**Structured Interview Guide for the Hamilton Depression Rating Scale**

**Identification**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
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<tbody>
<tr>
<td>John</td>
<td>James</td>
<td>Doe</td>
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<tr>
<th>Patient ID</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Age</th>
<th>Initials</th>
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<tbody>
<tr>
<td>123456789</td>
<td>3/23/1980</td>
<td>male</td>
<td>26</td>
<td>JJD</td>
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**Interview Date**


**1. DEPRESSED MOOD**

(sadness, hopeless, worthless, helpless)

- a. What has your mood been like this past week?
- b. Have you been feeling down or depressed?
- c. Sad? Hopeless?
- d. In the last week, how often have you felt (OWN EQUIVALENT)?
- e. Have you been crying at all?

**2. FEELING OF GUILT**

- a. Have you been especially critical of yourself this week, feeling you've done things wrong, or let others down? IF YES: What have your thoughts been?
- b. Have you been feeling guilty about anything that you've done or not done?
- c. Have you thought that you've brought (THIS DEPRESSION) on yourself in some way?
- d. Do you feel you're being punished by being sick?
- e. Do you ever hear voices - what do they say?

**3. SUICIDE**

This past week, have you had any thoughts that life is not worth living, or that you'd be better off dead? What about having thoughts of hurting or even killing yourself?

IF YES: What have you thought about? Have you actually done anything to hurt yourself?

**4. INSOMNIA EARLY**

- a. How have you been sleeping over the last week?
- b. Have you had any trouble falling asleep at the beginning of the night? (Right after you go to bed, how long has it been taking you to fall asleep)?
- c. How many nights this week have you had trouble falling asleep?

**5. INSOMNIA MIDDLE**

- a. During the past week, have you been waking up in the middle of the night? IF YES: Do you get out of bed? What do you do? (Only go to the bathroom)?
- b. When you get back in bed, are you able to fall right back asleep?
- c. Have you felt your sleeping has been restless or disturbed some nights?

**6. INSOMNIA LATE**
a. What time have you been waking up in the morning for the last time, this week?
b. IF EARLY: Is that with an alarm clock, or do you just wake up yourself? What time do you usually wake up (that is, before you got depressed)?

7. WORK AND ACTIVITIES
a. How have you been spending your time this past week (when not at work)?
b. Have you felt interested in doing (THOSE THINGS), or do you feel you have to push yourself to do them?
c. Have you stopped doing anything you used to do? IF YES: Why?
d. Is there anything you look forward to?
e. AT FOLLOW-UP: Has your interest been back to normal?

8. RETARDATION
(Slow movements and speech, impaired ability to concentrator, decreased motor activity)
Rating based on observation during interview.

9. AGITATION
Rating based on observation during interview

10. ANXIETY PSYCHIC
a. Have you been feeling especially tense or irritable this past week?
b. Have you been worrying a lot about little unimportant things you wouldn't ordinarily worry about?
IF YES: Like what, for example?

11. ANXIETY SOMATIC
(Err on the side of rating sx if you don't know the other cause)
a. In this past week, have you had any of these physical symptoms? READ LIST, PAUSING AFTER EACH SX FOR REPLY
b. How much have these things been bothering you this week? (How bad have they gotten? How much of the time, or how often have you had them?)
NOTE: DON'T RATE IF CLEARLY DUE TO MEDICATION (E.G., DRY MOUTH AND IMPRAMINE).

Physiological concomitants of anxiety:
GI: dry mouth, indigestion, diarrhea, cramps.
Cardio: Palpitation, headaches.
Resp: Hyperventilation, sighing.
Urinary frequency, Sweating.

12. SOMATIC SYMPTOMS: GASTROINTESTINAL
a. How has your appetite been this past week? (What about compared to your usual appetite)?
b. Have you had to force yourself to eat?
c. Have other people had to urge you to eat?
13. SOMATIC SYMPTOMS: GENERAL
a. How has your energy been this past week?
   - Absent
b. Have you been tired all the time?
   - Mild
c. This week, have you had any backaches, headaches, or muscle aches?
   - Severe
d. This week, have you felt any heaviness in your limbs, back, or head?

