A Simple Procedure for General Screening for Functional Disability in Elderly Patients

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We propose a short, simple approach that can be used by general internists to routinely screen the functional status of elderly patients in office practice. The approach relies on checking a limited number of targets that are commonly dysfunctional but often unappreciated when conventional histories and physical examinations are done for elderly patients. The new focus is on carefully selected tests of vision, hearing, arm and leg function, urinary incontinence, mental status, instrumental and basic activities of daily living, environmental hazards, and social support systems. Brief questions and easily observed tasks are used to obtain the information needed for a suitable, effective screening while minimizing the time for administration. The approach can be incorporated into routine practice if certain relatively unproductive procedures are eliminated from the routine clinical examination, and particularly if internists are suitably compensated for the additional time.


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We propose a screening examination that general internists (or other primary care clinicians) can use to evaluate the functional status of ambulatory elderly patients. The report was prepared in response to an assignment by the American College of Physicians Subcommittee on Aging to develop a simple, reasonably quick screening procedure for routine office practice use and to outline the next steps for managing positive findings.

A prime incentive for this work is the lack of systematic attention to patients' functional status in medical education. Students and clinicians regularly learn a "review of systems" to search for diseases and pathophysiologic disorders in different parts of the body but a "review of functions" does not exist for the diverse disabilities produced by the diseases and disorders. Because a unique correspondence to specific pathologic derangements does not exist, the disabilities are seldom recognized and managed with the same scientific "harmony" that links pathophysiologic explanations and therapeutic interventions. For many elderly people, however, functional limitations are a much more important problem in daily life than the particular chronic diseases, general frailty, or other medical ailments that may have led to the limitations.

Our first goal was to identify the common, often unappreciated functional disabilities that should be systematically reviewed for elderly patients. After we formulated the list, we devised suitable procedures to evaluate the disabilities. The criteria for suitability were that the procedures be brief and easy to carry out, had no extra costs or hazards, and had high efficacy in identifying the pertinent disabilities.

We had originally hoped that the desired procedures would readily be found among the many valid and reproducible "instruments" that have been reported for geriatric functional assessment (1-35). The instruments that we reviewed are listed in the bibliography in several topical groups: compendia of reviews and explanations for the available instruments (1-5); reviews of the general process of functional assessment (6-11); instruments for a broad range of disabilities (12-19); instruments for special targets (20-28) in mental, manual, or other individual functions; and investigations (29-35) of accomplishments when the instruments were applied in special geriatric consultation or assessment units. The published instruments had often been used successfully in research, for subspecialty assessments, in institutional care settings, or to describe details of extensive disabilities when considerable time and special personnel were available for the assessments.

Our goal, however, was to develop a procedure that would be quick, easily done, and pertinent for essentially asymptomatic ambulatory patients in general office practice. Most previously published instruments would have been unsatisfactory because they were too long and contained detailed examinations for functional disabilities that most screened patients probably would not have. Other instruments required special devices or computer scoring, focused on a general rather than geriatric population, or were not performance based. (We preferred performance-based appraisals in which the clinician actually observes the patient doing certain tasks rather than merely asking whether the tasks can be done.) Accordingly, although guided by the published instruments and using some excerpts, we prepared a simpler procedure that was directly and specifically aimed at the desired screening goals.

Our task force consisted of two general internists and five internists who specialize in geriatrics. We first reached consensus about the targets to be examined and then agreed about the procedures to be used for examination and the actions to be taken in response to abnormal findings.

