NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

SR1 SELF REPORT MEASURES FOR ADULTS AND OLDER PEOPLE K10 + LM

SMR060934

Instructions

The following ten questions ask about how you have been feeling in the **last four weeks**. For each question, mark the circle under the option that best describes the amount of time you felt that way.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. In the last four weeks, about how often did you feel tired out for no good reason?	○	○	○	○	○
2. In the last four weeks, about how often did you feel nervous?	○	○	○	○	○
3. In the last four weeks, about how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. In the last four weeks, about how often did you feel hopeless?	○	○	○	○	○
5. In the last four weeks, about how often did you feel restless or fidgety?	○	○	○	○	○
6. In the last four weeks, about how often did you feel so restless you could not sit still?	○	○	○	○	○
7. In the last four weeks, about how often did you feel depressed?	○	○	○	○	○
8. In the last four weeks, about how often did you feel that everything was an effort?	○	○	○	○	○
9. In the last four weeks, about how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. In the last four weeks, about how often did you feel worthless?	○	○	○	○	○

please turn over the page to continue

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

NH600928 271213

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The next few questions are about these feelings may have affected you in the **last four weeks**.

You need not answer these questions if you answered "None of the time" to **all** of the ten questions about your feelings.

11. In the last four weeks, how many days were you TOTALLY UNABLE to work, study or manage your day to day activities because of these feelings? ..... (Number of days)

12. [Aside from those days], in the last 4 weeks, HOW MANY DAYS were you able to work or study or manage your day to day activities, but had to CUT DOWN on what you did because of these feelings? ..... (Number of days)

13. In the last 4 weeks, how many times have you seen a doctor or any other health professional about these feelings? ..... (Number of consultations)

14. In the last 4 weeks, how often have physical health problems been the main cause of these feelings?

- None of the time ○
- A little of the time ○
- Some of the time ○
- Most of the time ○
- All of the time ○

Thank you for completing this questionnaire.

Please sign below and return to the staff member who asked you to complete it.

Consumer signature: .....

Date: .....

For Care Planning Purposes: K10 score ☐☐

Staff comments: .....

.....

.....

.....

Staff name: Signature Designation: Date:

NO WRITING