Algos Behavioral Health Services, Inc.
West Oaks Building
2161 NW Military Hwy., Suite 207
San Antonio, TX 78213
Tel. (210) 447-6363 Fax (210) 447-6364
www.thealgosgroup.com

Karri Lusk, Psy.D.
Sean Connolly, Ph.D.
Sandy Zamora, LPC-S

Behavioral Health Evaluation for Spinal Surgery Candidates

You have been referred by your pain management physician for a Behavioral Health Assessment (BHA) as part of evaluating your candidacy for a dorsal column stimulator, spinal cord stimulator, intrathecal pump, or spinal surgery.

This is a routine step for individuals having these procedures. Such treatment options are invasive medical procedures and frequently require a Behavioral Health Assessment. This step will assist your physician in selecting the preferred treatment procedure, maximizing recovery, and predicting potential surgical outcomes. Insurance companies require such a BHA to assist the physician in determining that this is an appropriate procedure for your pain treatment. The purpose of this assessment is to identify and evaluate possible risk factors that may predict a successful or unsuccessful outcome to this procedure. Since your physician is considering a major procedure for the treatment of your chronic pain, every effort is made to make the best clinical judgment for its effectiveness. Research has shown that there are some medical, psychosocial and emotional risk factors that may predict an unsuccessful outcome. This BHA will help to determine the presence of any of these risk factors so appropriate treatments can be identified and implemented before and after you undergo the proposed surgery. Thus, it will help your physician make a more informed clinical decision about this step in the treatment of your chronic pain.

The BHA will consist of a clinical interview including a review of medical history and past life experiences, completion of some informational checklists and psychological testing instruments. You will have the opportunity to discuss with the psychologist/clinical associate any concerns you may have, and medical questions will be conveyed to the physician and his/her medical team. This BHA may take 3-4 hours to complete. Some of the paperwork can be completed at home prior to the appointment in order to facilitate the process. The extent of the assessment and what instruments will be administered depends on what the insurance company has requested and/or approved. The psychologist/clinical associate will utilize standard professional guidelines to assist with the clinical judgment and determination of your candidacy for this surgery. Every effort will be made to complete the assessment as efficiently as possible. Feel free to ask the clinician any questions you have about these psychological procedures.

ALGOS BEHAVIORAL HEALTH SERVICES, INC.

NEW PATIENT INFORMATION RECORD

Today's Date:		Referred By:	
Patient Full Legal Name:			
Date of Birth: / /	Age:	Male / Female	Male
SSN: / /		Marital Status:	Widowed
Address **(physical)**:		Drivers License#:	
City:	State:	Zip Code(9 digits):	
Home Phone: ( )	Cell Phone: ( )	Work: ( )	EXT#
Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail?			
◉ **YES** ○ **NO**	**If yes, which is best:**	Work	
Email Address**:**			
Employer's Name:		Occupation:	
Address:	City:	State:	Zip:

PRIMARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Primary Insurance:		Phone # *(Located on the back of card)*	
Subscriber ID#:		Group # :	
Name of Policy Holder:		**DOB**:	
Insured's Address:		☐ **same as patient**	
City:	**State:**	**Zip Code(9 digits):**	
Policy Holder's Employer:			
Patient Relationship to Policy Holder:	Partner		

