Self-report screener for Depression and Binge Eating

1. Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several Days 1	More than Half the Days 2	Nearly Every Day 3
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐

Scoring: Add the two numbers from above (range = 0-6). A score of 3 or higher indicates further evaluation is recommended.

2. Do you have a loss-of-control eating, meaning it's hard to stop yourself from eating, and you eat a larger amount than usual?

☐ Yes ☐ No

3. **If yes,** does this happen more than 1 day/week for 3 months?

☐ Yes ☐ No

Scoring: Patients answering Yes for BOTH questions suggests further evaluation is recommended.

CLINICAL INTERVIEW FOLLOW UP QUESTIONS POSITIVELY ENDORSED:

1. "Have you (the patient) had any thoughts of self harm, history of harming yourself or others? Does your child ever say that he/she wants to die or kill someone else?"

2. "Does the binge eating interfere with daily functioning (e.g., school, friends, and family) and/or interfere with weight management treatment progress?"

3. Please complete a referral for full evaluation by mental health expert if endorsed.