



Public reporting burden for this collection of information is estimated to average 04 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0584). Do not return the completed form to this address.

OMB#: 0925-0584
Exp. 8/31/2017

HCHS/SOL- Visit 2- Well-Being Questionnaire

ID NUMBER:	<input type="text"/>	FORM CODE: WBE	Contact Occasion	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>						
								VERSION: 1, 6/28/2014		0	2			

ADMINISTRATIVE INFORMATION

0a. Completion Date: //

0b. Staff ID:

Instructions: Enter the answer given by the participant for each response. Set CDART Field Status to 'Refused', 'No Response', 'Missing', etc. for those questions that do not list these values as possible answer choices.

A. CES-D 10

I am going to read a list of some of the ways you may have felt or behaved. Please indicate how often you have felt this way during the past week. Respond by saying "rarely or none of the time", meaning less than one day during the past week, 'some or a little of the time', meaning one to two days during the past week, 'occasionally or a moderate amount of time, meaning three to four days, or 'all of the time' meaning five to seven days. Choose only one of these categories for each statement I read.

	Rarely or none of the time (<1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	All of the time (5-7 days)
1. I was bothered by things that usually don't bother me.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. I had trouble keeping my mind on what I was doing.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. I felt depressed.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. I felt that everything I did was an effort.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. I felt hopeful about the future.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. I felt fearful.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. My sleep was restless.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. I was happy.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
9. I felt lonely.	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
10. I could not "get going".	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

ID NUMBER:								
------------	--	--	--	--	--	--	--	--

FORM CODE: WBE
VERSION: 1, 6/28/2014

Contact Occasion

0	2
---	---

SEQ #

--	--

B. GAD-7

Over the **last 2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
11. Feeling nervous, anxious or on edge	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
12. Not being able to stop or control worrying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
13. Worrying too much about different things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
14. Trouble relaxing	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
15. Being so restless that it is hard to sit still	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
16. Becoming easily annoyed or irritable	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
17. Feeling afraid as if something awful might happen	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>