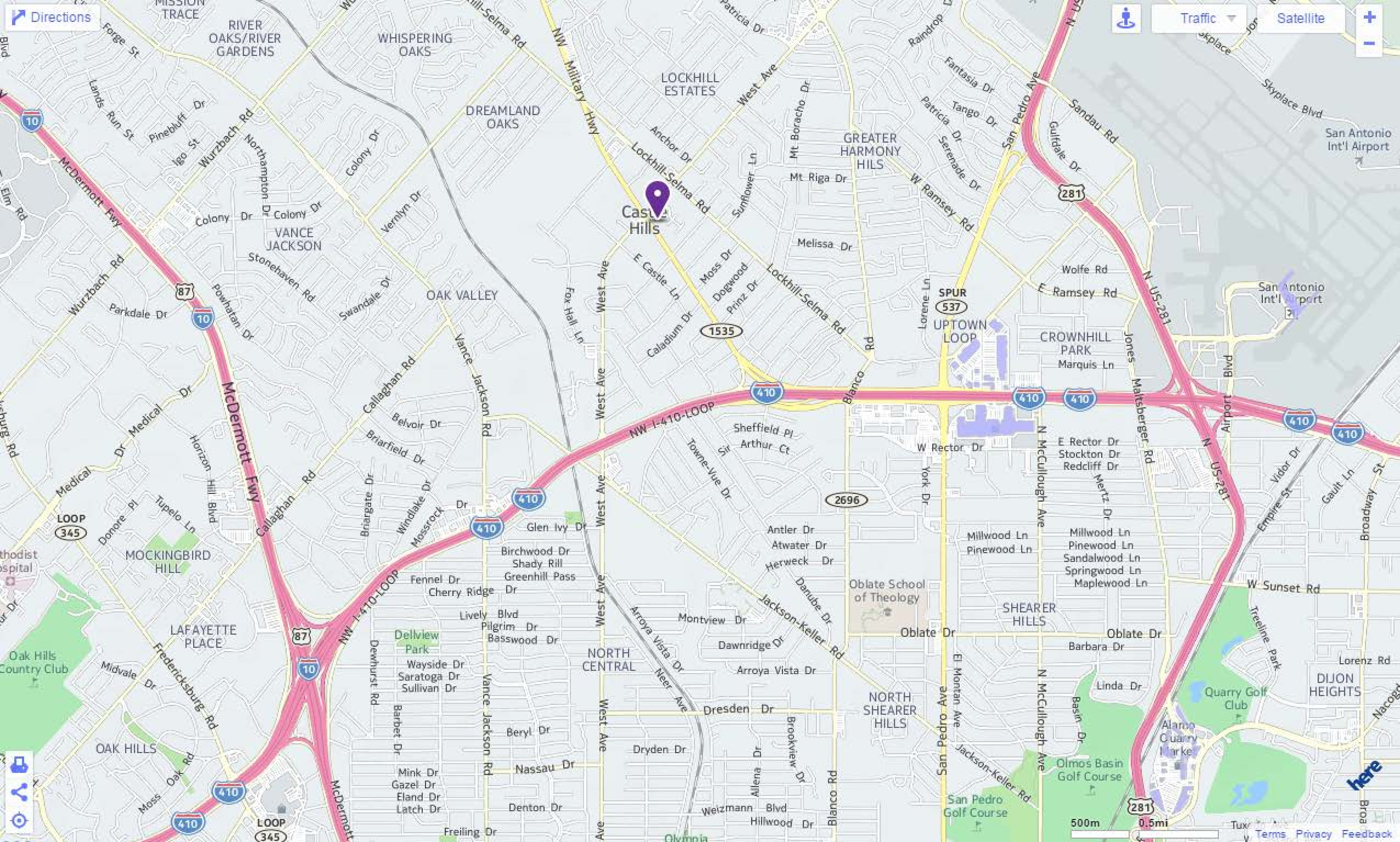
SECONDARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Secondary Insurance:		Phone # (*Located on the back of your card*):	
Subscriber ID#:		Group # :	
Name of Policy Holder:		**DOB**:	
Insured's Address:		☐ **same as patient**	
City:	**State:**	**Zip Code(9 digits):**	
Policy Holder's Employer:			
Patient Relationship To Insured: SEL	Partner		

EMERGENCY CONTACT PERSON

Name:	Relationship:	Other
Home Phone: ( )	Work Phone: ( )	EXT:


