Appendix 3: Shona symptom questionnaire for the detection of depression and anxiety

Client name:_____ Client ID:_____ Date: _____

	Musvondo rapfuura: *During the course of the past week:*	Ehe *Yes*	Aiwa *No*
1	Pane pamaimboona muchinyanya kufungisisa kana kufunga zvakawanda here? *Did you sometimes think deeply or think about many things?*		
2	Pane pamaimbotadza kuisa pfungwa dzenyu panwechete here? *Did you find yourself sometimes failing to concentrate?*		
3	Maimboshatirwa kanakuita hasha zvenhando here? *Did you lose your temper or get annoyed over trivial matters?*		
4	Maimborota hope dzinotyisa kana dzisina kunaka here? *Did you have nightmares or bad dreams?*		
5	Maimboona kana kunzwa zvinhu zvangazvisinga onekwe kana kunzwikwa nevamwe? *Did you sometimes see or hear things others could not see or hear?*		
6	Mudumbu menyu maimborwa dza here? *Was your stomach aching?*		
7	Maimbovhundutswa nezvinhu zvisina mature here? *Were you frightened by trivial things?*		
8	Maimbota dza kurara kana kushaya hope here? *Did you sometimes fail to sleep or did you lose sleep?*		
9	Pane pamaimbonzwa muchiomerwa neupenyu zvekuti makambochema kana kuti makambonzwa kuda kuchema here? *Were there times when you felt life was so tough you cried or wanted to cry?*		
10	Maimbonzwa kuneta here? *Did you feel run down (tired)?*		
11	Pane pamaimboita pfungwa dzekuda kuzviuraya here? *Did you sometimes feel like committing suicide?*		
12	Mainzwa kusafara here mune zvamaiita zuva nezuva? *Were you generally unhappy with the things you were doing each day?*		
13	Basa renyu raive rave kusarira muma shure here? *Was your work lagging behind?*		
14	Mainzwa zvichikuomerai here kuti muzive kuti moita zvipi? *Did you feel you had problems deciding what to do?*		
	Scoring : Add together the number of questions to which the client responded " yes"	**Total Score:**	

Scoring information

0-7: Re-screen in one year.

8-14: Provide brief counselling intervention. Refer for further assessment and to CBO for psychosocial services.

If a client scores 7 or less but is still suspected of mental health symptoms, they should be considered to have a positive score and receive a brief counselling intervention and referral as appropriate.

Action taken:_____

_____

Brief counselling: Yes No

Referral: Yes No

Referred to:_____