Killeen Psychiatry — Patient & Insurance Information

Patient name	Date of birth	Date

Enter the patient’s personal and contact details, then primary insurance and insured-person information. The insured person is the policyholder. For a required text field that does not apply, enter N/A.

Complete the patient and insurance information below. For a text field that does not apply, enter N/A.

1. Patient — First Name

2. Patient — Last Name

3. Patient — Date of Birth

4. Patient — Gender

Choose one.

- ◯ Male
- ◯ Female
- ◯ Unknown

5. Patient contact — Caregiver First Name

6. Patient contact — Caregiver Last Name

7. Patient contact — Email

8. Patient contact — Home Phone

9. Patient contact — Mobile Phone

10. Patient contact — Work Phone

11. Patient contact — Fax

12. Patient contact — Primary Phone

Choose one.

◯ Mobile Phone ◯ Home Phone ◯ Work Phone

13. Patient contact — Address Line1

14. Patient contact — Address Line2

15. Patient contact — City

16. Patient contact — Country

17. Patient contact — State

18. Patient contact — Zip code

19. Patient contact — Postbox No

20. Patient contact — Emergency Contact Name

21. Patient contact — Emergency Contact Number

22. Patient contact — Extn

23. Primary insurance — Insurance Type

Choose one.

- ◯ MEDICARE
- ◯ MEDICAID
- ◯ TRICARE CHAMPUS
- ◯ CHAMPVA
- ◯ GROUP HEALTH PLAN
- ◯ FECA BLK LUNG
- ◯ OTHER

24. Primary insurance — Insurance Plan Name or Program Name

25. Primary insurance — ID

26. Primary insurance — Insurance Company Name (Payer Name)

27. Primary insurance — Payer Id

28. Primary insurance — Payer Address

29. Primary insurance — Payer City

30. Primary insurance — Payer Country

31. Primary insurance — Payer State

32. Primary insurance — Payer ZipCode

33. Primary insurance — Valid From

34. Primary insurance — Valid Until

35. Primary insurance — Policy Group/FECA #

36. Primary insurance — Copay

37. Primary insurance — Deductible

38. Primary insurance — Employer/School Name

39. Primary insurance — Comments

40. Insured person / policyholder — Patient Relationship

Choose one.

◯ Self ◯ Spouse ◯ Child ◯ Other

41. Insured person / policyholder — Comments / other details for: Patient Relationship

42. Insured person / policyholder — First Name

43. Insured person / policyholder — Last Name

44. Insured person / policyholder — Date of Birth

45. Insured person / policyholder — Sex

Choose one.

◯ Male ◯ Female ◯ Unknown

46. Insured person / policyholder — Address Line 1

47. Insured person / policyholder — Address Line 2

48. Insured person / policyholder — City

49. Insured person / policyholder — Country

50. Insured person / policyholder — State

51. Insured person / policyholder — Zip Code

52. Insured person / policyholder — Home Phone

53. Insured person / policyholder — Mobile Phone

Killeen Psychiatry — New Patient Clinical Intake (PHQ-9 / GAD-7)

Patient name	Date of birth	Date

Tell us about your health history, symptoms, medications, and treatment goals. Required questions are marked. For a text question that does not apply, enter none or N/A. You can save your progress and return later.

1. Please confirm you are here for medication management.
Choose one.

◯ Yes ◯ No

2. Emergency Contact (name and phone number):

3. Therapist: (if none, list "none")

4. What are your treatment goals?

5. Please select any depressive symptoms you are experiencing or have been problematic for you in the past:

Check all that apply.

- [ ] sadness
- [ ] low mood
- [ ] lack of joy
- [ ] no longer enjoying activities previously enjoyed (M,P)
- [ ] apathy (lack of interest)
- [ ] sleep changes
- [ ] decreased or lack of energy
- [ ] changes in appetite
- [ ] brain fog
- [ ] slowed thinking
- [ ] pessimism
- [ ] irritability (M,A,P)
- [ ] angry episodes
- [ ] agitation (M,P)
- [ ] restlessness
- [ ] unstable mood
- [ ] hopelessness
- [ ] high energy
- [ ] euphoria
- [ ] excessive spending
- [ ] increased sex drive
- [ ] risky behaviors
- [ ] impulsivity
- [ ] disorganized thoughts
- [ ] crying spells
- [ ] none
- [ ] Other

6. Comments / other details for: Please select any depressive symptoms you are experiencing or have been problematic for you in the past:

7. Please select any anxiety symptoms you are experiencing or have been problematic for you in the past:

Check all that apply.

