LifeLinc Pain Centers New Patient Packet

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Nurse Practitioner
Director of Clinical Operations

Welcome to LifeLinc Pain Centers. Enclosed you will find important information regarding your upcoming appointment. To ensure your experience with our clinic is pleasant and the check-in process functions smoothly, we ask that you prepare for your appointment by completing this New Patient Packet. Please fill out all forms completely prior to arriving for your first visit. Bring all insurance cards, co-pays and a state issued ID or driver license. Also, arrive 30 minutes earlier than the designated appointment time to ensure proper handling of all necessary paperwork. If you are late, we will have to reschedule your appointment. On the day of your appointment, please make sure your bladder is full for any lab collection purposes. We look forward to meeting you and providing exceptional care here at LifeLinc. If you have any questions please feel free to contact our office.

- **PLEASE ARRIVE 30 MINUTES PRIOR to your appointment with packet filled out or you will be rescheduled.**
- **Bring your insurance card and ID.**
- **Be prepared to take a urine drug screen or you will be rescheduled.**
- **Be prepared to pay what your insurance does NOT cover.**

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LifeLinc Patient Information Sheet

Patient Name: ________________________________ __________ ______________________________________
Last Name M.I. First Name

Have you used any other names: __Yes __No If so, what? ____

Social Security Number: ____-____-________ DOB: _____/_____/_____

Address: ____

Phone Number(s): Home: ( ) ____-________ Cell: ( ) ____-________ Work: ( ) ____-________

May we leave a message? Please indicate which number is preferred: ____________________________

Email address: ____ Primary Language: ________________

Race: (check one) __American Indian or Alaska Native __ Asian __ Native Hawaiian or Pacific Islander
__Black or African American __ White __ Hispanic or Latin __Other __ Refuse to Disclose

Gender: (check one) __ Male __ Female Marital Status: ____________ Spouse Name: ________________

EMPLOYER INFORMATION:

Employer Name: ____ Employer Phone: ( ) ____-________

Address: ____

Is this a Worker's Comp injury or auto insurance claim? Yes or No (check one). If yes, please answer the following:

Responsible Party/Company Name: ____

Contact/Adjuster's Name: ____________________________________ Phone Number: ( ) ____-________

Claims Mailing Address: ____

Date of Injury: _____/_____/______ Body Part/Diagnosis Covered: _______________________

PROVIDER INFO:

Referring Provider: ____ Phone Number: ( ) ____-________

PCP Name: ____ Phone Number: ( ) ____-________

INSURANCE INFORMATION:

Primary Insurance: ____ Phone Number: ( ) ____-________

Identification Number: __________________ Policy Holder: _______________________

Policy Holder Relationship: ______________ Policy Holder's DOB: _____/_____/_____

Policy Holder Employer: ________________ Employer Phone Number: ( ) ____-________

Referral Required: __Yes __No (check one). (If referral is required by your insurance company, it is the patient's responsibility to make sure we have one in force and on file prior to services being rendered. If referral is not in force or invalid, patient will be responsible for all charges incurred.)

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Secondary Insurance: ____________________ Phone Number: ______________________

Identification Number: ____________________ Policy Holder: ________________________

Policy Holder Relationship: ________________ Policy Holder's DOB: _____/_____/_____

Policy Holder Employer: _________________ Employer Phone Number: (   ) ____-________

Consent for Insurance Assignment/Payment:

By my signature below: (1) I agree that LifeLinc will use my mobile phone number and email address for the purpose of notifying me of balances due; that , when necessary, I may receive multiple messages per day from LifeLinc; and that I can request alternative communications if I do not wish to receive the messages. (2) I agree that I will pay LifeLinc according to its standard rates for services it provides. (3) I assign all rights I may have against a third party, or that third-party's insurance carrier, who may be liable for the cost of services provided during my care and treatment. (4) I authorize LifeLinc to disclose medical information or copies of medical records to government agencies, insurance companies, and self-insured health plans as required to verify my eligibility for benefits and to obtain reimbursement from any such plans. (5) I agree that if I or my health plan fails to pay for these services and this account is placed in the hands of a collection agency or attorney for collection or suit, I will pay all reasonable collection fees, attorney's fees, costs, and other expenses reasonably incurred. (6) I agree to pay LifeLinc standard charges for completion of documentation I request and for missed appointments. (7) I agree to pay LifeLinc standard charges for missed or cancelled appointments. (8) I acknowledge that I have received and read LifeLinc's financial policy.