In the sections that follow, we describe the background reasoning in choosing targets to be examined, and the corresponding procedures and actions. A summary of the recommendations appears in Table 1. (For ancillary procedures that may not be familiar to all
<table>
<thead>
<tr>
<th>Target Area</th>
<th>Assessment Procedure</th>
<th>Abnormal Result</th>
<th>Suggested Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td>Test each eye with Jaeger card while patient wears corrective lenses (if applicable).</td>
<td>Inability to read greater than 20/40</td>
<td>Refer to ophthalmologist.</td>
</tr>
<tr>
<td>Hearing</td>
<td>Whisper a short, easily answered question such as “What is your name?” in each ear while the examiner’s face is out of direct view.</td>
<td>Inability to answer question</td>
<td>Examine auditory canals for cerumen and clean if necessary. Repeat test; if still abnormal in either ear, refer for audiometry and possible prosthesis.</td>
</tr>
<tr>
<td>Arm</td>
<td>Proximal: “Touch the back of your head with both hands.” Distal: “Pick up the spoon.”</td>
<td>Inability to do task</td>
<td>Examine the arm fully (muscle, joint, and nerve), paying attention to pain, weakness, limited range of motion. Consider referral for physical therapy.</td>
</tr>
<tr>
<td>Leg</td>
<td>Observe the patient after asking: “Rise from your chair, walk ten feet, return, sit down.”</td>
<td>Inability to walk or transfer out of chair</td>
<td>Do full neurologic and musculoskeletal evaluation, paying attention to strength, pain, range of motion, balance, and traditional assessment of gait. Consider referral for physical therapy.</td>
</tr>
<tr>
<td>Urinary incontinence</td>
<td>Ask: “Do you ever lose your urine and get wet?”</td>
<td>Yes</td>
<td>Ascertain frequency and amount. Search for remediable causes including local irritations, polyuric states, and medications. Consider urologic referral. Do appropriate medical evaluation.</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Weigh the patient. Measure height.</td>
<td>Weight is below acceptable range for height</td>
<td>Administer Folstein mini-mental status examination. If score is &lt; 24, search for causes of cognitive impairment. Assess certain onset, duration, and fluctuation of overt symptoms. Review medications. Assess consciousness and affect. Do appropriate laboratory tests.</td>
</tr>
<tr>
<td>Mental status</td>
<td>Instruct: “I am going to name three objects (pencil, truck, book). I will ask you to repeat their names now and then again a few minutes from now.” [See text discussion.]</td>
<td>Inability to recall all three objects after 1 minute</td>
<td>Administer Geriatric Depression Scale. If positive (normal score, 0 to 10), check for antihypertensive, psychotropic, or other pertinent medications. Consider appropriate pharmacological or psychiatric treatment. Corroborate responses with patient’s appearance; question family members if accuracy is uncertain. Determine reasons for the inability (motivation compared with physical limitation). Institute appropriate medical, social, or environmental interventions. Evaluate home safety and institute appropriate countermeasures.</td>
</tr>
<tr>
<td>Depression</td>
<td>Ask: “Do you often feel sad or depressed?”</td>
<td>Yes</td>
<td>List identified persons in the medical record. Become familiar with available resources for the elderly in the community.</td>
</tr>
<tr>
<td>ADL-IADL*</td>
<td>Ask: “Can you get out of bed yourself?”; “Can you dress yourself?”; “Can you make your own meals?”; “Can you do your own shopping?”</td>
<td>No to any question</td>
<td></td>
</tr>
<tr>
<td>Home environment</td>
<td>Ask: “Do you have trouble with stairs inside or outside of your home?”; ask about potential hazards inside the home with bathtubs, rugs, or lighting.</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Social support</td>
<td>Ask: “Who would be able to help you in case of illness or emergency?”</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*ADL-IADL = activities of daily living-instrumental activities of daily living.

Internists, the corresponding device or instrument is shown in Figure 1, Table 2, and the appendix.)

Selection of Targets

Because physicians have different beliefs about which targets to assess for disability, particularly in people without complaints of functional problems (36), clinicians often disagree simply about the scope of the list of targets. Should it be confined to “conventional” physical problems, or should the list include emotional, social, and economic difficulties? Clinicians also disagree about the intensity of the search for latent difficulties. Without suitable challenges, many “asymptomatic” problems may not be apparent as disabilities (37). For example, persons who cannot prepare a meal may not be functional disability if their meals are always provided by a spouse or caregiver. Patients with severe cataracts may believe they have no visual difficulty if they see...
well enough to do all activities of daily living without ever trying to read fine print.

