

Geriatric Depression Scale 10-Item (GDS-10)

(Completed for patient age 65 and greater)

Name: _____

Date of Assessment: _____ Completed By: _____

Instructions: Circle the answer that best describes how you felt over the past week.

- | | | |
|---|-----|----|
| 1. Are you basically satisfied with your life? | yes | no |
| 2. Have you dropped many of your activities and interests? | yes | no |
| 3. Do you feel that your life is empty? | yes | no |
| 4. Are you afraid that something bad is going to happen to you? | yes | no |
| 5. Do you feel happy most of the time? | yes | no |
| 6. Do you often feel helpless? | yes | no |
| 7. Do you feel that you have more problems with memory than most? | yes | no |
| 8. Do you feel full of energy? | yes | no |
| 9. Do you feel that your situation is hopeless? | yes | no |
| 10. Do you think that most people are better off than you are? | yes | no |

Total Score _____

HCA
Behavioral
Health Services

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(Completed for patient age 65 and greater) (#v2652) (11/16/16) *BAS*



NAME LABEL