# PHQ-15 Somatic Symptom Severity Scale

During the past 7 days, how much have you been bothered by any of the following problems?

| | Not bothered at all | Bothered a little | Bothered a lot |
|---|---|---|---|
| 1. Stomach pain | | | |
| 2. Back pain | | | |
| 3. Pain in your arms, legs, or joints (knees, hips, etc.) | | | |
| 4. Menstrual cramps or other problems with your periods WOMEN ONLY | | | |
| 5. Headaches | | | |
| 6. Chest pain | | | |
| 7. Dizziness | | | |
| 8. Fainting spells | | | |
| 9. Feeling your heart pound or race | | | |
| 10. Shortness of breath | | | |
| 11. Pain or problems during sexual intercourse | | | |
| 12. Constipation, loose bowels, or diarrhea | | | |
| 13. Nausea, gas, or indigestion | | | |
| 14. Feeling tired or having low energy | | | |
| 15. Trouble sleeping | | | |