Directions
Traffic
Satellite
MISSION TRACE
RIVER OAKS/RIVER GARDENS
WHISPERING OAKS
DREAMLAND OAKS
LOCKHILL ESTATES
GREATER HARMONY HILLS
San Antonio Int'l Airport
Castle Hills
VANCE JACKSON
OAK VALLEY
UPTOWN LOOP
CROWNHILL PARK
MOCKINGBIRD HILL
LAFAYETTE PLACE
Oak Hills Country Club
OAK HILLS
Dellview Park
NORTH CENTRAL
Oblate School of Theology
SHEARER HILLS
NORTH SHEARER HILLS
DIJON HEIGHTS
Quarry Golf Club
Alamo Quarry Market
Olmos Basin Golf Course
San Pedro Golf Course
Olympia
Methodist Hospital
McDermott Fwy
NW Military Hwy
Lockhill-Selma Rd
West Ave
Blanco Rd
San Pedro Ave
N McCullough Ave
N US-281
NW I-410-LOOP
Vance Jackson Rd
Callaghan Rd
Wurzbach Rd
Medical Dr
Fredericksburg Rd
Jackson-Keller Rd
Airport Blvd
E Ramsey Rd
W Ramsey Rd
Wolfe Rd
Sandau Rd
Skyplace Blvd
W Sunset Rd
Oblate Dr
Dresden Dr
Nassau Dr
W Rector Dr
10
87
410
281
1535
2696
SPUR 537
LOOP 345
500m
0.5mi
here
Terms
Privacy
Feedback

ALGOS BEHAVIORAL HEALTH SERVICES, INC.
Financial Policy

Thank you for choosing Algos Behavioral Health Services, Inc. as your mental health care provider. The following is a summary of our financial policies. Please read the information carefully and sign or initial where noted below. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/ or information prior to your visit will result in payment due in full at the time of visit.

Initial below please:

_____ 1. **PAYMENTS**. **All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment**.
Initial We accept cash or credit card (Visa, MasterCard, or Discover). Unpaid accounts may be referred to an outside collection agency.

_____ 2. **CANCELLATIONS**. To reserve the hour of the clinician's time, we request a credit card to assure you of the availability of the
Initial doctor. There is a fee of **$50.00** for a missed appointment or late cancellation. You can avoid this charge if you cancel 24 or more hours prior to the appointment. Your insurance carrier will not cover this fee.
____ ** When applicable, for individuals scheduled for a testing appointment – you will be charged **$50.00** for every hour of testing that is missed or not cancelled within 24 hours. For example, if you are scheduled for 3 hours of testing, and you cancel or do not show for that appointment time, you will be charged $150.

_____ 3. **CHANGE OF INFORMATION**. You are responsible to provide us with any change regarding your address, phone number or
Initial insurance information as soon as possible.

_____ 4. **PRIVATE INSURANCE AUTHORIZATION AND INFORMATION RELEASE.**
Initial I, the undersigned, authorize payment of mental health benefits to Algos Behavioral Health Services, Inc for any services rendered. **I understand that I am financially responsible for any amount not covered by my insurance policy including but not limited to co-payments, co-insurance and deductibles.** Any payments denied by the insurance company will be forwarded to the undersigned, and the undersigned will be held responsible for payment. I also authorize Algos Behavioral Health Services, Inc to release to my insurance company any information concerning health care, diagnosis or treatment provided to me. This information will be used only for the purpose of evaluating and administering claims of benefits.

_____5. **POTENTIAL NON COVERAGE**
Initial Although other medical services may be covered by your insurance, this psychological service may not be covered and, in that case, you will be fully responsible for the entire amount**.** If the clinician is *out-of-network* with your insurance policy, you will be required to pay the full amount of the service rendered. We will NOT file claims for out-of-network services.

_____ 6. **NON-COMPLIANCE.** We reserve the right to discontinue care with you for non-compliance with any of the above
Initial policies.