We decided to choose the most common targets, to search for disabilities that are often amenable to interventional help, to engage in certain acts of prophylaxis, and to identify (but not necessarily treat) certain asymptomatic problems.

Vision

Visual impairment, particularly from cataracts and abnormalities of accommodation, worsens with age. Because functionally important visual loss should be referred to specialists for definitive diagnosis and therapy, the generalist's main role is to identify the impairment and to make appropriate referrals. The standardized Jaeger card (38), shown in Figure 1, is a quick, easily administered test of functional vision. If the patient, while wearing appropriate corrective lenses and holding the chart at a distance of 14 inches, cannot read the chart correctly at a level greater than 20/40, he or she should be referred to an ophthalmologist. Examination of the fundus, pupillary responses, and extraocular movements may have value for investigating specific signs or symptoms but need not be tested routinely. If there is no evidence that visual loss can be prevented, tonometry is not recommended (39) as part of routine screening.

Hearing

The high prevalence of hearing loss in elderly patients and its association with isolation (40), confusion (41), and depression (42) make it an important target for screening. Hearing loss is usually bilateral and in the high-frequency range (43). The "Whisper test," or form of which has been validated (44) against audiometry, is an excellent simple check of hearing. The examiner keeps his or her face out of direct view and tests each ear by whispering a short, easily answered question, such as "What is your name?". If a patient fails the whisper test, the auditory canals should be examined for occlusion with cerumen. After the cerumen is removed, the test is repeated: failure should lead to referral for formal audiometry and possible prostheses.

Arms

For most activities of daily living, the work of the arm can be divided into proximal and distal functions. Proximal function is involved in transfers (from sitting to standing, or lying to sitting), raising the arms to comb hair or brush teeth, and putting on a coat. Distal function includes acts of manual dexterity, such as writing or using eating utensils. Because many pathologic processes can interact to cause functional disability of the arm, we defined some simple tasks whose abnormal performance would encompass many constituent disabilities that could then be further evaluated.

A patient who cannot touch the back of the head with both hands may have such common abnormalities of the upper arm as a frozen shoulder or arthritic limitations of range of motion. The maneuver takes the shoulder through a high degree of abduction and the elbow through nearly maximal flexion. A patient who cannot pick up a spoon has an impairment of the lower arm and hand that impedes the dexterity needed for most essential manual activities. These two tasks have been frequently used and found to be effective screening procedures by the geriatric member of our task force. Inability to do either of the tasks should lead to full examination of the entire extremity (muscle, joint, and nerve) with special attention to possible causes such as pain, weakness, and limited range of motion. Specific intervention will depend on the additional findings, and referral to an occupational or physical therapist may be desirable.

Legs

 Falls and mobility problems, common among the elderly, often arise from the accumulated effects of multiple disabilities, which can include problems in sensory and cognitive abilities, as well as dysfunction of the legs. When patients answer affirmatively about recent slips, trips, or falls, they should be questioned further.

Figure 1. Card used for Jaeger eye test.
about frequency, circumstances, and pattern to help clarify the roles of environment, specific dysfunctions, or both.

The function of the leg is evaluated well by watching the patient rise from a chair, walk about 10 feet, return, and sit down. The observation helps reveal the patient’s ability to transfer out of a chair and maneuver as well as walk. Difficulties in doing these tasks should lead to a full neurologic and musculoskeletal examination, with special attention to strength, pain, range of motion, balance, and the traditional evaluation of gait. A physical therapist can suggest environmental adaptations (for example, raised toilet seats), recommend appropriate walking aids, offer transfer and gait training, and provide strength and balance exercises.

Urinary Incontinence

Physicians are often unaware of a patient’s urinary incontinence even though it has been found in up to 30% of noninstitutionalized elderly persons (45). The problem should be sought in a nonjudgmental manner by a simple question: “Do you ever lose your urine and get wet?” The frequency and significance of individual or repetitive episodes of incontinence should be evaluated for remediable causes as well as for associated social or emotional problems.

