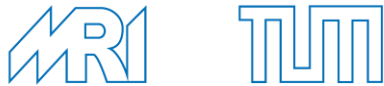


Supplementary material

Preliminary Questionnaire for the Assessment of Depression Symptoms in Primary Care (DESY-PC)

S1. Preliminary DESY-GP after iterative construction



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Development of a questionnaire for depression diagnosis in general practices

Documentation for general practitioner

Patient number

Dear colleague,

We would like to ask you to complete this questionnaire for depression diagnostics after the consultation with your patient. The following questions are intended to help you assess if the patient you are examining suffers from depression. Try to answer the following questions by using your **impression from the last consultation** and also your **general knowledge of the patient**. If none of the options seems correct, choose the one that is most likely to be accurate.

	Yes	No
1. Do I have the impression that this patient is depressed?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do I have the impression that this patient is irritated?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do I agree that the patient's reason for the encounter sufficiently explains the symptoms presented?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does this patient show a more substantial pain experience than that defined by medical findings (e.g. increased complaints)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does this patient show signs of reduced resilience in their daily life?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does this patient show signs of increased fatigue and/or exhaustion?	<input type="checkbox"/>	<input type="checkbox"/>
7. Has this patient claimed an abnormal number of attestations or work incapacity certificates?	<input type="checkbox"/>	<input type="checkbox"/>
8. Has this patient mentioned work-related problems?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has this patient mentioned family problems?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has this patient shown signs of social withdrawal?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has this patient shown signs of worrying about the future?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does this patient show signs of joylessness and/or loss of interest?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does this patient show signs of dejection, melancholy and/or hopelessness?	<input type="checkbox"/>	<input type="checkbox"/>
14. Does this patient show signs of sleep disorders?	<input type="checkbox"/>	<input type="checkbox"/>
15. Does this patient show signs of impaired concentration?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does this patient have a history of depressive phases?	<input type="checkbox"/>	<input type="checkbox"/>
17. Does this patient have any close relatives with mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
18. Does this patient show signs of an addiction problem (C2, nicotine, cannabis, medication, other drugs, media or gambling addiction)?	<input type="checkbox"/>	<input type="checkbox"/>
19. Does this patient have any relevant physical illnesses?	<input type="checkbox"/>	<input type="checkbox"/>
20. For women: Does this patient use hormonal contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>
21. Do I notice anything else unusual regarding depression?	<input type="checkbox"/>	<input type="checkbox"/>



Development of a questionnaire for the diagnostics of depression in general practices

Documentation for patient

Patient number

We are interested in **factors that are often associated with depression**. Please answer each question as well as you can. If none of the options seem suitable to you, choose the one that corresponds the most to your situation.

	Yes	No
1. Do you have any physical illnesses from which you particularly suffer?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you suffer from frequently occurring pain?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you currently have any family problems?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you currently have difficulties with friends and acquaintances?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you currently experience difficulties in your romantic relationship?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you currently experience difficulties at work?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you currently have any financial difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are you burdened by raising children?	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you had depressive phases before?	<input type="checkbox"/>	<input type="checkbox"/>
10. Were there any events in your life that were particularly distressing for you?	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you been or are you receiving treatment for a mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you taking medication to treat any mental illnesses (psychopharmacological drugs)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does anyone in your immediate family have a mental illness?	<input type="checkbox"/>	<input type="checkbox"/>

In the following, we are interested in how you have been feeling lately. The following questions are about **the past 2 weeks**. Please answer each question as well as you can. If none of the options seems suitable to you, choose the one that corresponds most to your situation.

	Yes	No
1. In the last 2 weeks, have you felt down and/or sad often?	<input type="checkbox"/>	<input type="checkbox"/>
2. In the last 2 weeks, have you had significantly less pleasure in things you usually like to do?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the last 2 weeks, have you had less interest in your activities than usual?	<input type="checkbox"/>	<input type="checkbox"/>
4. In the last 2 weeks, have you had more problems concentrating than usual?	<input type="checkbox"/>	<input type="checkbox"/>
5. In the last 2 weeks, have you been ruminating more than usual?	<input type="checkbox"/>	<input type="checkbox"/>
6. In the last 2 weeks, have you found decision-making more challenging than usual?	<input type="checkbox"/>	<input type="checkbox"/>
7. In the last 2 weeks, have you felt guilty?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the last 2 weeks, have you felt lonely?	<input type="checkbox"/>	<input type="checkbox"/>
9. In the last 2 weeks, have you found yourself reducing your social encounters?	<input type="checkbox"/>	<input type="checkbox"/>
10. In the last 2 weeks, did you find everyday activities (e.g. getting up, eating, going to work) more difficult to perform than usual?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
11. In the last 2 weeks, have you been sleeping worse than usual (e.g., trouble falling asleep, trouble staying asleep, early morning awakenings, and/or increased amount of sleep)?	<input type="checkbox"/>	<input type="checkbox"/>
12. In the last 2 weeks, have you felt tired and/or exhausted more often than usual?	<input type="checkbox"/>	<input type="checkbox"/>
13. In the last 2 weeks, have you felt listless and without energy?	<input type="checkbox"/>	<input type="checkbox"/>
14. In the last 2 weeks, has everything been more stressful for you than usual?	<input type="checkbox"/>	<input type="checkbox"/>
15. In the last 2 weeks, have you felt like everything is hopeless?	<input type="checkbox"/>	<input type="checkbox"/>
16. In the last 2 weeks, have you felt like everything is meaningless?	<input type="checkbox"/>	<input type="checkbox"/>
17. In the last 2 weeks, have you felt like you were failing?	<input type="checkbox"/>	<input type="checkbox"/>
18. In the last 2 weeks, have you been more irritable than usual?	<input type="checkbox"/>	<input type="checkbox"/>
19. In the last 2 weeks, have you been concerned about things or situations that usually do not bother you?	<input type="checkbox"/>	<input type="checkbox"/>
20. In the last 2 weeks, have you thought your speech and/or movements have been slower than usual?	<input type="checkbox"/>	<input type="checkbox"/>
21. In the last 2 weeks, have you been "fidgety" and/or restless and had a stronger urge to move than usual?	<input type="checkbox"/>	<input type="checkbox"/>
22. In the last 2 weeks, have you noticed any changes in appetite (e.g. less or more appetite than usual)?	<input type="checkbox"/>	<input type="checkbox"/>
23. In the last 2 weeks, have you had less desire for sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
24. In the last 2 weeks, have you felt like life is not worth living?	<input type="checkbox"/>	<input type="checkbox"/>
25. In the last 2 weeks, have you thought you would rather be dead?	<input type="checkbox"/>	<input type="checkbox"/>
26. In the last 2 weeks, have you tried to compensate for unpleasant feelings by smoking more?	<input type="checkbox"/>	<input type="checkbox"/>
27. In the last 2 weeks, have you tried to compensate for unpleasant feelings by drinking more alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
28. In the last 2 weeks, have you tried to compensate for unpleasant feelings by using other addictive substances (e.g., cannabis, ecstasy, cocaine, pills)?	<input type="checkbox"/>	<input type="checkbox"/>
29. In the last 2 weeks, have you tried to compensate for unpleasant feelings by consuming media (cell phone, television, internet)?	<input type="checkbox"/>	<input type="checkbox"/>