Signature of Responsible Party: ____

Have you appointed a healthcare agent or proxy, signed a power of attorney, otherwise named a person to make healthcare decisions for you, or do you wish now to designate a surrogate for this purpose? __Yes __No (check one). If, yes please provide his/her name and contact information below, and supply a copy of any appointment document.

Emergency Contact:

1.) Contact Name: ____ Phone Number : (   ) ____-________

Email address:______________________ Relationship:_____________ Is this person your agent/surrogate? __Yes __No

2.) Contact Name: ____ Phone Number : (   ) ____-________

Email address:______________________ Relationship:_____________ Is this person your agent/surrogate? __Yes __No

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LifeLincPain Centers℠

LifeLinc Financial Policy

We are pleased that you have chosen us for your pain management needs. We are committed to providing you with the highest quality care, achieving desired and reasonable outcomes through a collaborative and comprehensive treatment plan. We would like to thank you for allowing us to take care of you. It is important that you understand the financial policies of our practice. Although our staff is very knowledgeable of most insurance plans, it is equally important that you understand the terms of YOUR medical coverage. Typically you will find your insurance carrier's phone number on the back of your insurance card. We encourage you to contact your insurance company directly with questions regarding YOUR specific coverage.

If you have Medical Insurance Benefits: Please bring your insurance cards to EVERY office visit!

- If you have an insurance plan that requires a referral, such as an HMO or Tricare, you must contact your Primary Care Physician PRIOR to receiving care from our office. Generally, insurance carriers will not cover your claims without a referral AND these charges become your responsibility. If you do not have an active referral on file we will be unable to see you.
- We participate with most insurance plans and our business office will submit claims for services rendered. It is your responsibility to provide all necessary information to file claims prior to leaving our office. We will file insurance claims to all policies we have on file. We will work diligently with your insurance carrier to resolve any conflicts that may arise. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with these requests.
- Your insurance company may REQUIRE us to collect a co-pay for a specialist's office visit as part of your insurance carrier contract. Failure to collect or waive your co-payment may constitute fraud under state and federal law. Please be prepared to pay your copay at each office visit. If you do not have your co-pay, you will not be seen. Additionally, you may have co-insurance and/or deductible amounts required by your insurance carrier. Any outstanding balance on your account following insurance processing will be billed to you.
- It is the policy of LifeLinc to treat all patients in an equitable fashion related to account balances. The practice will not waive any charges due including copays, deductibles, co-insurance or other financial responsibility, as required by state and federal law as well as participation agreements with payers. Full or partial financial responsibility may only be waived by way of the practice's Financial Hardship Policy.

Patient Balances: Patients with account balances in excess of 90 days who have not made payment arrangements or hardship request may be discharged from our practice. If discharged you will have 30 days to seek alternative medical care.

- Our office accepts the following forms of payment: Money order, Check, Cashier's Check, Cash, Credit Card. (Self-pay patients can only pay by methods of Cashier's Check, Check or Credit Card. State regulations forbid us from accepting cash from an uninsured patient.)
- Return Checks will be charged a $40.00 fee. Once a check is returned will we no longer be able to accept future payments in this manner.

If genuine financial difficulties exist, please call our billing office at 901-844-1590. We are happy to work with you in resolving your balance and set up payment arrangements.

LifeLinc strives to provide the highest level of quality of care for our patients. If you have a problem during your visit, please contact our patient hotline at 844-510-0049.

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LifeLinc HIPAA NoPP Acknowledgement

Patient Name: ____ DOB: _____/_____/_____

LifeLinc is concerned about the privacy of our patients' health care information. Our intention is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights as a patient. The delivery of your health care service will not be conditioned in any way upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, operations and continuation of care when necessary.

I acknowledge I have received the Notice of Privacy Practices for LifeLinc Pain Centers.

