

Shelby Psychological Services Minor Patient Registration Form

PATIENT INFORMATION					
Name		Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	
Street Address		City		State	Zip Code
School	Grade	Patient /Guardian Employer		Work Phone ()	
Responsible Party's Email Address				Home Phone ()	
Primary Care Physician Name:				Cell Phone ()	
How Did you Hear About Us? <input type="checkbox"/> Physician <input type="checkbox"/> Internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Other _____					
INSURANCE INFORMATION (Please provide your insurance card for office to copy)					
Primary Insurance			Policy Holder's Name		
Policy Holder's Social Security #	Birth Date	Employer		Group number	
Policy Number		Patient's Relationship to Policy Holder			
Secondary Insurance					
Policy Holder's Name		Birth Date	Employer		Group number
Policy Number		Patient's Relationship to Policy Holder			
Person Responsible for Bill and address if different					
Your Signature					

- Acknowledges:**
- ▲ Accuracy of above information and financial responsibility to pay any balance and attorney if required for account collection
 - ▲ Notice of HIPPA and State of Alabama policy and practices to protect your health information
 - ▲ Consent for me or my minor child to be evaluated and/or treated by Shelby Psychological Services (SPS)
 - ▲ Dr. Vance has a small therapy-dog-in-training at SPS – we understand it is our responsibility to inform SPS staff if we do not want to interact with the dog

- Authorizes:**
- ▲ SPS to release information required to process my insurance claim and for insurance benefits to be paid to SPS
 - ▲ Consent to release treatment information to SPS providers only in the event of an interoffice referral
 - ▲ Consent to release requested information to the referring physician/source
 - ▲ Consent to release information for insurance purposes, when required, with supervising providers

I have read, understand and acknowledge/authorize the above.

Signature of Patient (if age 14 & older)	Printed Name of Patient	Date
Signature of Parent/Guardian	Printed Name of Parent/Guardian	Date

**Shelby Psychological Services
FINANCIAL AGREEMENT**

Patient/Guardian/Responsible Party Name: _____

Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.

IN ORDER TO CONTROL THE COST OF BILLINGS, IT IS REQUESTED THAT THE CHARGES FOR OFFICE VISITS BE PAID AT THE TIME OF THE VISIT. APPOINTMENTS NOT CANCELED 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE CHARGED AT THE REGULAR RATE. Automated reminder calls are sent out as a courtesy. However, computers do sometimes malfunction and phone numbers change etc. **YOU ARE STILL RESPONSIBLE TO KEEP YOUR APPOINTMENTS OR CANCEL ON A TIMELY BASIS** even if the reminder system does not work.

_____ Please initial

If a provider receives a subpoena with an order to appear for court proceedings regarding this case, it is the client/guardian's responsibility to reimburse the provider for their time. This includes preparation time, travel time and actual time at court at the cost of \$200/hour. A retainer fee of \$1000 is required at the time of the request. _____ Please initial

If this account is assigned to an attorney for collection and/or suit, I agree to pay a reasonable attorney's fee and cost of collection. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include any major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and/or other health plans to Shelby Psychological Services.

The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient/Responsible Party Signature _____ Date _____

Emily Tucker Counseling Services
with
Shelby Psychological Services (SPS)

(205) 664-4010

www.birmingham-counseling.com

emilytuckerlpc@gmail.com

CONSENT FOR COUNSELING / THERAPY

Welcome! It is important to me to co-create a counseling relationship that helps you make the changes you want and need to make in your life. The information provided below is to help you better understand the expectations of the counseling relationship. As well as assisting you by providing the information to allow a comprehensive informed consent between you and your counselor. This allows you to make an informed choice to engage in counseling with a counselor at Emily Tucker Counseling Services.

Counseling:

By its very nature counseling calls for change. If you don't change, you simply keep creating what you already have. When people come to counseling, some come because they are ready to improve some area of their life or relationship. They desire to work with a knowledgeable, trusted, and objective professional to assist them in exploring the issues and options for change. Other people start counseling because something has happened in their life that has forced them to make changes in some way. They may want help finding their way through the challenges. Others need to grieve what was lost. Some want to re-evaluate their lives and look at alternative goals and directions. Some people come to counseling because they are dragged or pushed by someone else to do so. No matter what your reason for coming to counseling I want to assist you in making the best use of the time.