Remediable causes include local irritation (urinary infections, vaginitis, fecal impactions, tumors), systemic sources of polyuria (diabetes, heart failure), excretion of retained fluid, medications (anticholinergics, sedatives, adrenergically active agents), and central nervous system disease. After these problems are treated, persistent incontinence may be due to mechanical causes, such as detrusor instability, sphincter weakness, obstruction, or overflow, for which urologic consultation and management are desirable. Diagnostic algorithms (46) can be helpful in the decision about whether to refer or to do more extensive office evaluation.

Nutrition

Poor nutrition in elderly persons may reflect concurrent medical illness, depression, inability to shop or cook, inability to feed oneself, or financial hardship.

Aside from visual inspection for signs of malnutrition, elderly patients should have their weight and height measured routinely. Although exact agreement has not been established about appropriate reference tables for the normal range of weight and height, physicians can choose from the available tables (47-49), and further evaluate patients who are substantially below the range.

Mental Status

Cognitive impairment, often called dementia, is the most common important disturbance in mental status. Because elderly patients often compensate well for the problem, it may be missed unless the clinician specifically checks for it (50). A sensitive indicator of cognitive impairment is loss of short-term memory and calculational ability (51), either of which can be used for a screening test. Short-term memory is probably the better test because the ability to calculate may be affected by the level of formal education and cultural biases.

To test short-term memory, we selected one item from the several listed in the Folstein mini-mental status examination (21), shown in Table 2. The patient is told the names of three common objects (such as pencil, truck, and book), and is asked to repeat the names immediately and to remember them for recall in 1 minute. The inability to recall all three names a minute later should lead to formal test of mental status with the complete Folstein mini-mental status examination.

If the Folstein score is less than 24, causes of dementia (32) should be sought with a more detailed history about the onset, duration, and fluctuation of overt symptoms: a complete neurologic examination, including assessment of affect; a review of possibly contributory prescription and nonprescription medications; and appropriate laboratory tests.

Patients with borderline normal mental status may sometimes appear to function well because of the aid given by a spouse or other assistant. If this help is later lost (by death, impairment, or removal of the assistant) the patient’s mental impairment may become more prominent. Although the complete Folstein examination might be done routinely to find these borderline patients, their discovery would not necessarily be followed by interventional therapy at that time. Consequently, an alternative option is to note the sources of support for all patients and to review each patient’s current status whenever an important source is lost. Either option—administering the complete Folstein test routinely or the shorter single-item test followed by ad hoc intensive review later when needed—can be used in the screening process.

Depression

Depression in elderly persons can be tested with several independent instruments and scales (22-27) that score the patient’s responses to an inventory of statements. Truncated versions of long inventories have been developed and validated (27), but are still too long for rapid screening. A single simple question: “Do you often feel sad or depressed?” can serve as an introduction to a more detailed investigation. (The adverb “often” is intended to distinguish depression from normal fluctuations in mood.) Patients who respond affirmatively should be tested with the Geriatric Depression Scale (26), shown in Appendix 1. The Geriatric Depression Scale is self-administered and easy to use, but its score must be interpreted with discretion. A score from 0 to 10 is regarded as normal, 11 to 13 is borderline, and 14 or greater usually indicates depression (25). Depressed patients should have a review of medications with special attention to antihypertensive and psychotropic drugs that may be causing depression. If a remediable medical cause cannot be found, patients may benefit from a trial of antidepressant therapy or other treatment by the internist, or referral to a psychiatrist.

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Activities of Daily Living

The term "activities of daily living" (13) refers to the abilities needed for independent self-maintenance in the basic functions of bathing, eating, dressing, toileting, transferring, and walking. The term "instrumental activities of daily living" (17) is often used for higher levels of independent function that are desirable for basic autonomous functioning. These tasks include cooking, shopping, and light housework.

Assessing activities of daily living and instrumental activities of daily living is hampered by three problems. First, an office assessment depends on the patient's self report, with all its possible errors. If the patient's statements may not be accurate, a family member can be asked to confirm them. In addition, the patient's motivation may play a large role in doing tasks (37), so that inability may not always reflect physical limitation. Finally, the existing instruments (12-19) for examining activities of daily living and instrumental activities of daily living contain a large inventory of diverse tasks—too many to be checked in a screening procedure.

