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OMB#: 0925-0584  
Exp. xx/xx/xxxx

## HCHS/SOL- Visit 2- Well-Being Questionnaire

ID NUMBER:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	FORM CODE: WBE	Contact Occasion	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
								VERSION: 1, 12/10/2013		0	2			

### ADMINISTRATIVE INFORMATION

0a. Completion Date: //

0b. Staff ID:

**Instructions:** Enter the answer given by the participant for each response. The special value, "Q", is allowed for cases where the response 'Don't know/refused' is not listed as an option.

### 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 item 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:								
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Contact  
Occasion

0	2
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SEQ #

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**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
1. Feeling nervous, anxious or on edge	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Not being able to stop or control worrying	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. Worrying too much about different things	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. Trouble relaxing	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. 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"/>
6. Becoming easily annoyed or irritable	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Feeling afraid as if something awful might happen	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>