_____ 7. The undersigned agrees that in the event of **default in payment** or if the account is placed with a collection agency for
Initial collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, and court costs, at the interest rate of 18% per annum.

For all services rendered to minor patients, the adult accompanying the patient, or the policy holder, is responsible for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____ **Date:** _____
Signature of Patient OR Responsible Party if a Minor

_____
Printed Patient Name

I WILL NOT BE USING INSURANCE FOR THIS SERVICE AND WILL PROVIDE ANOTHER FORM OF PAYMENT.

SIGNED: _____ **DATE:** _____

Behavioral Health Assessment

Name: _____ Age:_____
Today's Date: _____

Reason for Referral? ☐ Stimulator Implant ☐ Intrathecal Pump ☐ Spinal Surgery
☐ Depression/mood concerns ☐ Pain Management

Referring physician: _____

History of Pain

_____
_____
_____
_____
Was pain caused by injury? If so, when and how were you injured? _____
_____
_____

Medical Treatment for Pain

Surgery related to pain? _____ When & what type? _____
Outcome? _____
_____
Steroid injections _____; Trigger point injections_____; Physical therapy_____;
Chiropractor_____; Acupuncture_____; Massage therapy_____; Water therapy_____;
Nerve Blocks_____; Radio frequency_____; Medications _____; TENS unit _____;
Other procedures? _____
_____
Current pain medications: _____
Level of relief: poor (0%) ____ fair ____ moderate ____ good ____ very good (100%) _____

Psychological Pain Management Strategies

Have you used relaxation techniques? _____ Biofeedback Therapy_____
Clinical Hypnosis _____ Pain Management Psychotherapy _____ Pain Groups_____
Yoga _____ Other _____
Were these strategies helpful? _____

Other Medical Problems

High blood pressure _____ High Cholesterol_____ Diabetes _____ Heart problems _____
Migraines_____ CRPS/RSD_____ Fibromyalgia _____ Arthritis _____ Stroke _____
Hypothyroidism _____ COPD _____ Sleep apnea _____ Memory problems _____
Other conditions _____
_____
Other injuries, surgeries, accidents: _____
_____
Have you ever had a head injury or concussion? _____ Details - _____
_____

Pain Location/Intensity

Where is most of your pain localized? Lower back ___ upper back/neck ___ mid-back ____
right leg ___ left leg ___ both legs and feet ____ left arm ___ right arm ____
right shoulder ___ left shoulder ___ head ___ tailbone ___ headaches ____ hips ____

On a scale of 0 to 10, (0 being no pain, 10 being the worst pain imaginable) what level is your pain: Most of the time? ____ On a good day? ____ On the worst day? _____ Today? _____
The pain is most intense – When you get up in the morning? ____ As the day progresses? _____
Afternoon/Evening? _____ No change during the day? _____

Factors Influencing Pain

What *aggravates* your pain? movement ____ activity ____ standing _____ sitting _____
walking ____ lying down ____ weather changes ____ stress ____ conflict _____
Other_____
What *alleviates* your pain? inactivity ____ resting ____ lying down ____ walking ____
massage ____ medication ____ stretching ____ exercise ____ relaxation ____ sleeping _____
changing posture/position ____ ice ____ heat ____ other_____

Level of Activity

Currently employed? _____ **OR** When were you last employed? _____
Daily activity? _____
Are you awake most of the day? _____ Time spent in bed during the day? _____
Do you do household chores? cook meals ____ dishwashing ____ laundry ___ fold clothes ____
yard work ___ dust ____ vacuum ___ dust ____ sweep ____ repairs ___ care for children ____

Current level of functioning as compared to before injury/onset of pain?
60%___ 50%___ 40%___ 30%___ 20%___ 10%___ 5%___

How do you spend most of your time? _____
TV ___ Reading ___ Playing games/puzzles ___ Computer ___ School ___ Volunteer ____
Hobbies ____ Distractions ____ Other: _____