The first two problems can often be circumvented through carefully observing the patient. Some activities-of-daily-living targets can be surmised from observing the patient's hygiene, behavior, habitus, and ability to transfer and walk. The third problem can be approached by asking patients about their ability to do four tasks: transfer out of bed, dress, prepare meals, and shop. Successful performance of these tasks usually reflects independence in other basic activities (28, 53, 54). The most clinically pragmatic and unambiguous questions about these tasks (Table 1) are taken from the Duke OARS instrument (18). Ability rather than motivation can be ascertained by using "can" rather than "do" as the opening verb for each question.

Because so many environmental, physical, and psychologic factors are joined in the ability to do these complex functions, we cannot offer a single guideline to

Table 2. Instrument for Folstein "Mini-Mental State" Examination*

<table>
<thead>
<tr>
<th>Maximum Score</th>
<th>Score</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>( )</td>
<td>Orientation</td>
</tr>
<tr>
<td>5</td>
<td>( )</td>
<td>What is the (year) (season) (date) (day) (month)?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Where are we: (state) (county) (town) (hospital) (floor).</td>
</tr>
<tr>
<td>3</td>
<td>( )</td>
<td>Registration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name three objects: 1 second to say each. Then ask the patient all three after you have said them. Give 1 point for each correct answer. Then repeat them until he or she learns all three (for later checking).</td>
</tr>
<tr>
<td>5</td>
<td>( )</td>
<td>Attention and Calculation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Serial 7s. Give 1 point for each correct. Stop after five answers. Alternatively spell &quot;world&quot; backwards.</td>
</tr>
<tr>
<td>3</td>
<td>( )</td>
<td>Recall</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ask for the three objects repeated above. Give 1 point for each correct.</td>
</tr>
<tr>
<td>9</td>
<td>( )</td>
<td>Language</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Show patient a pencil and watch, and ask for their names. (2 points) Repeat the following: &quot;No ifs, ands, or buts.&quot; (1 point) Follow a three-stage command: &quot;&quot;Take a paper in your right hand, fold it in half, and put it on the floor.&quot;&quot; (3 points) Read and obey the following: &quot;&quot;Close your eyes.&quot;&quot; (1 point) &quot;&quot;Write a sentence.&quot;&quot; (1 point) &quot;&quot;Copy a simple design.&quot;&quot; (1 point)</td>
</tr>
</tbody>
</table>

* Adapted from reference 21.
* The original wording of the item is listed here. In office practice, the terms "hospital" and "floor" might be replaced by such alternatives as "street" and "building."
manage these difficulties. The clinician should discover the reason or reasons for each inability and develop appropriate medical, social, or environmental interventions.

Home Environment

The most troublesome obstacles in mobility for many patients at home are the stairs inside and outside. Patients should therefore be specifically asked about difficulty with stairs. If a problem exists, a physical therapist can do a home safety evaluation and institute appropriate countermeasures (for example, hand rails).

To prevent problems, patients should also be routinely asked about features inside the home that may lead to falls, such as slippery bath tubs, unanchored small rugs, and dark hallways. Appropriate measures for home safety should be introduced as needed.

Social Support

Actual and potential caregivers must be identified (55, 56). Doing so sensitizes the clinician to the social network in which the patient functions and enables availability of care to be anticipated in the event of transient illness, hospital discharge, or the loss or impairment of a “significant other.” Another prophylactic feature is determining what, if any, provision has been made for surrogate decision making in the event of disability. The patient should be asked for the names, addresses, and phone numbers of persons who can help in case of illness or emergency; this information should become part of the medical record. Clinicians should be familiar with the available resources in their communities so that appropriate help, and possibly social service referral, can be sought for patients with inadequate support.

