I N T A K E F O R M

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name:_____
(Last) (First) (Middle Initial)

Birth Date:_____ _____Age:_____Gender: _____

Marital Status:
__Never Married __Domestic Partnership __Married (Name of Spouse) : _____
__Divorced __Widowed __Separated

___Number of pregnancies ___ Number of live births ___Number of living children

Please list living children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? ___Yes ___No

Cell/Other Phone: ( ) May we leave a message? ___Yes ___No

E-mail:_____May we email you?___Yes___No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Insurance Information:

Member ID or SSN: _____ Plan Name: _____

Group Number: _____ Service Phone Number (back of card): _____

Subscriber / Policy Holder Name: _____ DOB: _____

Subscriber Address:_____

Subscriber Phone Number: _____ Relationship to Client: _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
___ No
___ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?
___ Yes
___ No

Please list: _____

_____

Have you ever been prescribed psychiatric medication?
___ Yes
___ No

Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health?

___Poor ___Unsatisfactory ___Satisfactory ___Good ___Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits?

___Poor ___Unsatisfactory ___Satisfactory ___Good ___Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in _____

4. Please list any difficulties you experience with your appetite or eating patterns

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
___ No ___ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks or have any phobias?
___ No
___ Yes

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain?
___ No
___ Yes

If yes, please describe _____

8. Do you drink alcohol more than once a week? ___ No ___ Yes

9. How often do you engage recreational drug use?

___ Daily ___ Weekly ___ Monthly ___ Infrequently ___ Never

10. Are you currently in a romantic relationship? ___ No ___ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Yes	No	List Family Member if yes
Alcohol/Substance Abuse	___	___	
Anxiety	___	___	
Depression	___	___	
Domestic Violence	___	___	
Eating Disorders	___	___	
Obesity	___	___	
Obsessive Compulsive Behavior	___	___	
Schizophrenia	___	___	
Suicide Attempts	___	___	

ADDITIONAL INFORMATION:

1. Are you currently employed? ___ No ___ Yes If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? ___ No ___ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weakness?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

Dulles Psychological Services
P: 703-493-0891 F: 703-552-1948

Cancellation Policy and Financial Agreement

If you fail to cancel a scheduled appointment in a timely manner, we cannot use this time for another client and you will be charged for the entire cost of your missed appointment.

A full session fee of $95 for resident, $150 Licensed Therapist or $175 for Psychologist will be charged to the card below for missed appointments or cancellations with less than a 24-hour notice unless it is due to serious illness or an emergency.

Additionally, any overdue balances that are the patient's responsibility will be charged to the credit card below, unless the patient specifies a different payment method by contacting our office.

A bill will be mailed to you if we are unable to process payment using the credit card below.
Thank you for your consideration regarding this important matter.

_____ *(Initial here)* I hereby authorize Dulles Psychological Services, LLC to make charges to my credit card for no-show appointments, late cancellations (less than 24 hours), or other agreed upon charges/balances. I understand that I may withdraw this authorization for subsequent charges at any time inwriting.

Card Type: _____Visa_____MasterCard_____ AMEX _____Discover
Name on Credit Card: _____
Credit Card Number:_____
Expiration Date: _____
CID # (on the back of the card): _____
Billing Address: _____

_____
Client Signature (Client's Parent/Guardian if under 18)

_____
Printed Name

_____
Signature of Financially Responsible Party

_____
Printed Name of Financially Responsible Party

_____
Today's Date

Dulles Psychological Services
P: 703-493-0891 F: 703-552-1948

Informed Consent
Client-Therapist Service Agreement

Welcome to Dulles Psychological Services. This document contains important information about our 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. 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.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, 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. Dulles Psychological Services has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy 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.

