Rejuvenated Minds, PLLC
3719 Benson Drive Raleigh, NC 27609
919-800-0757 office Fax 866-626-1755

New Patient Registration Packet

Personal Information

Please bring a valid driver's license or identification card. We will need a copy for our records.

Name: _____ DOB: _____ SS#: _____

Address: _____ _____ _____

Home Phone Number: _____ Cell Phone Number: _____

E-mail Address: _____ Age: _____ Race: _____ Gender: Male ___ Female ___

Employer: _____ Occupation: _____

Insurance Information

Please bring your insurance card. We will need a copy for our records.

Health Insurance Provider: _____ Copayment Amount: _____

Plan Name: _____ Plan Group Number: _____

Effective (Start) Date of Policy: _____ Effective (End) Date of Policy: _____

Insurance ID/Member ID: _____ Policy Holder: _____

Address of Policy Holder: _____ _____ _____

Policy Holder DOB: _____ Relationship to Client: _____

Employer of the Policy Holder: _____

Employer Address: _____ _____ _____

Employer Phone Number: _____

Emergency Contact Information

Name: _____ Relationship to Client: _____

Address: _____ _____ _____

Home Phone Number: _____ Cell Phone Number: _____

E-mail Address: _____

Reason for Visit:

_____

_____

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Medical History:

Have you received mental health counseling or been hospitalized *within the last 12 months?* Yes _____ No_____

If yes, list reason for treatment: _____

_____

_____

Previous Medical Providers:

Previous Psychiatrist Name: _____

Previous Psychiatrist Phone Number: _____

Previous Primary Care Physician Name: _____

Previous Primary Care Physician Phone Number: _____

Previous Nutritionist Name: _____

Previous Nutritionist Phone Number: _____

Previous Psychotherapist Name: _____

Previous Psychotherapist Phone Number: _____

Current Medical Providers:

Psychiatrist Name: _____

Psychiatrist Phone Number: _____

Primary Care Physician Name: _____

Primary Care Physician Phone Number: _____

Nutritionist Name: _____

Nutritionist Phone Number: _____

Psychotherapist Name: _____

Psychotherapist Phone Number:_____

Date of Last Physical Exam: _____ Allergies: _____

Medical Conditions: _____

_____

_____

_____

Current Medications (Please include prescribed dosage): _____

_____

_____ _____ _____

_____

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Medical History (continued):

Past Medications (Please include prescribed dosage):_____

_____

_____

Pharmacy Name: _____**Pharmacy Location:**_____

Pharmacy Contact Number: _____

Please list all surgeries including the year surgery was performed:

_____

_____

_____

Please list medical and psychiatric illnesses in your family.

Relationship to Client: _____ **Medical/Psychiatric Illness:** _____

Relationship to Client: _____ **Medical/Psychiatric Illness:**

_____

Relationship to Client: _____ **Medical/Psychiatric Illness:** _____

Relationship to Client: _____ **Medical/Psychiatric Illness:** _____

Relationship to Client: _____ **Medical/Psychiatric Illness:** _____

Do you drink alcohol? Yes _____ **No**_____ **If yes, how often**_____

Do you smoke tobacco? Yes _____ **No**_____ **If yes, how often**_____

Do you use recreational drugs? Yes _____ **No**_____ **If yes, what type and how often**_____

Have you ever been treated for substance abuse or dependency? Yes _____ **No**_____ **If yes, list substance and treatment details:**

_____

_____

_____

_____

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Getting to Know You: Client Questionnaire

1. Do you feel depressed? Yes _____ No_____
2. Are you experiencing changes in your sleep? Yes __ (how) _____ No__
3. Are you experiencing changes in your appetite or eating habits? Yes _ (how)_____No__
4. Are you self-critical? Yes _____ No_____
5. Do you have thoughts of death or suicide? Yes _____ No_____
6. Do you cry frequently? Yes _____ No_____
7. Are you having difficulty concentrating or remembering things? Yes _____ No_____
8. Do you feel tired or withdrawn? Yes _____ No_____
9. Have you lost interest in usually enjoyable activities? Yes _____ No_____
10. Have you ever experienced a period of unusually elevated or extremely irritable mood? Yes _____ No_____
11. Have you ever experienced decreased need for sleep? Yes _____ No_____
12. Do you worry excessively? Yes _____ No_____
13. Do you ruminate or obsess over certain ideas? Yes _____ No_____
14. Do you feel the urge to do things to relieve your anxiety? Yes _____ No_____
15. Do you have sleep disturbance? Yes _____ No_____
16. 16. Do you have muscle tension? Yes _____ No_____
17. Do you have difficulty focusing? Yes _____ No_____
18. Do you experience nightmares? Yes _____ No_____
19. Do you often feel irritable or overwhelmed? Yes _____ No_____
20. Do you ever have experiences that seem bizarre or unreal? Yes _____ No_____
21. Do you experience things that others around you do not? Yes _____ No_____
22. Have you ever attempted suicide? Yes _____ When _____No_____
23. Do you have difficulty with losing your place in conversation? Yes _____ No_____
24. Do you have trouble focusing while reading or working? Yes _____ No_____
25. Do you act impulsively or speak out of turn? Yes _____ No_____
26. Do you struggle with lack of organization? Yes _____ No_____

