RUSHING FAMILY PRACTICE
Where you and your family come first

WELCOME TO OUR OFFICE!

Please complete the forms in their entirety. This information is important for accurate health record maintenance as well as insurance billing. This information will remain confidential.

PATIENT INFORMATION TODAY'S DATE:_____

Full Name:_____

Address:_____ City:_____ State/Zip:_____

Home Phone:_____ Cell Phone:_____
May We leave confidential message?_____ May we leave confidential message?_____

Birthdate: _____ Age:_____ SSN:_____ Gender:_____ (M or F) Marital Status:_____ (S M D W O)

Patient Employer:_____ Occupation:_____

eMail Address:_____
Required for Portal Access May we communicate confidential information through the portal/eMail?_____

RESPONSIBLE PARTY

Full Name:_____

Address:_____ City:_____ State/Zip:_____

Home Phone:_____ Cell Phone:_____
May We leave confidential message?_____ May we leave confidential message?_____

Birthdate: _____ SSN:_____ Relationship to Patient:_____

Responsible Party Employer:_____

Business Address:_____ City:_____ State/Zip:_____

In case of an emergency, who should be notified? _____
Relationship:_____ Phone Number:_____
Are we authorized to release private health information to this person?_____

Patient Signature:_____ **Date:**_____

Guardian Signature:_____ **Date:**_____

INSURANCE INFORMATION

_____ Please check this line if you have no insurance, then skip to the signature line.

PRIMARY

Insured Full Name:_____

Address:_____ City:_____ State/Zip:_____

Home Phone:_____ Cell Phone:_____

May We leave confidential message?_____ May we leave confidential message?_____

Birthdate: _____ SSN:_____ Relationship to Patient:_____

Insured Employer:_____

Business Address:_____ City:_____ State/Zip:_____

Policy/ID Number:_____

Group Number:_____

Effective Date:_____ Copayment/Coinsurance:_____

SECONDARY

Insured Full Name:_____

Address:_____ City:_____ State/Zip:_____

Home Phone:_____ Cell Phone:_____

May We leave confidential message?_____ May we leave confidential message?_____

Birthdate: _____ SSN:_____ Relationship to Patient:_____

Insured Employer:_____

Business Address:_____ City:_____ State/Zip:_____

Policy/ID Number:_____

Group Number:_____

Effective Date:_____ Copayment/Coinsurance:_____

I understand that I am responsible for copayment at the time of visit, unless prior arrangements are made. If my insurance information changes, I will notify Rushing Family Practice in a timely manner so that the appropriate party may be billed.

Patient Signature:_____ **Date:**_____

Guardian Signature:_____ **Date:**_____

Rushing Family Practice

Health History Form

Full Name _____ M___ F___ DOB _____ Age _____

Allergies (i.e., medications, food, etc.): _____

_____

Disease (check all that apply	Self	Mom	Dad	Sister	Brother	GM	GF
Alcohol Abuse							
Anemia							
Anxiety							
Arthritis							
Asthma							
Bipolar Disorder							
Type: _____ Cancer _____							
Cataracts							
Chronic Bronchitis							
Crohn's Disease							
Depression							
Diabetes: Type 1 Type 2							
Drug Abuse							
Emphysema							
Endometriosis							
Esophgeal Reflux							
Hearing Problems							
Heart Attack							
Heart Disease							
High Blood Pressure							
High Cholesterol							
Irritable Bowel Syndrome							
Kidney Problems							
Leukemia							
Migraine Headaches							
Neurological Disease: Specifics _____							
Other Chronic Headaches							
Peptic Ulcer							
Schizophrenia							
Sexually Transmitted Disease							
Stroke							
Thyroid Problems (Hypo or Hyper)							
Tuberculosis							
Ulcerative Colitis							
Other:							

Rushing Family Practice

Name: _____ **Date**_____

Hospitalization/Surgery (be specific)	Reason for Hospitalization or Surgery	Year

Medications	Dose	How Often	How long

Healthcare Screening/Treatment	Date of Last
Routine Physical Exam	
Routine Eye Exam	
Stool Occult Blood Test	
Electrocardiogram (EKG)	
Cardiac Stress Test	
Sigmoidoscopy	
Colonoscopy	
Bone Density Scan	
Tetanus Injection	
Pneumonia Injection	
TB skin test	

Habits:

Do you use any form of tobacco? N____ Y____ Type and amount _____
Do you drink alcoholic beverages? N___ Y____ Type and amount _____
Have you been treated for substance abuse? N___ Y___ When? _____
Are you sexually active? N____ Y____ Have you ever been diagnosed with an STD? N___ Y____ Type_____