Sleep Patterns: Limited sleep _____ No sleep problems _____
Excessive sleep _____ Sleep during the day _____
No sleep _____ Interrupted sleep _____
Use of sleep meds. _____
Comments: _____
How does sleep deprivation affect you? _____
_____

Personal and Social History

With whom are you living? _____ How long have you been married? _____
Do you have children? _____ How many & ages? _____
Any other info. on family life? _____
_____

Birthplace: _____ Where have you lived most of your life? _____
_____
Family of origin - How many **total children** in your family growing up? _____
Where did you fit in the birth order? #_____ How was family life? _____
Abuse or trauma? _____
_____

Education and Work History

How far did you go in formal school? _____ City/State? _____
How did you do in school? _____

College Experience? _____
Vocational Training? _____

What kind of work have you done? _____
_____
How long have you been out of work? _____
Have you been able to return to work? _____
Work/Career concerns? _____

Psychological Functioning

How are you doing emotionally? _____
Depression_____; Anxiety or stress_____; Panic Attacks _____; Excessive anger_____
Current symptoms?

___loss of sleep
___excessive sleep
___insomnia
___loss of appetite
___excessive appetite
___crying episodes
___social withdrawal/wanting to be alone
___loss of energy/motivation to do things
___loss of interest in enjoyable activities
___mood swings/rapid mood changes
___agitation/restlessness
___negative/pessimistic thoughts
___sense of worthlessness
___sense of hopelessness
___low self-esteem/self-confidence
___irritability/getting upset with people easily
___loss of enjoyment in life (anhedonia)
___fatigue/always tired
___loss of sexual interest/desire (decreased libido)
___concentration problems
___forgetfulness/memory problems
___manic behavior
___sad feelings
___excessive feelings of guilt
___weight loss/gain _____
___indecisiveness/unable to make decisions
___inability/difficulty in thinking clearly
___thoughts of dying
___other mood problems_____
___thoughts of suicide; if so, how frequently_____
___passive death wishes; if so, how frequently_____
___any suicide attempts in your lifetime? _____ If so, how many? _____
What did you do? _____
What happened? _____
___hospitalized ___ER visit ___stomach pumped ___charcoal ___sutures
How recently was the *last suicide attempt*? _____ Details_____
Any serious consideration of suicide at this time? _____

*Anxiety/panic attacks? _____How often? _____
Symptoms of panic attacks:

___racing heart	___sweating	___trembling/shaking
___shortness of breath	___sense of choking	___fear of dying
___sense of terror	___chest pain/discomfort	___agitation
___nausea	___dizziness/lightheadedness	___chills
___fear of losing control	___hot flashes	___avoid people

How do you manage these episodes/attacks? _____
_____

Diagnosis
What mental health diagnosis have you had? _____
_____

Treatment
Have you ever seen a **Psychiatrist**? _____
Details - _____
Medications taken in the **past** for depression/anxiety_____
Current medications for emotional difficulties _____
Are the medications helping? _____ Are medications needed? _____

Have you ever been hospitalized for emotional issues? _____
Where? _____When? _____
For how long? _____Outcome_____
Follow-up treatment? _____

Have you ever seen a **therapist/counselor/psychologist**? _____
For how long? _____ Are you seeing anyone now? _____ Who? _____

Psychosocial Stressors

What contributes to your depression and stress? _____

___chronic/constant pain	___physical restrictions	___slow/no medical progress
___change in the quality of life	___inactivity	___loss of health
___loss of employment	___loss of independence	___loss of career
___financial problems	___being unproductive	___dependence on others
___hassles with insurance co.	___denial of treatment	___employer termination
___no income	___denial of Social Security	___bankruptcy
___dependence on spouse	___uncertainty about future	___changes in the family
___limited mobility	___inability to drive	___restricted social life
___disappointment with surgical outcome		___dependence on medication for relief
___marital problems	___changes in parenting	___disabling condition
___social isolation	___people's reactions to pain	___loss of friends/support
___trauma of injury	___changes in intimacy	___death of a loved one
___unable to play with kids	___change of roles in family	

