seeing or hearing things abnormally <input type="checkbox"/>	Sneezing in sunlight <input type="checkbox"/>
Poor dream recall <input type="checkbox"/>	Having delusions or illusions <input type="checkbox"/>	Crying, salivating or feeling nauseous easily <input type="checkbox"/>
Dry mouth <input type="checkbox"/>	Loose bowels or skin problems at onset of illness <input type="checkbox"/>	Easy orgasm with sex <input type="checkbox"/>
Poor memory or forgetfulness <input type="checkbox"/>	Difficult orgasm with sex <input type="checkbox"/>	Abnormal fears, compulsions, rituals <input type="checkbox"/>
Mental exhaustion <input type="checkbox"/>	Tendency to overweight <input type="checkbox"/>	Light sleeper <input type="checkbox"/>
Difficulty concentrating <input type="checkbox"/>	Frequent mood swings <input type="checkbox"/>	Fast metabolism <input type="checkbox"/>
Palpitations or blackouts <input type="checkbox"/>	Forgetfulness or confusion <input type="checkbox"/>	Depression or suicidal thoughts <input type="checkbox"/>
Fainting or dizziness or trembling <input type="checkbox"/>	Tendency to depression <input type="checkbox"/>	Producing a lot of body heat <input type="checkbox"/>
Excessive or night sweats <input type="checkbox"/>	Anxiety or irritability <input type="checkbox"/>	Little body hair and lean build <input type="checkbox"/>
Excessive thirst <input type="checkbox"/>	Feeling weak <input type="checkbox"/>	Large ears or long fingers and toes <input type="checkbox"/>
Chronic fatigue <input type="checkbox"/>	Aggressive outbursts or crying spells <input type="checkbox"/>	Good tolerance of alcohol <input type="checkbox"/>
Dry or rough skin <input type="checkbox"/>	Child history of colic, eczema, asthma, rashes or ear infections <input type="checkbox"/>	Inner tension or 'driven' feeling <input type="checkbox"/>
Dry hair, loss of hair or dandruff <input type="checkbox"/>	Frequent colds or blocked nose <input type="checkbox"/>	Shy or over-sensitive as a child <input type="checkbox"/>
PMS or breast pain <input type="checkbox"/>	Difficulty sleeping <input type="checkbox"/>	Seasonal allergies, eg hayfever <input type="checkbox"/>
Eczema, asthma or joint aches <input type="checkbox"/>	Facial puffiness, circles or discolouration around eyes <input type="checkbox"/>	Fatigue, moods, headaches, red ears or blocked nose after certain foods <input type="checkbox"/>
Dyslexia or learning difficulties <input type="checkbox"/>	Hyperactivity <input type="checkbox"/>	