The first 1-2 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, the therapist will be able to offer you some initial impressions of what the work might include. At that point, the therapist and client will discuss treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with the therapist. If you have questions about the procedures, you should discuss them with your therapist whenever they arise. If your doubts persist, the therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 50-60 minutes in duration, once per week at a time agreed upon by you and your therapist, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours notice. If you miss a session without canceling, or cancel with less than 24-hour notice, you may be required to pay full fee 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 for the cancellation fee. 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.

PROFESSIONAL FEES

The standard fee for an intake ranges from $175.00 - $225.00 and future therapy sessions range from $150.00 - $175.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash. Any checks returned to our office are subject to an additional fee of up to $25.00 to cover the bank fee that we incur. If you refuse to pay your debt, we reserve the right to use an attorney or collection agency to secure payment. You will be responsible for all attorney or collection agency fees.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (the therapist will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request. If you anticipate becoming involved in a court case, we recommend that you discuss this fully with your therapist before you waive your right to confidentiality. If your case requires the therapist's participation, you will be expected to pay for the professional time required even if another party compels them to testify.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, our billing service will assist you to the extent in filing claims but you are responsible for knowing your coverage and for letting us know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow the practice to provide services to you once your benefits end. If this is the case, the practice will do their best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize the practice to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems.) Sometimes the therapist has to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we 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 therapy 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 (which is called co-insurance) or a flat dollar amount (referred to as a co-payment) 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. This will typically mean that you will be responsible to pay for initial sessions with the practice until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above, unless prohibited by our provider contract.

If we are not a participating provider for your insurance plan, the therapist 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.

PROFESSIONAL RECORDS

Dulles Psychological Services is required to keep appropriate records of the psychological services that are provided. Your records are maintained in a secure location in the office. We keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress set for treatment, your diagnosis, topics discussed between you and your therapist, your medical, social, and treatment history, records we receive from other providers, copies of records we send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, we recommend that you initially review them with your therapist, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right to have the therapist's decision reviewed by another mental health professional, which the therapist will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

Dulles Psychological Services policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and have discussed those issues with your therapist. Please remember that you may reopen the conversation at any time.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is the practices policy not to provide treatment to a child under age 13 unless s/he agrees that the therapist can share whatever information they consider necessary with a parent. For children 14 and older, we request an agreement between the client and the parents allowing the therapist to share general information about treatment progress and attendance, as well as a treatment summary upon

completion of therapy. All other communication will require the child's agreement, unless the therapist feels there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

A therapist is often not immediately available by telephone. They do not answer their phones when they are with clients or otherwise unavailable. At these times, you may leave a message on their 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, go to your local hospital or call 911.

CONSENT TO PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

_____

Signature of Patient or Personal Representative

_____

Printed Name of Patient or Personal Representative

Date _____

Description of Personal Representative's Authority:_____

Dulles Psychological Services
P: 703-493-0891 F: 703-552-1948

Client Email/Texting Informed Consent Form

1. Risk of using email/texting
   The transmission of client information by email and/or texting has a number of risks that clients should consider prior to the use of email and/or texting. These include, but are not limited to, the following risks:
   a. Email and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
   b. Email and text senders can easily misaddress an email or text and send the information to an undesired recipient.
   c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
   d. Employers and on-line services have a right to inspect emails sent through their company systems.
   e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
   f. Email and texts can be used as evidence in court.
   g. Emails and texts may not be secure and therefore it is possible that the confidentiality of such communications may be breached by a third party.

2. Conditions for the use of email and texts
   Therapist cannot guarantee but will use reasonable means to maintain security and confidentiality of email and text information sent and received. Therapist is not liable for improper disclosure of confidential information that is not caused by Therapist's intentional misconduct. Clients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:
   a. Email and texting is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
   b. Email and texts should be concise. The client/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
   c. All email will usually be printed and filed into the client's medical record. Texts maybe printed and filed as well.
   d. Provider will not forward client's/parent's/legal guardian's identifiable emails and/or texts without the client's/parent's/legal guardian's written consent, except as authorized by law.
   e. Clients/parents/legal guardians should not use email or texts for communication of sensitive medical information.
   f. Provider is not liable for breaches of confidentiality caused by the client or any third party.
   g. It is the client's/parent's/legal guardian's responsibility to follow up and/or schedule an appointment if warranted.

