

High-Functioning Depression Test

Name: _____ Age: _____

Please read each statement and check the box that best describes your experience over the past two weeks, according to the scale below:

0 Not at all	1 Several days	2 More than half the days	3 Nearly every day
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	0	1	2	3
1. I feel tired or have little energy.				
2. I feel hopeless or pessimistic about the future.				
3. I struggle with feelings of worthlessness or excessive guilt.				
4. I have difficulty concentrating or making decisions.				
5. I have little interest or pleasure in doing things I used to enjoy.				
6. I experience changes in my sleeping patterns (too much or too little).				
7. I have changes in my appetite or weight (increase or decrease).				
8. I feel restless or have trouble sitting still.				
9. I have thoughts of death or self-harm.				
10. Even when I accomplish something, I feel unfulfilled or unsatisfied.				
Total:				

Interpretation and assessment

Get your total score. Scores fall into different classifications:

- **0-9:** Minimal or no symptoms
- **10-14:** Mild symptoms
- **15-21:** Moderate symptoms
- **22-30:** Severe symptoms

Note: *This test is not backed by research, and it is best used by a mental health professional for screening. This test does not provide a definitive diagnosis of high-functioning depression.*

Additional notes