Females Only:

Age Menses Began: _____ **Regular Menses Y___ N___ LMP** _____ **Last PAP** _____
Last Mammo _____ **OB/GYN** _____ **# of pregnancies** _____
Live Births _____ **Form of Birth control** _____

I certify that the above information is correct and true to the best of my knowledge. I will not hold my provider or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature (Patient Or Guardian) _____ **Date**_____

RUSHING FAMILY PRACTICE
Where you and your family come first

AUTHORIZATION AND CARE/RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

CONSENT TO TREAT

The term "healthcare provider(s)" in this document means Rushing Family Practice, its agents and employees, members of the medical staff, their agents and employees, and other healthcare providers who participate in the care of patients at Rushing Family Practice.

I, _____, understand that, as a part of my healthcare, Rushing Family Practice originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment and all care; including future treatment. I understand that this information serves as:

Basis for my diagnoses, treatment, and care
Information used to file claims with third party resources
Means by which third parties may verify services provided
Tool for routine operations including assessing quality and reviewing competencies for all staff

I understand that I have been provided with the Notice of Information Practices that provide complete information of uses and disclosures. I understand that I have the right to review the notice before signing this consent. I understand that Rushing Family Practice reserves the right to change notices and practices and prior to implementation will provide me with such notices via hand delivery, or to the address of record. I understand I have the right to restrict how my information may be used or disclosed to carry out treatment, payment or operations and that Rushing Family Practice is not required to agree to unreasonable restrictions. I understand that I have the right to revoke this consent in writing, except to the extent Rushing Family Practice has already taken action on my behalf. Permission is hereby granted to all healthcare providers involved in my care to administer examinations, treatment, testing, procedures and diagnoses as deemed necessary in the course of care.

Release of Information
Information pertaining to the patient necessary to substantiate third party billing, or to comply with government regulations may be released by the healthcare provider involved in care.

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

With Insurance
For those healthcare providers who accept assignment, I hereby authorize the insurance carrier outlined on the most current "INSURANCE" form signed by me, with whom the patient has an active policy, to reimburse Rushing Family Practice for services rendered. I agree to pay all amounts not reimbursed by the insurance carrier. If such amounts to are not paid after a reasonable period, the account shall become delinquent. I am aware that if the account becomes delinquent, there will be a service charge assessed monthly until the amounts are paid in full. In the event I default on the account, I will be responsible for collection fees, interest incurred, and any court costs/attorney fees incurred to satisfy the debt. If the debt is assigned to a third party for collection, I will be responsible for all fees incurred to satisfy the debt.

Without Insurance
I, _____, the undersigned, certify that I (or the patient listed if I am the guardian), do not have insurance coverage with any healthcare insurance carrier. I understand that I am responsible for all charges. I understand that full payment is due at the time of service.
I, _____. I have received a copy of Rushing Family Practice's Office Policy and Procedures and notice of Privacy Practices.

Patient Signature:_____ **Date:**_____

Guardian Signature:_____ **Date:**_____

CONSENT TO OBTAIN MEDICATION HISTORY

Rushing Family Practice has adopted an electronic medical record system. This system allows us to collect and review patient medication history, which is a comprehensive list of prescription medicines that we, or other physicians, have recently prescribed for the patient. This list is collected from a variety of sources, including pharmacies and healthcare insurance carriers.

Accurate medication history is very important in assisting this office with treatment and avoiding potentially dangerous drug interactions.

By signing this consent form, you authorize Rushing Family Practice to collect this information. This authorization also allows health insurance carriers and pharmacies to disclose this information to Rushing Family Practice. This includes prescription medication to treat all conditions, related to both health and mental conditions, as well as AIDS/HIV. This information will become part of the patient's medical record within our office.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make medication histories available to private practices, and the drug history from health insurance carrier may not include medication purchased without insurance policies. Medication history obtained from third parties may not include over the counter medication, supplements, or herbal remedies. For this reason, it is very important for us to take adequate time to discuss every medication taking and for the patient or guardian to point out to our office any errors in medication history.

I give permission for Rushing Family Practice to obtain medication history from my pharmacy(ies), healthcare insurance carrier(s) and other healthcare providers.

Patient Signature:_____ Date:_____

Guardian Signature:_____ Date:_____

CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Patient' s Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

Notice to Patient:
By signing this form, you grant us consent to disclose your protected health care information to the individual(s) listed below. Our **Notice of Privacy Practices** provides more details on uses and disclosures of your protected health information for treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

You have the right to **revoke** your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You are entitled to a copy of this **Consent Form** after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I, _____, have read the contents of this Consent Form and the Notice of Privacy Practices. I understand that I am giving you my consent to disclose my health care information with the person or persons listed below.

