

# Hamilton Depression Rating Scale

Patient's Name \_\_\_\_\_ Date of First Report \_\_\_\_\_

Diagnosis \_\_\_\_\_ Date of This Report \_\_\_\_\_

Current Therapy \_\_\_\_\_

*Instructions* For each item check the box next to the response that best characterizes the patient.

<b>Depressed Mood</b>	0 <input type="checkbox"/>	Absent.	<b>Feeling of sadness, hopelessness, helplessness, worthlessness.</b>
	1 <input type="checkbox"/>	These feeling states indicated only on questioning.	
	2 <input type="checkbox"/>	These feeling state spontaneously reported verbally.	
	3 <input type="checkbox"/>	Communicates feeling states nonverbally – ie, through facial expression, posture, voice, and tendency to weep.	
	4 <input type="checkbox"/>	Patient reports <i>virtually only</i> these feeling states in his spontaneous verbal and non-verbal communication.	
<b>Feelings of Guilt</b>	0 <input type="checkbox"/>	Absent.	
	1 <input type="checkbox"/>	Self-reproach, feels he has let people down.	
	2 <input type="checkbox"/>	Ideas of guilt or rumination over past errors or sinful deeds.	
	3 <input type="checkbox"/>	Present illness is a punishment. Delusions of guilt.	
	4 <input type="checkbox"/>	Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.	
<b>Suicide</b>	0 <input type="checkbox"/>	Absent.	
	1 <input type="checkbox"/>	Feels life is not worth living.	
	2 <input type="checkbox"/>	Wishes he were dead or any thoughts of possible death to self	
	3 <input type="checkbox"/>	Suicide ideas or gestures.	
	4 <input type="checkbox"/>	Attempts at suicide ( <i>only serious attempt rates 4</i> )	
<b>Insomnia Early</b>	0 <input type="checkbox"/>	No difficulty.	
	1 <input type="checkbox"/>	Complains of occasional difficulty falling asleep – ie, more than ½ hour	
	2 <input type="checkbox"/>	Complains of nightly difficulty falling asleep.	
<b>Insomnia Middle</b>	0 <input type="checkbox"/>	No difficulty.	
	1 <input type="checkbox"/>	Patient complains of being restless and disturbed during the night.	
	2 <input type="checkbox"/>	Waking during the night – any getting out of bed rates 2 ( <i>except for purposes of voiding</i> ).	
<b>Insomnia Late</b>	0 <input type="checkbox"/>	No difficulty.	
	1 <input type="checkbox"/>	Waking in early hours of the morning but goes back to sleep.	
	2 <input type="checkbox"/>	Unable to fall asleep again if gets out of bed.	
<b>Work and Activities</b>	0 <input type="checkbox"/>	No difficulty.	
	1 <input type="checkbox"/>	Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies.	
	2 <input type="checkbox"/>	Loss of interest in activity; hobbies or work – either directly reported by patient, or indirect in listlessness, indecision or vacillation ( <i>feels he has to push self to work or activities</i> ).	
	3 <input type="checkbox"/>	Decrease in actual time spent in activities or decrease in productivity. In hospital, rate 3 if patient does not spend at least three hours a day in activities ( <i>hospital job or hobbies</i> ), exclusive of ward chores.	
	4 <input type="checkbox"/>	Stopped working because of present illness. In hospital, rate 4 if patient engages in no activities except ward chores, or if patient fails to perform ward chores unassisted.	
<b>Retardation</b>	0 <input type="checkbox"/>	Normal speech and thought.	<b>Slowness of thought and speech; impaired ability to concentrate; decreased motor activity</b>
	1 <input type="checkbox"/>	Slight retardation at interview.	
	2 <input type="checkbox"/>	Obvious retardation at interview.	
	3 <input type="checkbox"/>	Interview difficult.	
	4 <input type="checkbox"/>	Complete stupor.	
<b>Agitation</b>	0 <input type="checkbox"/>	None.	
	1 <input type="checkbox"/>	“Playing with” hands, hair, etc	
	2 <input type="checkbox"/>	hand-wringing, nail-biting, hair-pulling, biting of lips	
<b>Anxiety Psychic</b>	0 <input type="checkbox"/>	No Difficulty.	
	1 <input type="checkbox"/>	Subjective tension and irritability.	
	2 <input type="checkbox"/>	Worrying about minor matters.	
	3 <input type="checkbox"/>	Apprehensive attitude apparent in face or speech.	
	4 <input type="checkbox"/>	Fears expressed without questioning.	

