White Sands Physical Therapy & Aquatics

Geriatric Depression Scale

Please circle YES or NO. Circle the best answer for how you have 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 your life is empty?	Yes	No
4	Do you often get bored?	Yes	No
5	Are you in good spirits most of the time?	Yes	No
6	Are you afraid that something bad is going to happen to you?	Yes	No
7	Do you feel happy most of the time?	Yes	No
8	Do you often feel helpless?	Yes	No
9	Do you prefer to stay at home, rather than going out and doing new things?	Yes	No
10	Do you feel you have more problems with memory than most?	Yes	No
11	Do you think it is wonderful to be alive now?	Yes	No
12	Do you feel pretty worthless the way you are now?	Yes	No
13	Do you feel full of energy?	Yes	No
14	Do you feel that your situation is hopeless?	Yes	No
15	Do you feel that most people are better off than you are?	Yes	No

Elder Abuse Suspicion Index

Please circle YES or NO. You do not have to answer these questions if you do not want to.

1	Do you rely on people for any of the following: bathing, dressing, shopping, banking, or meals?	Yes	No
2	Has anyone prevented you from getting: food, clothes, medication, glasses, hearing aids medical care, or from being with people you wanted to be with?	Yes	No
3	Have you been upset because someone talk to you in a way that made you feel shamed or threatened?	Yes	No
4	Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No
5	Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No

Patient Name: _____

(Please Print)

Patient Signature: _____

Staff Only:

Patient refused to fill out in part or in full _____

Staff Initials: _____