Psychological Assessment Questionnaire
Modified Zung Index

2950 N. Seventh St. Suite 200 • Phoenix, AZ 85014 • 800.598.0224 • phone 602.224.0220 • fax 602.224.0230 • www.activator.com

Name (Please Print):______________________________ Date:________________

Please indicate for each of these questions which answer best describes how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1 – 2 days per week)	A moderate amount of the time (3 – 4 days per week)	Most of the time (5 – 7 days per week)
1. I feel downhearted and sad	0	1	2	3
2. Mornings are when I feel best	3	2	1	0
3. I have crying spells or feel like it	0	1	2	3
4. I have trouble getting to sleep at night	0	1	2	3
5. I feel that nobody cares	0	1	2	3
6. I eat as much as I used to	3	2	1	0
7. I notice I am losing weight	0	1	2	3
8. I have trouble with constipation	0	1	2	3
9. My heart beats faster than usual	0	1	2	3
10. I get tired for no reason	0	1	2	3
11. My mind is as clear as it used to be	3	2	1	0
12. I tend to wake up too early	3	2	1	0
13. I find it easy to do the things I used to	0	1	2	3
14. I am restless and can't keep still	3	2	1	0
15. I feel hopeful about the future	0	1	2	3
16. I am more irritable than usual	0	1	2	3
17. I find it easy to make a decision	3	2	1	0
18. I feel quite guilty	0	1	2	3
19. I feel that I am useful and needed	3	2	1	0
20. My life is pretty full	3	2	1	0
21. I feel that others would be better off if I were dead	0	1	2	3
22. I am still able to enjoy the things I used to	3	2	1	0

TOTAL SCORE:________ **SIGNATURE:**______________________ **DATE:**__________

over please

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Psychological Assessment Questionnaire

Modified Somatic Perception

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Please indicate for each of these questions which answer best describes how you have been feeling recently.

	Not at all	A little, slightly	A great deal, quite a bit	Extremely, could not have been worse
Heart rate increase	0	1	2	3
Feeling hot all over	0	1	2	3
Sweating all over	0	1	2	3
Sweating in a particular part of the body	0	1	2	3
Pulse in the neck	0	1	2	3
Pounding in the head	0	1	2	3
Dizziness	0	1	2	3
Blurring of vision	0	1	2	3
Feeling faint	0	1	2	3
Everything appearing unreal	0	1	2	3
Nausea	0	1	2	3
Butterflies in stomach	0	1	2	3
Pain or ache in stomach	0	1	2	3
Stomach churning	0	1	2	3
Desire to pass water	0	1	2	3
Mouth becoming dry	0	1	2	3
Difficulty swallowing	0	1	2	3
Muscles in neck aching	0	1	2	3
Legs feeling weak	0	1	2	3
Muscles twitching or jumping	0	1	2	3
Tense feeling across forehead	0	1	2	3
Tense feeling in jaw muscles	0	1	2	3

TOTAL SCORE:__________ **SIGNATURE:**____________________________ **DATE:**____________

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