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<b>Anxiety Somatic</b>	0 <input type="checkbox"/>	Absent.	<i>Physiological concomitants of anxiety, such as: Gastrointestinal – dry mouth, wind, indigestion, diarrhea, craps, belching. Cardiovascular – palpitations, headaches. Respiratory – hyperventilation, sighing. Urinary frequency. Sweating.</i>
	1 <input type="checkbox"/>	Mild.	
	2 <input type="checkbox"/>	Moderate.	
	3 <input type="checkbox"/>	Severe.	
	4 <input type="checkbox"/>	Incapacitating.	
<b>Somatic Symptoms Gastrointestinal</b>	0 <input type="checkbox"/>	None.	
	1 <input type="checkbox"/>	Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.	
	2 <input type="checkbox"/>	Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for GI symptoms.	
<b>Somatic Symptoms General</b>	0 <input type="checkbox"/>	None.	
	1 <input type="checkbox"/>	Heaviness in limbs, back or head. Backaches, headache, muscle aches. Loss of energy or fatigability.	
	2 <input type="checkbox"/>	Any clear-cut symptom rates 2	
<b>Genital Symptoms</b>	0 <input type="checkbox"/>	Absent.	<i>Symptoms such as: Loss of libido. Menstrual disturbances.</i>
	1 <input type="checkbox"/>	Mild.	
	2 <input type="checkbox"/>	Severe.	
<b>Hypochondriasis</b>	0 <input type="checkbox"/>	Not present.	
	1 <input type="checkbox"/>	Self-absorption (bodily).	
	2 <input type="checkbox"/>	Preoccupation with health.	
	3 <input type="checkbox"/>	Frequent complaints, requests for help, etc.	
	4 <input type="checkbox"/>	Hypochondriacal delusions.	
<b>Loss of Weight</b> (Answer only A or B)		<b>A. When rating by history:</b>	
	0 <input type="checkbox"/>	No weight loss.	
	1 <input type="checkbox"/>	Probable weight loss associated with present illness.	
	2 <input type="checkbox"/>	Definite (according to patient) weight loss.	
		<b>B. On weekly ratings by ward psychiatrist, when actual weight changes are measured:</b>	
	0 <input type="checkbox"/>	Less than 1 lb weight loss in week.	
	1 <input type="checkbox"/>	Greater than 1 lb weight loss in week.	
	2 <input type="checkbox"/>	Greater than 2 lb weight loss in week.	
<b>Insight</b>	0 <input type="checkbox"/>	Acknowledges being depressed and ill.	
	1 <input type="checkbox"/>	Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.	
	2 <input type="checkbox"/>	Denies being ill at all.	
<b>Diurnal Variation</b>		<b>Note whether symptoms are worse in the morning or evening.</b>	
		<input type="checkbox"/> No variation.	
		<input type="checkbox"/> Worse in AM.	
		<input type="checkbox"/> Worse in PM.	
		<b>When present, rate the variation.</b>	
	1 <input type="checkbox"/>	Mild.	
	2 <input type="checkbox"/>	Severe.	
<b>Depersonalization And Derealization</b>	0 <input type="checkbox"/>	Absent.	<i>Such as: Feelings of unreality. Nihilistic ideas.</i>
	1 <input type="checkbox"/>	Mild.	
	2 <input type="checkbox"/>	Moderate.	
	3 <input type="checkbox"/>	Severe.	
	4 <input type="checkbox"/>	Incapacitating.	
<b>Paranoid Symptoms</b>	0 <input type="checkbox"/>	None.	
	1 <input type="checkbox"/>	Suspicious.	
	2 <input type="checkbox"/>	Ideas of reference.	
	3 <input type="checkbox"/>	Delusions of reference and persecution.	
<b>Obsessional and Compulsive Symptoms</b>	0 <input type="checkbox"/>	Absent.	
	1 <input type="checkbox"/>	Mild.	
	2 <input type="checkbox"/>	Severe.	
<b>Total Score</b>			