____ _____/_____/_____

Signature of Patient or Legal Guardian/Relationship Date Signed

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LifeLincPain Centers℠

LifeLinc Pain Management Agreement

Patient Name: ____ DOB: ____/_____/____

The primary goal of the treatment of pain is to clinically improve function, which may include the prescribing of opioid medications. The purpose of this agreement is to assure that you and your health care provider (HCP) comply with all state and federal regulations concerning the prescribing of controlled substances, including opioids. A trial of opioid therapy can be considered for moderate to severe pain with the intent of reducing pain and increasing function. The HCP's goal is for you to have the best quality of life possible given the reality of your clinical condition. The success of treatment depends on mutual trust and honesty in the HCP/patient relationship and full agreement and understanding of the risks and benefits of using opioids to treat pain. It is important to understand that the treatment of pain is not solely focused on opioid therapy, other modalities include non-opioid pharmaceuticals and non-pharmacologic therapies.

I understand opioids (morphine-like drugs) may be prescribed as a part of my treatment for chronic pain. I understand that these medications can be very useful, but have a high potential for misuse and are therefore closely controlled by the local, state and federal governments. Because my HCP may prescribe such medication to help manage my pain, I agree to the following conditions:

1) I am responsible for my pain medications. I agree to take the medication only as prescribed.
    a. I understand that increasing my dose without the close supervision of my HCP could lead to accidental drug overdose causing severe sedation and respiratory depression and even death.
    b. I understand that decreasing or stopping my medication without the close supervision of my HCP can lead to withdrawal. Withdrawal symptoms can include yawning, sweating, watery eyes, running nose, anxiety, tremors, aching muscles, hot and cold flashes, "goose flesh", abdominal cramping and diarrhea. These symptoms can occur 24-48 hours after the last dose and can last up to 3 weeks.
2) I will not request or accept controlled substance medications from any other HCP or individual while I am receiving such medication from my HCP at this pain clinic. This includes emergency rooms, urgent care centers, dentists, surgeons, specialists, etc.
3) There are side effects with opioid therapy, which may include skin rash, constipation, sexual dysfunction, sleeping abnormalities, sweating, swelling of joints, sedation, or the possibility of impaired cognitive ability (mental status) and/or movement. Overuse of opioids can cause decreased respiration (breathing).
4) It is my responsibility to notify my HCP of any side effects that continue or are severe (sedation, confusion, etc.). **I am also responsible for notifying my pain HCP immediately if I need to visit another HCP or ER due to pain or if I become pregnant.**
5) I understand that my prescribed opioid medication is strictly for my own personal use. The opioids should NEVER be given, shared or sold to others because it may endanger that person's health and it is against the law.
6) I should inform all of my HCPs of all medications I am taking, including herbal remedies and over-the-counter products. Benzodiazepines like Valium, Ativan or Xanax, etc.; sedatives like Soma, Fiorinal, etc.; antihistamines like Benadryl; some herbal remedies; alcohol; and cough syrups containing alcohol, codeine or hydrocodone can interact with opioids and produce serious harmful effects.

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7) I understand that opioid prescriptions cannot be called in to a pharmacy or mailed. Proper follow up is required at appropriate intervals in this pain clinic.

8) Any evidence of drug hoarding, acquiring opioid medication or other pain medication from other HCPs (including emergency rooms and dentists), uncontrolled dose increase or reduction, loss of prescriptions or failure to follow this agreement may result in termination of your relationship with this pain clinic.

9) I will communicate fully with my HCP to the best of my ability at the initial and all follow-up visits about my pain level and functional ability along with any side effects of the medications. This information allows our HCP to adjust your treatment plan accordingly.

10) You are NOT to use any illicit substances, such as cocaine, marijuana, methamphetamines, etc. while taking these medications. This may result in a change to your treatment plan, including safe discontinuation of your opioid medications when applicable or complete termination of your relationship with this pain clinic.

11) The use of alcohol together with opioid medication is dangerous and must be avoided.

12) I am responsible for my opioid prescription. I understand that:

   a. Refill prescriptions can be written for a maximum of one month supply and will be filled at the following pharmacy:

      Pharmacy: ______________________________

      Address: ______________________________

      Phone Number: ______________________________

   b. It is my responsibility to schedule appointments for the next opioid refill before I leave the clinic or within 3 days of the last clinic visit.

   c. I am responsible for keeping my pain medications in a safe and secure place. I am expected to protect my medi cation from loss or theft. It is recommended that all controlled substances be kept in a locked cabinet or safe. I am responsible for taking the medication in the dose prescribed and for keeping track of the amount remaining. Replacement of a lost or stolen prescription will be at the discretion of the HCP, and not without a police report.

   d. Refills on an “emergency” basis are not provided by our office.

   e. Prescriptions for pain medicine or any other prescription from our office will be provided only during an office visit during regular office hours. No refill of medications will be given after hours, weekends or on holidays.

   f. You must bring back all opioid medications and other medications prescribed by your HCP in the original bottles/containers at each visit. You must participate in pill counts required by your HCP.

   g. If an appointment for a prescription refill is missed, another appointment will be made as soon as possible, but immediate or emergency appointments cannot be provided.

   h. No walk-in appointments for opioid refills will be made.