Discussion

Although we found relative unanimity within our task force, we do not expect all clinicians to accept all our recommendations. Many physicians will doubtless disagree about the targets to be emphasized, the procedures to be used for the screening examinations, and the actions to be taken in response to abnormalities. Our goal, however, was to light a working candle in relative darkness, rather than establish a permanent electrical lighting system. We believe the proposed screening procedures will serve their role well if clinicians are alerted to the need for functional assessment of elderly patients, and if the procedures help in doing the assessment. Details of the proposed procedures can readily be changed by clinicians who prefer alternative strategies and tactics.

We deliberately omitted screening for the patient’s economic status or related legal difficulties, although we believe that clinicians should routinely try to determine which patients need financial help. We omitted this target from the formal list because it was difficult to choose an appropriate standard question and because we were concerned that the inquiry itself might be misinterpreted by the patient. Questions about economic status might make certain patients suspect that the physician was assessing affluence in planning fees, or conversely, that a revelation of poverty might adversely affect the physician’s decisions concerning care. Because the clinician may be the only person who might note an elderly patient’s fiscal plight and who could arrange for appropriate interventions, we urge clinicians to be aware of the problem. The mechanisms of perception and action, however, must be individualized for each patient.

We also did not attempt to construct either the more extensive procedure, or details of the more exhaustive investigation of positive targets, that could be developed if the examination were conducted as a specific consultation rather than screening procedure. Because a screening process involving no high-technology tests would probably not be highly reimbursed, we wanted the process to be effective without adding a large amount of time to the standard office examination.

Some of the time needed for the additional screening activities can readily be obtained by omitting other parts of the “routine” physical examination that might be relatively nonproductive (57). For example, routine examination of the ocular fundus and ear drum are less productive than, and can readily be replaced by, a routine test of vision and hearing. In the customary routine neurologic examination, such procedures as the Romberg test and tests for reflexes are readily and effectively replaced by functionally oriented checks for gait, mobility, and balance (58). In the same way that clinicians have become accustomed to evaluating the diagnostic efficacy of routine laboratory tests, an analogous evaluation of the routine history and physical examination might readily identify relatively ineffective activities that could be usefully replaced by more productive assessments of functional disabilities.

Although elderly persons may have chronic diseases that cannot be eliminated, their functional disabilities, if recognized, can often be improved greatly. In a world of burgeoning technology, clinicians who focus on the latter targets can carry out the old but still cogent medical maxim that a doctor’s job is to cure occasionally, to relieve often, and to comfort always.

Addendum

Since this paper was submitted, an important consensus and review paper (59) has been published.

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Appendix 1: Instrument for Geriatric Depression Scale*

Score 0 for each "non-depressive" and 1 point for each "depressive" answer. The "depressive" answers are no questions 1, 5, 7, 9, 15, 19, 21, 27, 29, and 30, and yes for all others.) Add up the total points. Normal score for the aged is 0 to 10.

Instructions to patient:

Choose the best answer (yes or no) to each question about how you felt the past week.

1. Are you basically satisfied with your life?
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you hopeful about the future?
6. Are you bothered by thoughts you can't get out of your head?
7. Are you in good spirits most of the time?
8. Are you afraid that something bad is going to happen to you?
9. Do you feel happy most of the time?
10. Do you often feel helpless?
11. Do you often get restless and fidgety?
12. Do you prefer to stay at home, rather than going out and doing new things?
13. Do you frequently worry about the future?
14. Do you feel you have more problems with memory than most?
15. Do you think it is wonderful to be alive now?
16. Do you often feel downhearted and blue?
17. Do you feel pretty worthless the way you are now?
18. Do you worry a lot about the past?
19. Do you feel life very exciting?
20. Is it hard for you to get started on new projects?
21. Do you feel full of energy?
22. Do you feel that your situation is hopeless?
23. Do you think that most people are better off than you are?
24. Do you frequently get upset over little things?
25. Do you frequently feel like crying?
26. Do you have trouble concentrating?
27. Do you enjoy getting up in the morning?
28. Do you feel you have no friends?
29. Is it easy for you to make decisions?
30. Is your mind as clear as it used to be?


References