14. GENITAL SYMPTOMS
a. How has your interest in sex been this week? (I'm not asking about performance, but about your interest in sex--how much do you think about it?)
   - Absent
b. Has there been any change in your interest in sex (from when you were not depressed)?
   - Mild
c. Is there something you've thought much about? IF NO: Is that unusual for you?
   - Severe

15. HYPOCHONDRIASIS
a. In the last week, how much have your thoughts been focused on your physical health or how your body is working (compared to your normal thinking)?
   - Absent
b. Do you complain much about how you feel physically?
   - Any amount of symptoms
c. Have you found yourself asking for help with things you could really do yourself? IF YES: Like what, for example? How often has that been happening?
   - Mild

16a. LOSS OF WEIGHT (RATING BY HISTORY)
a. Have you lost any weight since this DEPRESSION began? IF YES: DOW MUCH?
   - Absent
b. IF NOT SURE: Do you think your clothes are any looser on you?
   - Mild
AT FOLLOW-UP: Have you gained any of the weight back?
   - Severe

16b. LOSS OF WEIGHT (RATING WITH ACTUAL WEIGHT)
a. Have you lost any weight since this DEPRESSION began? IF YES: DOW MUCH?
   - Absent
b. IF NOT SURE: Do you think your clothes are any looser on you?
   - Mild
AT FOLLOW-UP: Have you gained any of the weight back?
   - Severe

17. INSIGHT
Rating based on observation during interview.
   - Absent

18a. DIURNAL VARIATION (A.M.)
a. This past week have you been feeling better or worse at any particular time of day -- morning or evening?
   - Absent
b. IF VARIATION: How much worse do you feel in the (MORNING/EVENING)?
   - Mild
c. IF UNSURE: A little bit worse or a lot worse?
   - Severe

18b. DIURNAL VARIATION (P.M.)
a. This past week have you been feeling better or worse at any particular time of day -- morning or evening?
   - Absent
b. IF VARIATION: How much worse do you feel in the (MORNING/EVENING)?
   - Mild
c. IF UNSURE: A little bit worse or a lot worse?
   - Severe

19. DEPERSONALIZATION AND DEREALIZATION
a. In the past week, have you ever suddenly had the feeling that everything is unreal, or you're in a dream, or cut off from other people in some strange way?
   - Absent
Any spacey feelings?
   - Any amount of symptoms
b. IF YES: How bad has that been? How often this week has that happened?
   - Mild
### 20. PARANOID SYMPTOMS

- a. This past week, have you felt that anyone was trying to give you a hard time or trying to hurt you?
- b. IF NO: What about talking about you behind your back?
- c. IF YES: Tell me about that.

### 21. OBSESSIOINAL AND COMPULSIVE SYMPTOMS

- a. This past week, have there been things you’ve had to do over and over again, like checking the locks on the doors several times.
- b. IF YES: Can you give me an example?
- c. Have you had any thoughts that don’t make any sense to you, but that keep running over and over in your mind?
- d. IF YES: Can you give me an example?

### 22. HELPLESSNESS

- a. Do you feel helpless?
- b. Have you been able to make yourself feel better?
- c. Do you feel you are able to control what happens to you?
- d. Do you feel at the mercy of others?

### 23. HOPELESSNESS

- a. How does the future look to you?
- b. Can you see yourself getting any better?
- c. Do you think treatment will help you get better?

### 24. WORTHLESSNESS

(Loss of esteem, feelings of inferiority)
- a. Are you disappointed with yourself?
- b. Do you think that you are of no use to others?
- c. Do you think that you are a bad person?
- d. Do you feel that you are not worth the trouble others are going through to help you?

- Absent
- Any amount of symptoms
- Mild
- Moderate
- Severe