- [ ] excessive worrying
- [ ] difficulty controlling worry
- [ ] restlessness
- [ ] feeling "on edge"
- [ ] feeling frequently overwhelmed
- [ ] easily fatigued / feeling wiped out by the end of the day
- [ ] poor concentration
- [ ] irritability
- [ ] muscle tension
- [ ] frequent awakening from sleep (A,P)
- [ ] difficult falling asleep (A,P)
- [ ] none
- [ ] Other

8. Comments / other details for: Please select any anxiety symptoms you are experiencing or have been problematic for you in the past:

_____

_____

_____

9. Please select any PTSD symptoms you are experiencing or have been problematic for you in the past:

Check all that apply.

- [ ] none
- [ ] exposure to actual or threatened death, serious injury, or sexual violence
- [ ] recurrent, involuntary, and intrusive distressing memories of the traumatic event(s)
- [ ] recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
- [ ] emotional upset when exposed to triggers that symbolize or resemble an aspect of the traumatic event(s)
- [ ] physical reactions to triggers that symbolize or resemble an aspect of the traumatic event(s)
- [ ] being hostile
- [ ] hyper-vigilance / overly alert to surroundings
- [ ] isolating from others
- [ ] feeling lonely
- [ ] flashbacks of traumatic event(s)
- [ ] lack of enjoyment
- [ ] excessive guilt
- [ ] nightmares
- [ ] emotional detachment
- [ ] intrusive thoughts
- [ ] Other

10. Comments / other details for: Please select any PTSD symptoms you are experiencing or have been problematic for you in the past:

11. Please select any attention/concentration symptoms you are experiencing or have been problematic for you in the past: If you select any symptoms below, please complete Section B.

Check all that apply.

- ☐ poor attention to detail
- ☐ difficulty completing tasks
- ☐ disorganization,
- ☐ easily distracted
- ☐ none
- ☐ limited attention span duration
- ☐ difficulty starting tasks
- ☐ making careless mistakes,
- ☐ forgetfulness
- ☐ Other

12. Comments / other details for: Please select any attention/concentration symptoms you are experiencing or have been problematic for you in the past:

13. Section B: Please select any ADHD symptoms you experienced prior to the age of 16:

Check all that apply.

- ☐ often failed to give close attention to details or makes careless mistakes in schoolwork, at work, or with other activities
- ☐ often had trouble holding attention on tasks or play activities
- ☐ often did not seem to listen when spoken to directly
- ☐ often did not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., loses focus, side-tracked)
- ☐ often had trouble organizing tasks and activities
- ☐ often avoided, disliked, or was reluctant to do tasks that require mental effort over a long period of time (such as schoolwork or homework)
- ☐ often lost things necessary for tasks and activities (e.g. school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, mobile telephones)
- ☐ was often easily distracted
- ☐ was often forgetful in daily activities
- ☐ often fidgeted with or tapped hands or feet, or squirmed in seat
- ☐ often left seat in situations when remaining seated was expected
- ☐ often ran about or climbed in situations where it was not appropriate
- ☐ often unable to play or take part in leisure activities quietly
- ☐ was often “on the go” acting as if “driven by a motor”
- ☐ often talked excessively
- ☐ often blurted out an answer before a question was completed
- ☐ often had trouble waiting turn
- ☐ often interrupts or intrudes on others
- ☐ none
- ☐ Other

14. Comments / other details for: Section B: Please select any ADHD symptoms you experienced prior to the age of 16:

15. Please select any panic symptoms you are experiencing or have been problematic for you in the past:

Check all that apply.