Others_____

Addiction/Dependence Issues

Current use of tobacco products? _____ How many, how often? _____
For how long? _____ History of use? _____

Current use of alcohol? _____
Any history of abuse of alcohol? _____ Have you ever been an alcoholic? _____
Treatment_____ Outcome _____

Current use of street drugs? _____ Which drugs? _____
How much, how often? _____
Treatment _____ Outcome _____

History of overuse or abuse of (pain) medications? _____
Details _____

Ever been arrested? _____ For what? _____
Details _____
Current status _____

Any current involvement in lawsuit/legal dispute? _____

Form E

Algos Behavioral Health Services, Inc.

Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., Sandy Zamora, LPC-S

CONSENT TO TREATMENT AND CLINICAL ASSESSMENT SERVICES

This is to certify that I give permission to Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., or Sandy Zamora, LPC-S at Algos Behavioral Health Services, Inc. to provide psychological and behavioral health services for myself and/or child(ren), or for an adult child for whom I am the legal guardian.

I have reviewed the **Statement of Office Policies for Clinical Practice** and the specific assessment and/or treatment procedures have been explained to me.

Service:

___ Psychological Evaluation
___ Psychoeducational Evaluation
___ Neuropsychological Evaluation
___ Behavioral Health Assessment
___ Biofeedback Therapy
___ Other: _____

___ Couple Psychotherapy
___ Group Psychotherapy
___ Family Psychotherapy
___ Individual Psychotherapy
___Group Behavior and Health Intervention

The specific treatment has been described in the written **Statement of Office Policies for Clinical Practice** and/or explained by the clinician. If applicable, alternatives to treatment have been explained to me. Due to the complex nature of psychotherapy and other behavioral health services, including discussing past and present emotional pain and the stresses in life, it is quite common for persons entering this type of treatment to have periods of time when they experience their feelings as more intense, and perceive their condition as possibly worse. This should be discussed as part of the treatment, and is usually temporary. Please note that it is impossible to guarantee any specific results regarding psychological treatment. However, every effort will be made to achieve the best possible results for you. Maximum benefits occur with regular attendance and your active emotional investment in the process.

The issues of confidentiality have been reviewed, and I have been assured that all communications between a professional and a client are held in strict confidence. However, I also understand that there are exceptions to those laws and regulations. I understand it is the clinician's legal responsibility to disclose certain issues for my protection and that of others, and these situations have been clarified to me. Every reasonable effort will be made to resolve issues through discussion and planning within the clinical setting, and I will be notified of any anticipated compromise of the client-therapist relationship.

I have the right to terminate the therapeutic relationship at any time that I desire, without fault, and I have the right to seek and obtain a second opinion on the procedures and/or treatment process.

I understand that I am fully financially responsible for my treatment provided by the clinician, and for any balance that is not covered by my insurance company. A billing service may be used for the

collection of insurance reimbursement and co-pay fees. Psychologists have the right to seek the services of a collection agency to obtain payment of past due balances.

My signature certifies that I have read and understand all the information provided by Algos Behavioral Health Services Inc., about the clinicians, the treatment to be provided, and the expense to be incurred. I hereby voluntarily give my informed consent for treatment. A copy of this authorization shall be considered valid. I understand that I will be informed of any changes concerning what is in this document and my consent will be obtained regarding these changes.

You are assured that the services will be provided in a professional manner, consistent with the rules and regulations of the Texas State Board of Examiners of Psychologists and the ethical principles of the American Psychological Association. Every effort will be made to provide services in a caring, supportive and trustworthy environment.

In addition to the specified procedure checked above, the initial goals of treatment will be established after the first or second session.