3. Client Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email and/or texts between my therapist and me, and consent to the conditions and instructions outlined, as well as any other instructions that my Therapist may impose to communicate with me by email or text.

Client name: _____

Client signature:_____ Date:_____

Parent/Legal Guardian name: _____

Parent/Legal Guardian signature:_____Date: _____

Provider name: _____

Provider signature:_____ Date: _____

"Notice of Privacy Practices"

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me.

II. "Limits of Confidentiality"

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization
There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

- Emergency If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.
- Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Virginia law to report the matter immediately to the Virginia Department of Social Services.
- Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Virginia law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
- Health Oversight: Virginia law requires that licensed psychologists report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.
- Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you can file a motion to quash (block) the subpoena. However, while awaiting the judge's decision, I am required to place said records in a sealed envelope and provide them to the Clerk of Court. In civil court cases, therapy information is not protected by patient-therapist privilege in child abuse cases, in cases in which your mental health is an issue, or in any case in which the judge deems the information to be "necessary for the proper administration of justice." In criminal cases, Virginia has no statute granting therapist-patient privilege, although records can sometimes be protected on another basis. Protections of privilege may not apply if I do an evaluation for a third party or where the evaluation is court- ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety: Under Virginia law, if I am engaged in my professional duties and you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to

an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or law enforcement officer, whether you are a minor or an adult.

- Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- Records of Minors: Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child. Other circumstances may also apply, and we will discuss these in detail if I provide services to minors.
- Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

- Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations — You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.
- Right to an Accounting of Disclosures – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process
- Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.
- Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your request if you ask me to amend information that: 1) was not created by me; I will add your request to the information record; 2) is not part of the medical information kept by me; 3) is not part of the information which you would be permitted to inspect and copy; 4) is accurate and complete.
- Right to a copy of this notice – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: _____

==========

Patient's Acknowledgement of Receipt of Notice of
Privacy Practices Please sign, print your name, and
date this acknowledgement form.

I have been provided a copy of the Notice of Privacy Practices.

We have discussed these policies, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.

Signature: _____

Printed Name: _____

Date: _____

Dulles Psychological Services
P: 703-493-0891 F: 703-552-1948

PHYSICIAN NOTICE AND RELEASE OF INFORMATION

It is helpful for physicians and mental health therapist to coordinate care when needed. Please complete and sign the authorization below to enable communication between our practice and your primary care physician. If you do not wish for your physician to have this notice in your medical files, please indicate below.

_____ Name of Primary Care Physician
_____ PCP Address
_____ City, State and zip
_____ PCP Phone Number

FOR THE PHYSICIAN: The client named below is receiving psychotherapy at Dulles Psychological Services. The client or legal guardian has indicated that you are his/her primary physician. This client or legal guardian has signed this authorization form allowing us to exchange pertinent information with you and the primary care clinic. If you would like any further contact regarding this case, or if you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly.

I _____ (printed name) authorize ___ yes ___ no that this notice be sent to the above named doctor and further authorize consultations between my doctor and therapist relative to my medical and psychological care.

