

During the past 4 weeks, how much have you been bothered by any of the following problems?

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
Stomach pain			
Back pain			
Pain in your arms, legs, or joints (knees, hips, etc.)			
Menstrual cramps or other problems with your periods WOMEN ONLY			
Headaches			
Chest pain			
Dizziness			
Fainting spells			
Feeling your heart pound or race			
Shortness of breath			
Constipation, loose bowels, or diarrhea			
Nausea, gas, or indigestion			
Feeling tired or having low energy			
Trouble sleeping			

(For office coding: Total Score T (x) \_\_\_\_\_ = \_\_\_\_\_ + \_\_\_\_\_ ). In females  $y = x (15/14)$ . In males  $y = x (14/13)$

**Supplementary file 2.** Modified PHQ-15 questionnaire

	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods <b>WOMEN ONLY</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Feeling tired or having low energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>