

YOUR NAME:

DATE:

dd-mmm-yy

## Sheehan Disability Scale

**A brief, patient rated, measure of disability and impairment.**

Please mark ONE circle for each scale.

**WORK\* / SCHOOL**

**The symptoms have disrupted your work / school work:**

Not at all                      Mildly                      Moderately                      Markedly                      Extremely

0   ←    1   —    2   —    3   —    4   —    5   —    6   —    7   —    8   —    9   →    10

I have not worked / studied at all during the past week for reasons unrelated to the disorder.  
\* Work includes paid, unpaid volunteer work or training

**SOCIAL LIFE**

**The symptoms have disrupted your social life / leisure activities:**

Not at all                      Mildly                      Moderately                      Markedly                      Extremely

0   ←    1   —    2   —    3   —    4   —    5   —    6   —    7   —    8   —    9   →    10

**FAMILY LIFE / HOME RESPONSIBILITIES**

**The symptoms have disrupted your family life / home responsibilities:**

Not at all                      Mildly                      Moderately                      Markedly                      Extremely

0   ←    1   —    2   —    3   —    4   —    5   —    6   —    7   —    8   —    9   →    10

### Days Lost

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? \_\_\_\_\_

### Days Unproductive

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? \_\_\_\_\_