My signature certifies that I have been provided the opportunity to read/review the following relevant documents:

- **Notice of Privacy Practices**
- **Statement of Office Policies for Clinical Practice: Psychotherapy, Psychological or Neuropsychological Testing and Behavioral Health Assessments**

My signature certifies that I voluntarily give my informed consent to the clinical services offered by this psychological practice.

X_____ _____

Signature of Client/Patient Date

_____ _____

Signature of Responsible Party (if client is a minor) Date

Form A

Algos Behavioral Health Services, Inc.

Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., Sandy Zamora, LPC-S

Health Insurance Portability and Accountability Act (HIPAA) Consent

General Notice
When seeking psychological consultation and/or treatment in this practice, **P**rotected **H**ealth **I**nformation **(PHI)** will be gathered about you. This information may include a clinical history, medical history, personal information, and possibly performance/responses on psychological testing instruments.

Notice to Protect the Privacy of Your Health Information

A complete description of how your **PHI** may be used and disclosed is available for your review in the **"HIPAA Notice of Privacy Practices."** A copy of this document is available at the reception desk. You may request a copy for your records.

Individual Rights

You have the right to restrict the uses and disclosures of your **P**rotected **H**ealth **I**nformation **(PHI)** for the purpose of treatment and health care. A signed consent form is usually required. This practice is not required to agree to requested restrictions, but is bound by any restrictions to which it agrees.
You have the right to revoke this consent in writing, except to the extent that our practice has taken action on the reliance on this consent. You have the right to refuse to sign this consent. This practice has the right to refuse to provide the clinical services requested, if you refuse to sign the consent or if you revoke this consent at any time.

Your signature below acknowledges:

- You have read and understand this consent;
- You have agreed to have your **P**rotected **H**ealth **I**nformation **(PHI)** used by this practice for the purposes of your consultation and treatment, to secure payment for your treatment, and for this practice's psychological care operations;
- Prior to signing this consent, you were given the opportunity to review the practice's **"HIPAA Notice of Privacy Practices;"**
- You are aware that you may now, or at any time in the future, request restrictions to the use and disclosure of your **P**rotected **H**ealth **I**nformation **(PHI)**;
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent.

X_____ _____
Signature of Client/Patient or Representative Date

Form C

Authorization Form to Release Protected Health Information (PHI)

This form when completed and signed by you authorizes this psychological clinic to release Protected Health Information (PHI) from your clinical record to the person(s) you designate.

I hereby authorize my psychologist and/or clinical associate, Karri Lusk, Psy.D., Seán G. Connolly, Ph.D., or Sandy Zamora, LPC-S and their practice management company, Algos Behavioral Health Services, Inc. and/or their administrative and clinical staff to release *the following specific clinical record and/or administrative/payment information*: (please list which information you want released)
_____results of the psychological evaluation_____

**This information should be released to only the person(s) below:
_____
_____
_____

I am requesting the release of this information for the following reasons:
☐ at the request of the individual ☐ for continuing care ☐ for public agency use
☐ legal purposes ☐ other:_____

This authorization shall remain in effect until _____ (date),
or until _____
(specific purpose).

You have the right to revoke this authorization in writing at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist or clinical associate generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X_____ _____
Signature of Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Algos Behavioral Health Services, Inc.
West Oaks Building
2161 NW Military Hwy., Suite 207
San Antonio, TX 78213
Tel. (210) 447-6363 Fax (210) 447-6364
www.thealgosgroup.com

Karri (Zumwalt) Lusk, Psy.D.
Sean Connolly, Ph.D.
Sandy Zamora, LPC-S

PATIENT NAME: _____

MEDICATION LIST

* Please list all prescribed meds, over-the-counter meds, herbals, supplements, vitamins

Medication Name	Dosage	Frequency	Route of Administration (oral, topical, injection)

NAME: _____ DATE: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score ___ = Add Columns ___ + ___ + ___

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

NAME: _____
DATE: _____
DOB: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Submit Form