13) While physical dependence is a probable outcome and expected after long-term use of opioids, signs of addiction, abuse or misuse shall prompt the need for substance dependence treatment as well as weaning and detoxification from the opioids.

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a. Physical dependence is common to many medications/drugs, such as blood pressure medications, anti-seizure medications and opioids. It results in biochemical changes such that abruptly stopping these medications will cause a withdrawal response. Physical dependence does not equal addiction. For example, one can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

b. Addiction is a primary, chronic neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and cravings. This means the drug decreases one's quality life. If you exhibit such behavior, the medication will be tapered and you will no longer be a candidate for opioid therapy, and you will be referred to an addiction medicine specialist.

c. Tolerance means a state of adaptation in which exposure to the drug induces changes that result in a lessening of one or more of the drug's effects over time. The dose of the opioid may have to be adjusted up or down to a dose that produces maximum function and a realistic decrease of your pain. It is our goal to maintain levels of opioids at the lowest dose possible to achieve these goals.

14) If it appears to the HCP that there is no improvement in my daily function or quality of life from the controlled substance, my opioids may be slowly weaned and discontinued. I agree to gradually taper my medications as outlined by my HCP.

15) If I have a history of alcohol or drug misuse/addiction, I must notify the HCP of such history since the treatment with opioids for pain increases the potential for relapse. A history of addiction does not, in most instances, disqualify one for opioid treatment of pain, but starting or continuing a program for recovery is a necessity.

16) I will be seen on a regular basis and given prescriptions for enough medication to last from appointment to appointment.

17) I agree and understand that my HCP reserves the right to perform random or unannounced urine drug testing. I agree to cooperate if requested to provide a urine sample, I agree to cooperate. If I decide not to provide a urine sample, I understand that my HCP may change my treatment plan, including safe discontinuation of my opioid medications when applicable or complete termination of my relationship with this clinic. Urine or oral drug testing is done for my benefit as a diagnostic tool and in accordance with certain legal requirements for the use of controlled substances for the treatment of pain.

18) I agree that my HCP may contact any health care provider, pharmacy, legal authority or regulatory agency to obtain or provide information about my care or actions if the HCP feels it is necessary.

19) I agree to a conference with my family or significant other if the HCP feels it is necessary.

20) I understand that non-compliance with the above conditions may result in a re-evaluation of my treatment plan and discontinuation of opioid therapy. I may be gradually taken off these medications, or even discharged from the clinic.

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I have read the above information or it has been read to me and all my questions regarding the treatment of my pain by LifeLinc Pain Centers with opioids have been answered to my satisfaction. I hereby give my consent to participate in my pain treatment plan and acknowledge receipt of this document.