_____ _____
Signature Date

Thank You,

Dulles Psychological Services, LLC
21351 Gentry Drive
Suite 200
Sterling, VA 20166
703-493-0891

cc: Member Medical Record

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name: _____ **Age**: ____ **Date**: _____

1. During bothered the last 4 weeks, how much have you been by any of the following problems?	**Not Bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	____	____	____
b. Back pain	____	____	____
c. Pain in your arms, legs, or joints (knees, hips, etc.)	____	____	____
d. Menstrual cramps or other problems with your periods	____	____	____
e. Pain or problems during sexual intercourse	____	____	____
f. Headaches	____	____	____
g. Chest pain	____	____	____
h. Dizziness	____	____	____
i. Fainting spells	____	____	____
j. Feeling your heart pound or race	____	____	____
k. Shortness of breath	____	____	____
l. Constipation, loose bowels, or diarrhea	____	____	____
m. Nausea, gas, or indigestion	____	____	____

2. Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
a. Little interest or pleasure in doing things	____	____	____	_____
b. Feeling down, depressed, or hopeless	____	____	____	_____
c. Trouble falling or staying asleep, or sleeping too much	____	____	____	_____
d. Feeling tired or having little energy	____	____	____	_____
e. Poor appetite or overeating	____	____	____	_____
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	____	____	____	_____
g. Trouble concentrating on things, such as reading the newspaper or watching television	____	____	____	_____
h. 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	____	____	____	_____
i. Thoughts that you would be better off dead or of hurting yourself in some way	____	____	____	_____

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are “a lot” and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least “More than half the days” (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least “More than half the days” (count #2i if present at all).

3. Questions about anxiety.	**NO**	**YES**
a. In the last 4 weeks, have you had an anxiety attack suddenly feeling fear or panic?	____	____
If you checked "NO", go to question #5.	____	____
b. Has this ever happened before?	____	____
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	____	____
d. Do these attacks bother you a lot or are you worried about having another attack?	____	____

4. Think about your last bad anxiety attack.	**NO**	**YES**
a. Were you short of breath?	____	____
b. Did your heart race, pound, or skip?	____	____
c. Did you have chest pain or pressure?	____	____
d. Did you sweat?	____	____
e. Did you feel as if you were choking?	____	____
f. Did you have hot flashes or chills?	____	____
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	____	____
h. Did you feel dizzy, unsteady, or faint?	____	____
i. Did you have tingling or numbness in parts of your body?...	____	____
j. Did you tremble or shake?	____	____
k. Were you afraid you were dying?	____	____

5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**
a. Feeling nervous, anxious, on edge, or worrying a lot about different things.	____	____	____
If you checked "Not at all", go to question #6.			
b. Feeling restless so that it is hard to sit still.	____	____	____
c. Getting tired very easily.	____	____	____
d. Muscle tension, aches, or soreness.	____	____	____
e. Trouble falling asleep or staying asleep.	____	____	____
f. Trouble concentrating on things, such as reading a book or watching TV.	____	____	____
g. Becoming easily annoyed or irritable.	____	____	____

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

6. Questions about eating. **NO** **YES**

a. Do you often feel that you can't control what or how much you eat? ____ ____
b. Do you often eat, within any 2-hour period, what most people would regard as an usually large amount of food? ____ ____
If you checked "NO" to either #a or #b, go to question #9.
c. Has this been as often, on average, as twice a week for the last 3 months? ____ ____

7. In the last 3 months have you <u>often</u> done any of the following in order to avoid gaining weight? **NO** **YES**

a. Made yourself vomit? ____ ____
b. Took more than twice the recommended dose of laxatives? ____ ____
c. Fasted — not eaten anything at all for at least 24 hours? ____ ____
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating? ____ ____

NO **YES**

8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week? ____ ____

9. Do you ever drink alcohol (including beer or wine)? ____ ____
If you checked "NO" go to question #11.

10. Have any of the following happened to you <u>more than once in the last 6 months</u>? **NO** **YES**

a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health. ____ ____
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities. ____ ____
c. You missed or were late for work, school, or other activities because you were drinking or hung over. ____ ____
d. You had a problem getting along with other people while you were drinking. ____ ____
e. You drove a car after having several drinks or after drinking too much. ____ ____

11. If you checked off <u>any</u> problems on this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

___ Not difficult ___ Somewhat ___ Very difficult ___ Extremely difficult

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank. Alc Abu if any of #10a-e is 'YES'.