_____

_____

_____

_____

_____ _____
Patient's Signature or Signature of Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

FOR OFFICE USE ONLY:

Name of Practice _____

Privacy Officer's Signature or Practice Representative _____

Date _____

As required by the Privacy Rule, created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this Notice describes how medical information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable medical information. Please review this Notice carefully.

OUR COMMITMENT TO YOUR PRIVACY
We are required by law to:

- Maintain the privacy of protected health information
- Give you this Notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION:
The following categories describe the different ways in which we may use and disclose your medical information.

Treatment: We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information only with your written permission. You may revoke such permission at any time in writing to our privacy officer.

Payment: We may use and disclose your Health so that we or others may bill and receive payment form you, an insurance company, or a third party for the treatment and services you received. For example; we may give your health plan information so that they will pay for your treatment.
Healthcare operations: We may use and disclose your medical information to operate our business. We may use your medical information to review the care you received and to evaluate the performance of our staff in caring for you; to help us decide what additional services to offer; to determine how we can improve the quality and efficiency of our services or whether certain treatments are effective. We may also use your medical information to resolve any complaints you may have and to help ensure your satisfaction with the care you receive.
Appointment Reminder, Treatment Options, and Health Related Benefits: We may use and disclose your medical information to contact you and remind you of an appointment. or a laboratory result. We may use and disclose your medical information to inform you of potential treatment options or alternatives.
Release of Information to Family/ Friends: Unless you notify us that you object, we may release your medical information to family members or friends who are involved in your care, or who help pay for your care. We may also release your medical information by allowing another person, as approved by you, to pick up medical records, reports of lab/diagnostic studies, or prescriptions at our office.
USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

Public Health Risks; Our practice may disclose your medical information to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as, births and deaths
- Reporting suspected child abuse or neglect
- Preventing or controlling disease, injury or disability
- Notifying a person who may have been exposed to a communicable disease or may be at risk of contracting or spreading a disease or condition
- Reporting reactions to medications or problems with medical products or devices
- Notifying appropriate government agencies and authorities if we believe a patient has been a victim of abuse, neglect, or domestic violence; however, we will only disclose this information if the patient agrees or we are required or authorized by law to do so

Health Oversight Activities; Our Practice may disclose your medical information to a health oversight agency for activities authorized by law; including, for example, investigations, inspections, audits, surveys, and licensure actions. Such activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
Lawsuits and Disputes; We may disclose your medical information in response to a court or administrative order if you are involved in a lawsuit or a dispute. We also may disclose your medical information in response to a discovery request, subpoena, or other lawful process by another party involved in a dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information requested.
Law Enforcement; We may release medical information if asked to do so by a law enforcement official:

- regarding a crime victim if, under certain limited circumstances, we are unable to obtain the person's agreement
- concerning a death we believe may have been the result of criminal conduct
- regarding criminal conduct at our offices
- in response to a warrant, summons, court order, subpoena or similar legal process
- to identify or locate a suspect, material witness, fugitive or missing person
- in an emergency to report a crime; the location of the crime or victims; or the description, identity or location of the perpetrator
- in an emergency when necessary to maintain the safety and security or our personnel and patients

Deceased Patients; We may release medical information to a medical examiner or coroner to identify a deceased individual or to determine the cause of death. We also may release medical to information funeral directors in order for them to perform their duties.
Organ and Tissue Donation; If you are an organ donor, we may release your medical information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation.
Research; We may use and disclose your medical information for research purposes in certain limited circumstances. We will obtain your written authorization to use your medical information for research purposes except when an Institution Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: the use or disclosure involves no more than minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers form improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); (C) adequate written assurances that the PHI will not be reused or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would be otherwise permitted; (ii) the research could not practicably be conducted without the waiver, and (iii) the research could not practicably be conducted without access to and use of the PHI.

Serious Threats to Health or Safety; We may use and disclose your medical information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances we will only make disclosures to a person or organization able to help prevent the threat.
Military Services and Veterans We may disclose your medical information if you are a member (or veteran) of the U. S. or foreign military forces as required by military command authorities.

National Security; We may disclose your medical information to federal officials for intelligence, counterintelligence and other national security activities authorized by law; including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.

Inmates; If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose your medical information to the correctional institution or law enforcement official as necessary for: the institution to provide you with health care; to protect your and other persons' health and safety; and for the safety and security of the correctional institution.