Patient's Signature:____ Date:__________________

Print Name:____

Witness' Signature ____ Date: _________________

Provider Signature: ____

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LifeLincPain Centers℠

New Patient Medical History Form

Patient Name: ______________________________

Name Of Primary Care Provider: ______________________________

DOB: _____/_____/_____ Referring Provider: ______________________________

Gender: ______________________________

PAIN HISTORY BACKGROUND

1. What is your age? ______________________

2. Your main pain complaint and how did it start?

____

____

____

3. If pain is located in the neck or back, does it radiate into your arms or legs?

Y ___ N ___

4. How long has pain been present?

(Please Indicate Number) Months ___ Years ___

5. Is the pain associated with any other symptoms?

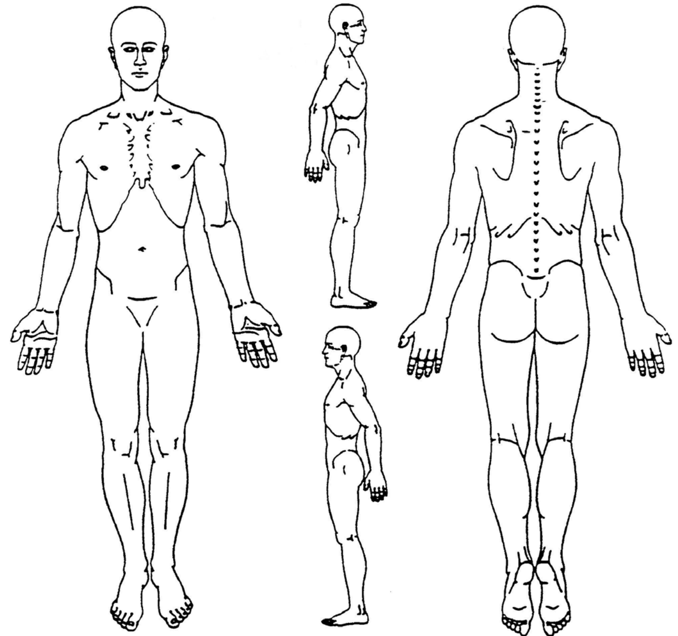
__ None __ Difficulty Walking
__ Numbness, Where: ________________________
__ Weakness, Where: ________________________
__ Sexual Dysfunction
__ Other: ________________________

6. What words best describe how your pain feels?

__ Sharp __ Burning __ Shooting
__ Deep __ Stabbing __ Throbbing
__ Aching __ Pressure __ Dull
__ Tingling __Other: ________________________

7. How often is the pain present?

__ Frequent (Several Times Hourly)
__ Occasional (Several Times Weekly)
__ Constant
__ Sporadic (Several Times Daily)
__ Rare (Several Times Monthly)



Please shade the areas where you are having pain
(For The Scales Below Circle A Number Using 0 To Indicate None Up To 10 To Indicate The Most Painful/ Most Severe.)

Is your pain going anywhere else (draw arrows)?

Please indicate your current pain:
0 1 2 3 4 5 6 7 8 9 10

Please rate your worst pain in past week:
0 1 2 3 4 5 6 7 8 9 10

Please rate your least pain in past week:
0 1 2 3 4 5 6 7 8 9 10

8. What makes your pain better?

__ Rest __ Heat __ Cold __ Medication __ Exercise __ Other: ________________________

9. What makes your pain worse?

__ Heat __ Cold ___ Walking __ Bending/Twisting __Sitting __ Standing __ Lying __ Stress
__ Coughing/Sneezing __ Standing From Sitting __ Other: ________________________

10. Since your pain began, have you experienced any of the following:

___ Bowel Incontinence ___ Bladder Incontinence ___ Neither

11. Has the pain affected your sleep? ___ Yes ___ No

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Name: ____ DOB: _____/_____/_____

PAIN HISTORY:

__ Work related injury Date: _________________

__ Motor vehicle accident Date: _________________

__ Fall or other trauma Date: _________________

__ Following surgery Date: _________________

__ Following illness Date: _________________

__ Unknown reason

__ Other: ____

TREATMENT HISTORY:

Have you ever been treated by another pain management provider or clinic? ___ Yes ____ No

Name of provider/clinic: Location: Dates of treatment: Reason for leaving:

____

____

____

Have you been evaluated by any other provider for your main pain complaint? ___ Yes ___ No

Name of provider: Date: Was surgery recommended? __Y __N

____

____

____

Have you had surgery intended to treat your current pain complaint? ___ Yes ___ No

Injections/Procedure name: Date: Provider:

____

____

____

Have you ever been hospitalized/ER for this condition? ___ Yes ___ No If so, length of stay____________________

Name of hospital/ER: Date seen:

____

____

____

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Name: ______________________________ DOB: _____/_____/_____

Have you had an Electromyography or EMG test to evaluate nerve function? ___ Yes ___ No
Performed on arms/legs/both? Provider performing test: Date:

____

____

____

Have you had Radiologic Imaging for your current pain complaint? ___ Yes ___ No
(Please bring actual films or CD containing the images to your initial appointment.)