27. Do you have difficulty completing tasks or with procrastination? Yes _____ No_____

28. Do you consume far fewer calories than what you consider to be adequate? Yes _____ No_____

29. Are you concerned about your weight? Yes _____ No_____

30. Do you ever induce vomiting or use laxatives due to concern about your weight? Yes _____ No_____

31. Do you have difficulty in relationships? Yes _____ No_____

32. Do you struggle with intense emotions? Yes _____ No_____

33. Do you think you perceive things differently than most other people? Yes _____ No_____

34. Are you easily frustrated? Yes _____ No_____

35. Do you ever hurt yourself intentionally? Yes _____ No_____

36. Do you use any drugs? Yes _____ No_____

37. Do you drink alcohol? (if no, then skip questions 39-42) Yes _____ No_____

38. Do you feel the need to reduce your alcohol intake? Yes _____ No_____

39. Do you feel guilty about your alcohol consumption? Yes _____ No_____

40. Do you ever feel annoyed by others' comments about your drinking? Yes _____ No_____

41. Do you ever need alcohol first thing in the morning? Yes _____ No_____

42. Do you often eat too much or too quickly or feel out of control when eating? Yes _____ No_____

43. Do you have thoughts of death or dying? Yes _____ No_____

44. Are you married? _____ Yes _____ No_____

Name of spouse, if married _____

45. Do you have children Yes _____ No_____

Name of children: _____

46. Last grade completed: _____

47. What is your sexual orientation: _____

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Financial Agreement

Thank you for choosing Rejuvenated Minds, PLLC for your mental health care. Please understand that payment of your bill is considered part of your treatment. A breach in payments or repeated cancellation of appointments can result in administrative discharge from Rejuvenated Minds, Pllc. Full payment is due at the time of service. Cash, credit cards, debit cards and payments submitted via PayPal are accepted. Payments plans and sliding scale fees can be discussed in cases of financial hardship. You are responsible for full payment of your session fee, copay, late fees and past due balances at the time of service unless other arrangements have been discussed prior to the session.

Rejuvenated Minds is committed to providing the best treatment for patients and we charge the usual and customary rate for our area. If I am not credentialed with your insurance company submission for reimbursement from your insurance company will be your responsibility. A receipt of payment will be provided. I encourage you to call your provider to inquire about your in network and out of network benefits. If you fail to maintain insurance coverage or your insurance company denies your claims, you will be held financially responsible for full payment of services provided. A **cancellation fee** is charged unless your session is cancelled at least **48 hours** in advance. It is our policy to charge a rate of **$75** for the missed appointment. Reminder calls and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment.

Please indicate how you plan to pay for co-pays/services: ___ Money Order ___Cashier's Check ___PayPal __Credit Card Payment ___Cash

This section must be completed by the Authorized User of this Credit Card.

If you selected the Credit Card option, please provide the following information:

Name as it appears on Credit Card: _____

Credit Card Statement Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Type of Credit Card: ____ MasterCard ____ Visa ____ American Express ____ Discover

Credit Card Number: _____ **Exp. Date:** _____ **CVV Code (3 digit code on back of card):** _____

By signing this section of the financial agreement, I authorize Rejuvenated Minds, PLLC to charge any past due balances on my account to the to the credit or debit card listed above. **Printed Name of Authorized User:** _____
Signature of Authorized User: _____ **Date:** _____

Rejuvenated Minds, PLLC
919-800-0757
Fax 866 626-1755

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This is a shorter version of the attached, full, legally required notice of privacy practices. Please talk to our privacy officer (see the end of this form) about any questions or problems.