Workers' Compensation; We may disclose your medical information to insurance carriers, the Texas Dept. of Insurance / Division of Workers' Compensation and other healthcare providers for purposes of treatment for work-related injuries and illnesses under workers' compensation

YOU'RE RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding your medical information that we maintain:

Confidential Communications; You have the right to request that we communicate with you about your health and related issues in a particular manner or at a certain location. For example you may ask that we contact you at home rather than at work. To request a type of confidential communication you must make a written request to our Privacy Officer, specifying the requested method of contact and/or the location where you wish to be contacted. We will accommodate reasonable requests, and you do not need to give a reason for your request.

Request Restrictions. You have the right to request a restriction or limitation on our use or disclosure of your medical information for treatment, payment or health care operations. You have the right to request that we restrict our disclosure of your medical information to certain individuals involved in your care or the payment for your care, such as family members and friends. For example, you may ask that we not use or disclose information about a surgery you had, a laboratory test ordered or a medical device prescribed for your care.

To request a restriction in our use or disclosure of your medical information, you must make your request in writing to our Privacy Officer. Your request must describe in a clear and concise fashion:

- the information you wish restricted;
- whether you are requesting to limit our use, disclosure or both;
- and to whom you want the limits to apply (for example disclosures to your spouse).

We will carefully consider all requests; however, we may not be able to accommodate all requests nor are legally required to agree to your request. However, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

Inspection and Copies; You have the right to inspect and obtain a copy of your medical information, including medical and billing records, but not psychotherapy notes. To inspect or obtain a copy of your medical information you must submit your request in writing to our Privacy Officer. We may charge a reasonable fee for the costs of copying, mailing, labor and supplies associated with your request. On rare occasions we may deny a request to inspect or obtain a copy of some medical information if, in the professional judgment of your physician/provider, the information could cause a threat to you or others. If you are denied access to information, you may request a review of the denial. Another licensed healthcare professional, who was not involved in the original decision by us, will independently review both the original request and denial. You may contact our Privacy Officer for more information

Amendment; You may ask us to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. You must provide a reason that supports your request for an amendment. We will deny your request if it is not in writing or does not include a reason supporting your request. We may deny your request if you ask us to amend information that, in our opinion:

- is accurate and complete;
- is not part of the medical information kept by or for the practice;
- is not part of medical information which you would be permitted to inspect and copy; or
- was not created by our practice unless the individual or entity that created the information is not available to amend the information.

Accounting of Disclosures; You have the right to request an "accounting of disclosures." This list would provide you with a summary of all disclosures we have made of your medical information that you would not otherwise expect or already know about. This list would not include any of the following disclosures:

- made for treatment, payment and healthcare operations;
- made directly to you or your personal representative;
- that you have specifically authorized;
- made for national security or intelligence purposes;
- made to correctional institutions or law enforcement having custody of the patient;
- made prior to the effective date of this Notice.

A request for an accounting of disclosures must be in writing, dated and signed and sent to our Privacy Officer. All requests for an accounting of disclosures must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before August 1, 2009. The first list you request within a 12-month period is free of charge, but we may charge you for the cost of providing additional lists within the same 12-month period. We will notify you of the costs involved with the additional request, and you may withdraw your request before you incur any costs.

Paper Copy of This Notice; You are entitled to receive a paper copy of this Notice of Privacy Practices, and you may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. You may obtain a copy of this Notice on our website, www.rushingfamilypractice.com. or you may obtain a paper copy of this Notice at our clinic.

Right to File a Complaint; If you believe your privacy rights have been violated, you may file a complaint with Rushing Family Practice or with the Secretary of the Department of Health and Human Services. Complaints must be submitted in writing to our Privacy Officer. You will not be penalized for filing a complaint.

Provide an Authorization for Other Uses and Disclosures. We will obtain your written authorization for uses and disclosures that are not identified by this Notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your medical information may be revoked at any time in writing. If you revoke your authorization we will no longer use or disclose your medical information for the reasons described in your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain records of the care and treatment that we have provided to you.

Effective date 04/14/2003

RUSHING FAMILY PRACTICE
Where you and your family come first

OFFICE POLICIES AND PROCEDURES

Demographics:

1. We are required to verify Date of Birth, Address, Phone Number, and Insurance Eligibility
2. With the initial appointment, and subsequent visits, the patient or guardian will be asked to provide current insurance card and a picture form of ID. Please have this information available at all visits.
3. If the patient is not the primary insured of the policy, we will need the subscriber's name, Date of Birth, Social Security Number, and relationship to patient.