STUDY TYPE	BODY PART IMAGED	DATE OF STUDY	WHERE STUDY WAS PERFORMED
X-RAY	______	______	______
MRI	______	______	______
CT	______	______	______
ULTRASOUND	______	______	______
BONE SCAN	______	______	______
OTHER	______	______	______

Review of Systems (*Please check all of the following symptoms you currently have.*)

General/Constitutional
- ☐ Weight loss
- ☐ Weight gain
- ☐ Fever
- ☐ Night sweats
- ☐ Fatigue

Head
- ☐ Headaches
- ☐ Hearing loss
- ☐ Sinusitis

Endocrine
- ☐ Abnormal blood sugars
- ☐ Insulin dependent diabetes Controlled/Non-controlled
- ☐ Type 2 diabetes Controlled/Non-controlled

Respiratory
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ COPD
- ☐ CPAP use
- ☐ Chronic cough

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ History of Stroke
- ☐ History of cardiac arrest
- ☐ Coronary artery bypass graft
- ☐ Swelling in legs

Gastrointestinal
- ☐ Appetite loss
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Constipation
- ☐ Heartburn
- ☐ Difficulty swallowing
- ☐ Exposure to Hepatitis
- ☐ Gastric Ulcers
- ☐ Diarrhea

Hematology
- ☐ Bleed easily
- ☐ Easy bruising
- ☐ Blood thinner use
- ☐ History of blood clots
- ☐ Peripheral vascular disease

Genitourinary
- ☐ Urinary retention
- ☐ Difficulty urinating
- ☐ Painful urination
- ☐ Enlarge prostate
- ☐ Blood in urine

Musculoskeletal
- ☐ Joint pain
- ☐ Muscle spasms
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid–back (Thoracic) pain
- ☐ Knee pain
- ☐ Ankle/foot pain

Skin
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Discoloration of skin
- ☐ Blistering of skin

Neurologic
- ☐ Balance difficulty
- ☐ Drowsiness
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Neck pain
- ☐ Uncontrolled loss of urine or bowel

Psychiatric
- ☐ Depression
- ☐ Anxiety Attacks
- ☐ Schizophrenia
- ☐ Bipolar disease
- ☐ PTSD
- ☐ Thoughts of suicide
- ☐ Previous admission to psychiatric facility

Women's Care
- ☐ Birth Control use
- ☐ Type of Contraception used: ______________
- ☐ Date of last menstrual period: ______________
- ☐ Possibility of pregnancy

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Name: ______________________________ DOB: _____/_____/_____

PAST SURGICAL HISTORY

If yes, please check and give approximate date in blank space.

___ Carotid artery ___ Hernia repair ___ Mastectomy ___ Back surgery ___ Gallbladder
___ Hysterectomy ___ Prostate removal ___ Neck surgery ___ Heart angloplasty ___ Heart Bypass
Other surgery not listed: ______________________________

PAST MEDICAL HISTORY

Check each condition that applies:

___ Glaucoma ___ Stomach/bowel problems ___ Bleeding problems ___ Breathing problems
___ Hepatitis/liver problems ___Take blood thinners or aspirin ___ High BP (Hypertension) ___ Thyroid problems
___ Anesthetic problems ___ Heart problems ___ Kidney problems ___ Diabetes ___ Cancer ___ Arthritis
___Seizures/Strokes Other conditions not listed: ______________________________

ALLERGIES

Do you have any known allergies? ___Y ___N
Are you allergic to shellfish? ___Y ___N
Are you allergic to IV contrast dye? ___Y ___N
Are you allergic to local anesthetic? ___Y ___N
Are you allergic to latex? ___Y ___N

CURRENT MEDICATIONS

NAME OF MEDICATION: DOSE: FREQUENCY:

____
____
____
____

SOCIAL HISTORY

__ Y __ N Tobacco Use Currently? # of Packs Per Day: ________ # of Years: __________
__ Y __ N Tobacco Use in Past? When did you quit smoking? ______________________
__ Y __ N Alcohol Use? __ Beer __ Wine __ Mixed Liquor # of Drinks Per Day: ________
__ Y __ N Do you have any history of alcohol dependence or alcoholism?
__ Y __ N Exercise regularly? Type: ____________________ Times per week: ____________________
__ Y __ N Do you have any history of recreational or street drug use? Which ones? ____________________
__ Y __ N Do you have any history of prescription drug abuse? Which ones?____________________
__ Y __ N Do you have any history of physical or sexual abuse? Which one?____________________

______________________________ ______________
Patient Signature Date Signed

______________________________ ______________
Provider Signature/Title ☐ I have reviewed the review of systems with the patient. Date Signed

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, 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 <u>any</u> problems, how <u>difficult</u> 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**
☐	☐	☐	☐

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GAD-7

Over the <u>last 2 weeks</u>, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	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

(*For office coding: Total Score T____* = ____ + ____ + ____)

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