How we use and disclose your protected health information with your consent

We will use the information we collect about you mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities that are called, in the law, **health care operations.** After you have read this notice we will ask you to sign a **consent form** to let us use and share your information in these ways. If you do not consent and sign this form, we cannot treat you.

If we want to use or send, share, or release your information for other purposes, we will discuss this with you and ask you to sign an authorization form to allow this.

Disclosing your health information without your consent

There are some times when the laws require us to use or share your information. For example:

1. When there is a serious threat to your or another's health and safety or to the public. We will only share information with persons who are able to help prevent or reduce the threat.
2. When we are required to do so by lawsuits and other legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For workers' compensation and similar benefit programs.

There are some other rare situations. They are described in the longer version of our notice of privacy practices.

Your rights regarding your health information

1. You can ask us to communicate with you in a particular way or at a certain place that is more private for you.For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
2. You can ask us to limit what we tell people involved in your care or the payment for your care, such as familymembers and friends.
3. You have the right to look at the health information we have about you, such as your medical and billingrecords. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
4. If you believe that the information in your records is incorrect or missing something important, you can ask usto make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this notice, we will post the new version in ourwaiting area, and you can always get a copy of it from the privacy officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file acomplaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise.

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Notice of Privacy Practices

I, _____, have received a copy of Rejuvenated Minds, PLLC Notice of Privacy Practices.

_____ _____

Signature of Patient (or Guardian if Patient is under 18 years old) **Date**

Rejuvenated Minds, PLLC
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Release of Information Consent

One consent form is required, per medical service provider.

I_____, hereby authorize Rejuvenated Minds, PLLC to exchange the following information with my (check all that apply):

Psychotherapist _____ Primary Care Provider _____Psychiatrist ____Nutritionist ___ Other _____

Agency/Person's Name: _____

Address: _____

Phone: _____Fax:_____

The following information may be exchanged (check all that apply):

____ All Medical Records

____ Substance Use/Abuse History and Treatment (if applicable)

____ Discharge Summary

____ General Information Related to Treatment Progress

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: **one year from signature and date.**

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that I may request a copy of this authorization. I understand that to revoke this authorization, I must provide a written request to Rejuvenated Minds.

Client authorizes the electronic release of information: Yes _____ No_____

_____ _____

Signature of Patient (or Guardian if Patient is under 18 years old) **Date**

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Psychotherapist _____ Primary Care Provider _____Psychiatrist ____Nutritionist ___ Other _____

Agency/Person's Name: _____

Address: _____

Phone: _____Fax:_____

The following information may be exchanged (check all that apply):

____ All Medical Records

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_____ _____

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Client authorizes the electronic release of information: Yes _____ No_____

_____ _____

Signature of Patient (or Guardian if Patient is under 18 years old) **Date**

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Informed Consent Client-Counselor Service Agreement

Welcome to Rejuvenated Minds, Pllc. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. You will be provided a copy of the privacy laws. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Goals of Counseling

There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide where you want to go.

Risks/Benefits of Counseling

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages. You have the right to terminate counseling at any point you desire. Your counselor will provide referrals and recommendations for continued care.

Appointments

Appointments for counseling will ordinarily be 50-60 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. Medication management appointments typically are about 20- 30 minutes. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 24 hours' notice. Cancellations with less than 24 hours' notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot. If you miss a session without canceling, or cancel with less than 24 hour notice, you may be required to pay for the session [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible the cancelation fee of $75. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. Reminder calls and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment. If an appointment is cancelled on your counselors behalf every effort will be made to notify you in a timely manner and reschedule as soon as possible.

Confidentiality

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service.

In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

Confidentiality and Group Therapy

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your counselor cannot guarantee that other group members will maintain your confidentiality. However, your counselor will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your counselor also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Skype, telephone, email, text or chat. Due to the nature of online counseling, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions. Should a client have concerns about the safety of their email, your counselor can arrange to encrypt email communication with you.

Record Keeping

Your counselor may keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer. Records will be kept either electronically on a USB flash drive or in a paper file and stored in a locked cabinet in the counselor's office.

Professional Fees

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check, cash or debit/credit card. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. Paying is a part of your treatment agreement and refusal to pay may result in refusal of continued services based on your breaking your agreement. I encourage you to call your insurance provider to inquire about your in network and out of network benefits. If you fail to maintain insurance coverage or your insurance company denies your claims, you will be held financially responsible for full payment of services provided.

If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required.