Billing and Collections:

1. Applicable copayment/coinsurance due for each visit must be paid at the time of the visit, unless prior arrangements have been made. Per our contractual obligations with the healthcare insurance carrier, we are obligated to collect for copayment/coinsurances due.
2. Healthcare insurance carriers may refuse to make a payment on a claim for any of the following reasons:
    a. Pre-existing conditions
    b. Deductible remaining/not met
    c. Services provided not covered
    d. Coverage not in effect at time of service
    e. Change in insurance plan or carrier and our office was not notified
3. If the healthcare insurance carrier denies a claim, and our office provided due diligence in submitting the claim correct to the best of our knowledge. We will hold the patient or responsible party responsible for any remaining amounts due.
4. The patient or guardian is responsible for understanding the patient's benefit plan and what it covers. We recommend that the patient or guardian contact the insurance company prior to the visit if there is any question regarding whether the carrier will cover the service.
5. The patient or responsible party will receive a statement for outstanding balances on services provided. Amounts billed are expected to be paid within thirty (30) days. If additional payment options are needed, please contact the billing phone number listed on the statement to arrange payment.
6. All payments are applied to the oldest balances first to avoid collection activity.

Auto Accidents and Workers Compensation

We do not bill for auto accidents or workers compensation related visits. We will first request that the patient or guardian seek a contracted provider through the appropriate insurance carrier. If an emergency arises and the patient needs the attention of our office, we will collect fees on a private pay basis at the time of service, provide an invoice for services rendered, and the patient or guardian can submit to the appropriate party for reimbursement.

Refill Requests

Prescription refills are granted, provided the patient is following the protocol and periodic visit requirements as requested by the provider. Please contact the pharmacy to request a refill, even if refill authorization limits have exhausted.
Please allow 48-hours for prescription refills to be processed.
If this office did not write the original prescription, a new prescription will be required, as we cannot refill another provider's prescription. A visit at this office to discuss the specific condition and medication is required prior to writing a prescription.

Many healthcare insurance carriers require pre-authorization on certain medications. If the medication requires this, please allow this office at least 1-week to finalize. We have no control over the carrier's process or the time required to secure the appropriate authorization. If appropriate authorization is not obtained, the pharmacy may hold the patient or guarantor responsible.

Patient Signature:_____ **Date:**_____

Guardian Signature:_____ **Date:**_____

Rushing Family Practice

Authorization for Use or Disclosure of Protected Health Information

I hereby request and authorize the release of my medical records

Patient name:_____ **Date of Birth:** _____

TO: (Doctors name) Rushing Family Practice
~~5005 Live Oak Street~~
Greenville, TX 75402

FROM:(Doctors name)_____

Address: _____ **Address:**_____

Telephone #:_____ **Telephone # :**_____

Fax #:_____ **Fax #:**_____

This authorization applies to all reports including (check all that apply)

_____**History** _____**Physical Examination** _____**Blood/lab test**

_____**Progress Notes** _____**Radiology Reports** _____**Physical Assessment**

_____**ALL MEDICAL RECORDS**

The Purpose of Disclosure (check all that apply)

_____**Continued Medical care** ____**Attorney** _____**Insurance** _____**Other**

I have the right to revoke this authorization in writing at any time by notifying Rushing Family Practice. A revocation does not pertain to information used or disclosed by Rushing Family Practice prior to the time of revocation. I understand that my Protected Health Information used or disclosed pursuant to this authorization may be re-disclosed by the entity receiving it and may therefore no longer be protected by law.

_____ _____

Signature of Patient or Responsible Party **Printed name of Patient or Responsible Party**

_____ _____

Relationship to Patient **Date**

Name _____ Date of Birth _____ Doctor_____ Date _____

A Survey from Your Healthcare Provider

Part of routine screening for your health includes reviewing mood and emotional concerns. (PHQ-2)

During the past two weeks, have you often been bothered by of the following problems?

Feeling down, depressed, irritable or hopeless? ☐ Yes ☐ No

Little interest or pleasure in doing things? ☐ Yes ☐ No

If you answered "Yes" to either question above, please answer all questions below. (PHQ-9)

During the past two weeks, how often have you been bothered by the following problems?	**Not at All**	**Several Days**	**More Than Half the Days**	**Nearly Everyday**
Feeling down, depressed, irritable or hopeless				
Little interest or pleasure in doing things				
Trouble falling or staying asleep or sleeping too much				
Poor appetite, weight loss or overeating				
Feeling tired or having little energy				
Feeling bad about yourself- or feeling you are a failure or have let yourself or family down				
Trouble concentrating on things, like reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite- being so fidgety or restless that you were moving around a lot more than usual				
Thoughts that you would be better off dead or of hurting yourself in some way				

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home or get along with others?

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

For Office Use Only: Total Score ☐