

AMD-12

Name: _____ DOB: _____ Date: _____

Statements	Answers	
I am more tired / I sleep more than normal	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I have trouble falling or staying asleep	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I have a loss of appetite	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I am losing weight without trying	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I am no longer interested in intimacy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I cry easy or more often	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I am depressed	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I have general aches and pains	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I feel more anxious than usual	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I fidget or am restless prior to or during sleep	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Things seem to irritate me more than usual	<input type="checkbox"/> YES	<input type="checkbox"/> NO
I have not felt like myself lately	<input type="checkbox"/> YES	<input type="checkbox"/> NO