My goal is to assist you in the ways that you want and not to make you dependent on therapy. The goal is to help you develop ways that will empower you to make the changes you want now and in the future. Counseling is not giving you the answers, although I may have information that is useful for you. Counseling helps you find within yourself the choices, behaviors, directions that have integrity for you and then exploring steps and tools to help you achieve them. No therapist can do YOUR part of the work. It is important for you to take responsibility for doing your own work. There can never be any guarantee in counseling for a specific result. I am committed to doing my part, but to be successful, you have to try out new coping skills/behaviors etc. It will require conscious, consistent effort on your part, changing comfortable habits and patterns of protecting *yourself*. That is not always easy, comfortable or 'natural'. You may take 2 steps forward and one back. You may experience discomfort, anxiety, emotional pain, frustration, and embarrassment. You will need to make the commitment to continue even when things become uncomfortable.

Ending Therapy:

You are free to stop counseling at any time. If you or I believe that progress is not being made, either of us may talk about ending counseling and possible alternatives. I encourage you to let me know about your desire to end therapy (for any reason) so that we can summarize some of

Emily Tucker Counseling Services

Other Legal Proceedings:

Your work with me is not intended for use in any legal proceedings that you may be involved in with others, or with your spouse or partner.

You agree through this consent to not subpoena any counselor at Emily Tucker Counseling Services to testify against or for either party or to provide records in court actions (these include divorces and child custody proceedings).

Emergencies/Crisis/Availability:

When you have difficulty, try using tools and information you have learned. If you need immediate help in a crisis or emergency situation after hours, weekends or when you cannot reach me soon enough during regular work hours and feel in crisis contact:

- 911
- Crisis Center help line 205-323-7777
- TeenLink 205-328-LINK(5465)
- Senior Help Line 205-328-8255
- The National Suicide Prevention Lifeline 1-800-273-TALK(8255)
- 211 to help gain assistance with resources in your area

I do not always check telephone messages after hours and I do not have an answering service. Please use the above numbers if you have an emergency. The quickest way to reach me is usually through e-mail emilytuckerlpc@gmail.com or by leaving a message on the office line (205) 664-4010. If you think you are in crisis please use one of the above numbers, do not wait for me to return a phone call or email. Please obtain help at the time. Occasionally an e-mail does not come through, so if you do not hear from me within 1-2 working days, please re-send. If I am returning calls during regular hours, it is usually between clients and therefore I need keep it short. I am happy to answer questions, but if you need to discuss something in depth, it is best to schedule an appointment or try e-mail. My e-mail is not encrypted. You need to take precautions to keep your own e-mail confidential. See *Notice of Privacy Practices* for further information.

If you have read & understood this section, sign below

Patient (age 14 & above)

Date

Parent/Guardian/Spouse

Date

Emily Tucker, LPC

Date

Emily Tucker Counseling Services

Appointments and Cancellations:

Appointment times begin at 9am Monday through Friday. Appointments are 45 minutes unless scheduled for a longer period. 60 min session are available and most insurance will cover these as well. If you are late, the session will not be extended and will end as scheduled. If you are more than 15 minutes late, without calling, the session may be cancelled. The Therapist is not required to wait in the office for you if you are more than 15 minutes late and have not called.

When you make an appointment, you are reserving the therapist's time, which means no one else is scheduled in that time period. Also, you prevent someone on the waiting list from being seen. Therefore, you need to cancel at a minimum of 24 hours in advance to avoid being charged for the session. Otherwise, you will be billed full price for the session. If you no show/no call you will be charged the full session rate. Insurance will not pay for missed appointment, therefore if not cancelled in a timely manner you will be responsible for the payment. By signing this consent form you are agreeing to the cancellation policy as well as other policies identified in this document.

Payment and Insurance:

Payment is due at the time of your session and can be paid with valid check, credit card, or cash. Most insurance requires that you qualify by being given a diagnosis. I will only give you a diagnosis if you truly meet the criteria for a diagnosis. That diagnosis will become part of your insurance record. You are responsible for paying deductibles, copayments, and other charges that are not covered by your insurance provider.

Consent for Counseling:

I have read, understood, and agree to the terms of this consent. (If you have any questions, please ask before you sign). By signing, I voluntarily agree to participate fully in counseling.

If you are coming to me for any type of relationship counseling, the signatures of both participants are required. If the identified client is a minor a guardian's signature is required.

