Hamilton Depression Rating Scale Scoring

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There are no right or wrong answers. Mark the response that best describes you over the period stated, and answer every item.

Name: _____ **Date completed:** _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy **Record / MRN number:** _____

Answer each of the 10 items below. Choose the response that best describes the last two weeks unless you are told otherwise.

1. I understand what hamilton depression rating scoring involves and why it has been recommended.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

2. I am confident managing presenting concerns and symptom severity day to day.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

3. Risk indicators and protective factors has been discussed with me.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

4. I know who to contact if something changes between appointments.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

5. I am able to follow the advice I have been given about agreed goals and between-session tasks.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

6. I have enough information to make decisions about my care.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

7. The symptoms I came in with have affected my daily activities.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

8. I have found it difficult to keep up with progress against baseline scores.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

9. I have had support from family, friends or carers with this.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

10. I am satisfied with the care I have received so far.

◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

Anything else you would like the team to know

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Total score: _____ **Interpretation:** _____

Completed by: _____ **Reviewed by / date:** _____