- [ ] none
- [ ] a period of intense fear or discomfort
- [ ] palpitations, pounding heart, or accelerated heart rate
- [ ] sweating
- [ ] trembling or shaking
- [ ] shortness of breath
- [ ] feeling of choking
- [ ] chest pain or discomfort
- [ ] nausea or abdominal distress
- [ ] feeling dizzy, unsteady, lightheaded, or faint
- [ ] derealization (feelings of unreality)
- [ ] depersonalization (being detached from oneself)
- [ ] fear of losing control or “going crazy”
- [ ] fear of dying
- [ ] numbness or tingling sensation
- [ ] chills or hot flushes
- [ ] persistent concern about additional attacks or their consequences
- [ ] significant change in behavior related to these attacks
- [ ] Other

16. Comments / other details for: Please select any panic symptoms you are experiencing or have been problematic for you in the past:

17. Have you had feelings or thoughts that you didn't want to live in the last 6 months?

Choose one.

- ◯ Yes
- ◯ No

18. How often do you have these thoughts?

Answer only if you answered "Yes" to question 17.

19. When is the last time you had these thoughts?

Answer only if you answered "Yes" to question 17.

20. On a scale of 0 (no desire) to 5 (actively considering suicide) what it is your desire to harm yourself currently?

Answer only if you answered "Yes" to question 17.
Choose one.

◯ 0 ◯ 1 ◯ 2 ◯ 3
◯ 4 ◯ 5

21. Is there anything that would make this situation better?

Answer only if you answered "Yes" to question 17.

22. Have you decided how you will kill yourself?

Answer only if you answered "Yes" to question 17.
Choose one.

◯ Yes ◯ No

23. Have you decided when you will kill yourself?

Answer only if you answered "Yes" to question 17.
Choose one.

◯ Yes ◯ No

24. Is your method of suicide available to you now?

Answer only if you answered "Yes" to question 17.
Choose one.

◯ Yes ◯ No

25. Is there anything that would stop you from killing yourself?

Answer only if you answered "Yes" to question 17.
Choose one.

◯ Yes ◯ No

26. Has there been a recent incident that has caused you to feel this way?

Answer only if you answered "Yes" to question 17.

27. Have you ever attempted suicide in the past? If yes, please provide number of attempts, dates of attempts & how it was stopped.

28. Do you have access to guns?

Answer only if you answered "Yes" to question 17.
Choose one.

◯ Yes ◯ No

29. List allergies (type, severity, reactions). If none, enter none.

30. Would you be interested in our Clinic placing you on our priority list? If a sooner appointment becomes available we will be able to quickly text you with the appointment option to which you are welcome to accept or deny the option to move up your appointment to that date and time.

Choose one.

- ◯ Yes
- ◯ No

31. List medications (name, dose, frequency / intake details). If none, enter none.

32. Medical conditions for which you are treated or have been diagnosed with:

Check all that apply.

- ☐ None
- ☐ Allergies
- ☐ Autism
- ☐ Asthma
- ☐ Arthritis
- ☐ Anemia
- ☐ Back problems
- ☐ Bleeding disorder
- ☐ Broken bones
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Crohn's
- ☐ Diabetes 1
- ☐ Diabetes 2
- ☐ Dementia
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ GERD
- ☐ Head injury / TBI
- ☐ Hearing impairment
- ☐ Heart attack
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Immune disorder
- ☐ Irritable Bowel Syndrome
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Organ transplant
- ☐ Osteoporosis
- ☐ Liver disease
- ☐ Low testosterone
- ☐ Menopause
- ☐ Migraines or chronic headaches
- ☐ Pancreatitis
- ☐ Parkinson's
- ☐ PCOS
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Seizure disorder
- ☐ Thyroid disorder
- ☐ Tuberculosis
- ☐ Vision impairment
- ☐ Other

33. Comments / other details for: Medical conditions for which you are treated or have been diagnosed with:

34. Are you pregnant?

Choose one.

- ◯ Yes
- ◯ No
- ◯ No, but may become pregnant in the future
- ◯ Currently breastfeeding

35. Mental health conditions for which you are treated or have been diagnosed with:

Check all that apply.