If you have no further questions, please sign below:

Patient (age 14 & above)

Date

Parent/Guardian/Spouse

Date

Emily Tucker, LPC

Date

Notice of Privacy Practices

Client Name _____

This notice describes how Medical/Mental Health Information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective 01/01/2014. Emily Tucker Counseling Services will only release information in accordance with state and federal laws and the ethics of the counseling profession. The following describes policies related to the disclosure of client's healthcare information. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality of care. State and Federal Laws allow Emily Tucker Counseling Services to use and disclose health information for these purposes.

USES and DISCLOSURES

- *Help manage the health care treatment you receive* – Example: A psychiatrist sends information about your diagnosis and treatment plan so additions or changes in your care can be provided.
- *Payment* – Example: Verifying your insurance coverage or processing claims to collect fees
- *Healthcare operations* – Example: Site review for compliance
- *Other uses and disclosures without your consent* – Example: Mandated reporting to a suspected crime or abuse

CLIENT RIGHTS

- Right to request where to contact or notify you

			Number or email to use:
Home	___YES	___NO	
Work	___YES	___NO	
Cell	___YES	___NO	
Email	___YES	___NO	
Voice Mail	___YES	___NO	
- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask to limit the information shared
- Get a list of those with whom your information has been shared
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You can complain if you feel we have violated your rights by contacting Emily Tucker with Emily Tucker Counseling Services, LLC. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. I will not retaliate against you for filing a complaint.

Emily Tucker Counseling Responsibilities include: 1. Required to maintain the privacy and security of your protected health information 2. Let you know promptly if a breach occurs that may have compromised the privacy or security of your information. 3. Follow the duties and privacy practices described in this notice and give you a copy of it. 4. Not use or share your information other than as described here unless you inform Emily Tucker Counseling Services, LLC in writing. If you inform in writing, you may change your mind at any time. Inform Emily Tucker Counseling Services, LLC in writing if you change your mind.

Client Signature (age 14 & up) _____ Date ____/____/____

Guardian Signature _____ Date ____/____/____

Client Name: _____ Date: _____

History

Presenting Issue that brings you to counseling: _____

How long has there been an issue? _____ How intense is the problem? (1=not intense; 10=very intense) _____

List any Diagnosis (treated, resolved, re-occurring etc.) _____

What goals would you like to achieve through counseling? _____

Psychiatric History

I have received treatment for: Substance Abuse Mental Health Issues Both

The treatment occurred at:

Private Psychiatrist Hospital Private Counselor/Therapist

Mental Health Center Other

Present Treatment: Yes No By Whom: _____

Family History

Parent's marital status (*circle one*): Single Married Separated Divorced Deceased

Psychiatric History for you or someone in your family: _____

Have you ever been hospitalized for a mental illness? Yes No If YES, please explain what happened and where _____

Is there a history of substance abuse in the family? If yes please explain: _____

Is there a history of abuse/domestic violence in the family? If yes please explain: _____

Any significant medical history or trauma? _____

Court, Legal or Social Service History

Are you or your family involved with DHR, or have history with DHR or court custody issues? _____

Judge: _____ DHR Worker and Number: _____

Do you have a current legal case pending? _____

Attorney: _____ Judge: _____

Client Name: _____ Date: _____

CHECKLIST OF CONCERNS

(please check any relevant concerns that apply currently or within the past 3 months)

THOUGHTS/FEELINGS/MOOD

- Anger/frustration/hostility
- Anxiety, nervousness
- Attention, concentration, distractibility
- Confusion
- Depression
- Disliking others
- Emptiness
- Euphoria
- Excessive worry
- Failure
- Fatigue
- Fear
- Grieving (death, loss, divorce, etc)
- Guilt
- Hearing things other people don't
- Homicidal thoughts
- Intrusive thoughts
- Judgment problems
- Memory difficulties
- Negative thoughts
- Obsessive thoughts
- Oversensitivity to criticism
- Oversensitivity to rejection
- Panic attacks
- Perfectionism
- Sadness
- Seeing things other people don't
- Self-centeredness
- Self-esteem (low)
- Shyness
- Spiritual, religious, or moral issues
- Stress
- Sudden mood changes
- Suicidal thoughts
- Suspiciousness
- Temper problems
- Thoughts of hurting self or others

