

## Depression Questionnaire

1. Have you been diagnosed by a doctor as depressed?     Yes     No
2. Rate your level of depression from 1-10. (0 = None)    0   1   2   3   4   5   6   7   8   9   10
3. Frequency of your depression throughout the month.        25%    50%    75%    100%
4. Have you had suicidal thoughts?         Yes     No
5. If yes, how often?     Occasionally     Monthly     Weekly     Daily     Several times a day
6. Have you attempted suicide?         Yes     No
7. Do you take anti-depressants?         Yes     No
8. If so, list them and how often you take them? \_\_\_\_\_
9. List other drugs including hormones that you take. \_\_\_\_\_  
\_\_\_\_\_
10. Do you take Supplements? (Vitamins, Minerals, Digestive Enzymes)     Yes     No
11. If yes, please list them. \_\_\_\_\_  
\_\_\_\_\_
12. Please check symptoms/problems you experience.     Agitations     Amnesia     Dizziness     Insomnia  
 Tremors     Decreased sex drive     Problems with Appetite     Alcohol and/or Nicotine cravings  
 Drug Abuse     Digestion     Reflux/Heartburn     Gas     Bloating     Constipation     Diarrhea  
 Heart Problems     Anxiety     Cold/ Hot     Cold Hands/Feet     Migraines     Headaches  
 Mental Fog     Mood Swings     Impulse Control     Aggression     Motivation     Sleep-wake cycle  
 Fatigue     Irritability in the afternoon     Get sick if a meal is missed     Hair Loss     Brittle Nails
13. How often do you exercise?     Never     Occasionally     1-2 days a Week     3-5 Days     6-7 Days
14. Length of exercise     10-15 Minutes     20-30 Minutes     35-55 Minutes     60-90 Minutes     Longer
15. How much direct sunlight do you get daily?     15 Minutes     30 Minutes     60 Minutes     More
16. Do you wear sunscreen and/or sunglasses?     Sunscreen     Sunglasses
17. Do you have any food allergies?     Yes     No
18. If so, list them. \_\_\_\_\_

19. Please check how often you consume these foods/beverages.

	Never	Occasionally	Once a day	Twice a day	3 Times a day	More
Salads	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cooked Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beef	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poultry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuts/seeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sea salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Iodized salt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bread (Whole Grain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bread (refined, white)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cereal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pasta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cookies/Cake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corn products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sodas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruit juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeinated drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food out of a box/can	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice Cream	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

20. How much water do you drink daily? \_\_\_\_\_ ounces or \_\_\_\_\_ cups

21. Rate your energy level 1-10 (10 is the best). 0 1 2 3 4 5 6 7 8 9 10

22. Rate the best you have ever felt in you life. 0 1 2 3 4 5 6 7 8 9 10 What age? \_\_\_\_\_

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