

# Geriatric Depression Scale (GDS)

## Scoring Instructions

**Instructions:** Score 1 point for each bolded answer. A score of 5 or more suggests depression.

- |   |            |           |
|---|------------|-----------|
| 1. Are you basically satisfied with your life?                            | yes        | <b>no</b> |
| 2. Have you dropped many of your activities and interests?                | <b>yes</b> | no        |
| 3. Do you feel that your life is empty?                                   | <b>yes</b> | no        |
| 4. Do you often get bored?  | <b>yes</b> | no        |
| 5. Are you in good spirits most of the time?                              | yes        | <b>no</b> |
| 6. Are you afraid that something bad is going to happen to you?           | <b>yes</b> | no        |
| 7. Do you feel happy most of the time?                                    | yes        | <b>no</b> |
| 8. Do you often feel helpless?  | <b>yes</b> | no        |
| 9. Do you prefer to stay at home, rather than going out and doing things? | <b>yes</b> | no        |
| 10. Do you feel that you have more problems with memory than most?        | <b>yes</b> | no        |
| 11. Do you think it is wonderful to be alive now?                         | yes        | <b>no</b> |
| 12. Do you feel worthless the way you are now?                            | <b>yes</b> | no        |
| 13. Do you feel full of energy?   | yes        | <b>no</b> |
| 14. Do you feel that your situation is hopeless?                          | <b>yes</b> | no        |
| 15. Do you think that most people are better off than you are?            | <b>yes</b> | no        |

*A score of  $\geq 5$  suggests depression*

**Total Score** \_\_\_\_\_

Ref. Yes average: The use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986

# Instructions for Geriatrics Depression Scale (GDS-S): Scoring The Short Form

## Instructions

The GDS-S should be given orally. A clear YES or NO answer is required for each question. If necessary, repeat the question but do not accept a qualified answer from the test-taker. Cross off either yes or no for each question. Depressive answers (errors) are circled on the form and are bolded below. Count up 1 for each depressive answer (error). The final score is the tally of the number of depressive answers with the following scores indicating depression.

- 0-4 No depression
- 5-10 Suggestive of a mild depression
- 11+ Suggestive of severe depression

### **What to do if a patient does not answer a few items.**

For example, if 3 of 15 items are not answered then the total score is score on 12 completed PLUS 3/15ths of total score to make-up for omitted items, e.g. if they got a 4 on the 12 they completed or 1/3 positive, add 1/3 of the 3 missing or 1 point for a total of 5.

### **What if the patient is aphasic?**

Use a point-board, or a board with the scale and yes/no next to the items and have patient point out correct answer. If the patient is aphasic due to dementia then other measures should be used to determine the patients level of depression.