BEHAVIOR

- Aggression, violence
- Alcohol use
- Argumentative
- Avoidant
- Compulsive behavior/rituals
- Controlling
- Decreased/lack of sexual interest
- Dependency
- Destruction of property
- Drug use: prescription, over-the-counter, street
- Eating problems
- Financial problems, debt
- Gambling
- Hyperactivity
- Internet problems
- Irresponsibility
- Isolation
- Legal problems
- Letting others take advantage of you
- Lying
- Not able to relax
- Preoccupation with sex
- Procrastination
- Purging
- History of running away
- Self destruction/sabotaging
- Self-neglect
- Sexual dysfunction
- Smoking
- Stealing
- Threats
- Weight, gain/loss
- Withdrawal from others
- Loss of interest in what I used to like
- Sleep difficulty
- Loss of appetite
- Overeating

FAMILY & RELATIONSHIPS

- Affair
- Childhood issues (client's childhood)
- Divorce
- Friendships
- Housework/chores
- Interpersonal conflicts
- Parenting
- Problems with child(ren)
- Problems with parents
- Problems with spouse/partner
- Separation

ABUSE

- Abuse of alcohol
- Abuse of drugs
- Physical abuse by another
- Physical abuse of another
- Sexual abuse by another
- Sexual abuse of another

WORK & SCHOOL

- Absenteeism
- Career concerns, goals, choices
- Difficulty with coworkers
- Difficulty with supervisor
- Performance
- Tardiness
- Procrastination
- School problems

OTHER CONCERNS

- _____
- _____
- _____

- _____
- _____
- _____

- _____
- _____
- _____

PROMIS-29 Profile v1.0

Please respond to each question or statement by marking one box per row.

<u>Physical Function</u>		Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
PFA11 1	Are you able to do chores such as vacuuming or yard work?.....	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
PFA21 2	Are you able to go up and down stairs at a normal pace?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
PFA23 3	Are you able to go for a walk of at least 15 minutes?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
PFA53 4	Are you able to run errands and shop?	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
<u>Anxiety</u>						
In the past 7 days...		Never	Rarely	Sometimes	Often	Always
EDANX01 5	I felt fearful.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDANX40 6	I found it hard to focus on anything other than my anxiety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDANX41 7	My worries overwhelmed me.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDANX53 8	I felt uneasy	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<u>Depression</u>						
In the past 7 days...		Never	Rarely	Sometimes	Often	Always
EDDEP04 9	I felt worthless	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP06 10	I felt helpless	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP20 11	I felt depressed	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
EDDEP41 12	I felt hopeless	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
<u>Fatigue</u>						
During the past 7 days...		Not at all	A little bit	Somewhat	Quite a bit	Very much
HI7 13	I feel fatigued	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
A3 14	I have trouble <u>starting</u> things because I am tired.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
In the past 7 days...						
FATEXP41 15	How run-down did you feel on average? ...	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

PROMIS-29 Profile v1.0

Fatigue

In the past 7 days...

FATEXP40
16

How fatigued were you on average?

Not at all	A little bit	Somewhat	Quite a bit	Very much
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

Sleep Disturbance

In the past 7 days...

Sleep109
17

My sleep quality was.....

Very poor	Poor	Fair	Good	Very good
<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

In the past 7 days...

Sleep118
18

My sleep was refreshing.....

Not at all	A little bit	Somewhat	Quite a bit	Very much
<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1

Sleep20
19

I had a problem with my sleep

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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Sleep44
20

I had difficulty falling asleep

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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Satisfaction with Social Role

In the past 7 days...

SRPSAT07
21

I am satisfied with how much work I can do (include work at home)

Not at all	A little bit	Somewhat	Quite a bit	Very much
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

SRPSAT24
22

I am satisfied with my ability to work (include work at home).....

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
-------------------------------	-------------------------------	-------------------------------	-------------------------------	-------------------------------

SRPSAT47
23

I am satisfied with my ability to do regular personal and household responsibilities

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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SRPSAT49
24

I am satisfied with my ability to perform my daily routines.....

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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Pain Interference

In the past 7 days...

PAININ9
25

How much did pain interfere with your day to day activities?

Not at all	A little bit	Somewhat	Quite a bit	Very much
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

PAININ22
26

How much did pain interfere with work around the home?

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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PAININ31
27

How much did pain interfere with your ability to participate in social activities?

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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PAININ34
28

How much did pain interfere with your household chores?

<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
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Pain Intensity

In the past 7 days...

PAINI07
29

How would you rate your pain on average?.....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
0	1	2	3	4	5	6	7	8	9	10
No pain										Worst imaginable pain

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