Fees are non-negotiable. To receive sliding scale fees, you must present proof of income through recent pay stubs or tax forms. Fees are subject to change at counselor's discretion.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Contacting Me

I am often **not immediately available by telephone**. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, **but it may take a day or two for non-urgent matters**. If you feel you cannot wait for a return call or it is an emergency situation, go to your local hospital, Mental Health Crisis Center or call 911. Please consider this carefully before signing the agreement. Please contact me at least a week prior to the need for a medication refill to minimize any delays in getting your prescription filled.

Email

Counselor may request client's email address. Client has the right to refuse to divulge email address. Counselor may use email addresses to periodically check in with clients who have ended therapy suddenly. Counselor may also use email addresses to send newsletters with valuable therapeutic information such as tips for depression or relaxation techniques. Counselor also has a blog and if this is appropriate for the client, counselor may send information through email about subscribing to the blog or information related to mental health and wellness. Your signature below acknowledges that you would like to receive any correspondence through email.

Clients rights are as follows:

Be treated with dignity and respect.

Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.

Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the clients' permission.

Easily access care in a timely fashion.

Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.

Share in developing their plan of care.

Receive information in a language they can understand, and free of charge.

Receive a clear explanation of their condition and treatment options.

Receive information about your insurance provider, its providers, programs, services and role in the treatment process.

Receive information about clinical guidelines used in providing and managing their care.

Ask their provider about their work history and training.

Give input on the clients' Rights and Responsibilities policy.

Know about advocacy and community groups and prevention services.

If asked, your insurance provider will act on the client's behalf as an advocate.

Freely file a complaint or appeal and to learn how to do so.

Know of their rights and responsibilities in the treatment process.

Request certain preferences in a provider.

Have provider decisions about their care made on the basis of treatment needs.

Receive information about Insurance provider's staff qualifications and any organization your provider has contracted with to provide services.

Decline participation or withdraw from programs and services.

Know which staff members are responsible for managing their services and from whom to request a change in services.* **Statement of Client's Responsibilities**

Clients have the responsibility to:

Treat those giving them care with dignity and respect.

Give providers and insurance provider information that they need.

This is so providers can deliver quality care and your insurance provider can deliver appropriate services.

Ask questions about their care. This is to help them understand their care.

Follow the treatment plan. The plan of care is to be agreed upon by the client and provider.

Follow the agreed upon medication plan.

Tell their provider and primary care physician about medication changes, including medications given to them by others.

Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.

Let their provider know when the treatment plan is not working for them.

Let their provider know about problems with paying fees.

Report abuse and fraud.

Openly report concerns about the quality of care they receive.

Let their insurance company and their provider know if they decide to withdraw from the program.*

Rejuvenated Minds, PLLC
3719 Benson Drive Raleigh, NC 27609
919-800-0757 office Fax 866-626-1755

Acknowledgment of notices signatures page

(Please print this page only and return with intake form)

Consent to Counseling Agreement

Your signature below indicates that you have read the **Informed Consent Client-Counselor Service Agreement** and that I have been informed of my rights and responsibilities in regards to my mental health treatment, and that I understand this information and agree to the terms of this agreement. Included in the Client –Counselor service agreement is the **financial agreement** and the **explanation of the privacy laws**. By signing below you indicate you have read and understand your responsibility.

__ I have been offered/received a copy of this form.

Client Signature: _____ Date_____ Parent

Signature If client is a minor: _____ Date _____

If you would like to opt out of email correspondence, please check here _____.

Effective April 14, 2003

I understand that this facility is part of an organized healthcare arrangement that includes various third party payers and that, with my consent; these entities may share my health information for treatment, billing and other healthcare operations. I understand there is a publicly posted copy at this location of this organization's notice of privacy practices that describes how my health information is used and shared. I understand that this facility has the right to change this notice at any time, and that I may obtain a current copy by contacting the facility's administration office or by visiting the facility's website.

My Signature below constitutes my acknowledgement that I have been provided with a copy of the notice of privacy practices.

Signature of Patient (or Guardian if Patient under age of 18):

_____

Date: _____

If signed by a legal representative,

Parent/GuardianOther: _____

*Reference: Health Insurance Portability and Accountability Act (45 CFR Part 160-164) HIPPA Privacy Rule—Standards for Privacy Individually Identifiable Health Information

Please retain a copy of this for your records. Please sign and return a copy of the **signature page**. A signed copy of this agreement is **required** for your medical record.

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. 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 _____

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.