- ☐ none
- ☐ Adjustment disorder
- ☐ Attention deficit disorder
- ☐ Bipolar 1
- ☐ Depression
- ☐ Insomnia
- ☐ Panic disorder
- ☐ Phobia
- ☐ Psychosis
- ☐ Social anxiety disorder
- ☐ Addiction
- ☐ Anxiety
- ☐ Autism
- ☐ Bipolar 2
- ☐ Eating disorder
- ☐ Obssessive compulsive disorder
- ☐ Personality disorder
- ☐ Post traumatic stress disorder
- ☐ Schizophrenia
- ☐ Other

36. Comments / other details for: Mental health conditions for which you are treated or have been diagnosed with:

37. Please select all previous psychiatric medications tried:

Check all that apply.

- [ ] none
- [ ] sertraline / Zoloft
- [ ] fluoxetine / Prozac
- [ ] citalopram / Celexa
- [ ] escitalopram / Lexapro
- [ ] fluvoxamine / Luvox
- [ ] paroxetine / Paxil
- [ ] vilazodone / Viibryd
- [ ] vortioxitine / Trintellix
- [ ] desvenlafaxine / Pristiq
- [ ] duloxetine / Cymbalta
- [ ] venlafaxine / Effexor
- [ ] levomilnacipran / Fetzima
- [ ] milnacipran / Savella
- [ ] bupropion / Wellbutrin
- [ ] amitriptyline / Elavil
- [ ] clomipramine / Anafranil
- [ ] doxepin / Silenor
- [ ] impramine / Tofranil
- [ ] nortriptyline / Pamelor
- [ ] isocarboxazid / Marplan
- [ ] phenelzine / Nardil
- [ ] tranylcypromine / Parnate
- [ ] selegiline / Emsam
- [ ] pramixapole / Mirapex
- [ ] ketamine
- [ ] alprazolam / Xanax
- [ ] chlordiazepoxide / Librium
- [ ] clonazepam / Klonipin
- [ ] diazepam / Valium
- [ ] lorazepam / Ativan
- [ ] temazepam / Restoril
- [ ] buspirone / Buspar
- [ ] clonidine
- [ ] hydroxyzine / Vistaril
- [ ] gabapentin / Neurontin
- [ ] guanfacine
- [ ] atomoxetine/Strattera
- [ ] Qelbree
- [ ] propranolol

- [ ] haloperidol / Haldol
- [ ] chlorpromazine / Thorazine
- [ ] aripiprazole / Abilify
- [ ] asenapine / Saphris
- [ ] bexpiprazole / Rexulti
- [ ] cariparizine / Vraylar
- [ ] clozapine / Clozaril
- [ ] iloperidone / Fanapt
- [ ] lumateperone / Caplyta
- [ ] lurasidone / Latuda
- [ ] olanzapine / Zyprexa
- [ ] olanzapine -samidorphan / Lybalvi
- [ ] paliperidone / Invega
- [ ] quetiapine / Seroquel
- [ ] quetiapine XR / Seroquel XR
- [ ] risperidone / Risperidone
- [ ] ziprasidone / Geodon
- [ ] carbamazepine / Tegretol
- [ ] divalproex / Depakote
- [ ] oxcarbazepine / Trileptal
- [ ] stimulant / Adderall / Concerta / Vyvanse
- [ ] hypnotic / Ambien / Lunesta
- [ ] Belsomra
- [ ] ramelteon / Rozerem
- [ ] melatonin
- [ ] mirtazepine / Remeron
- [ ] trazodone / Deseryl
- [ ] modafinil / Provigil
- [ ] armodafinil / Nuvigil
- [ ] Lithium
- [ ] Other

38. Comments / other details for: Please select all previous psychiatric medications tried:

39. Please list any hospitalizations you have had for your mental health in the past?

40. Are you adopted?

Choose one.

- ◯ Yes
- ◯ No

41. Any history of mental health condition(s) in your family?

Check all that apply.

- ☐ none
- ☐ mother
- ☐ father
- ☐ siblings
- ☐ grandmother
- ☐ grandfather
- ☐ Other

42. Comments / other details for: Any history of mental health condition(s) in your family?

43. Any history of suicide in your family?

Check all that apply.

- ☐ none
- ☐ grandmother
- ☐ grandfather
- ☐ father
- ☐ mother
- ☐ sibling
- ☐ child
- ☐ Other

44. Comments / other details for: Any history of suicide in your family?

45. Is your mother still alive?

Choose one.

- ◯ Yes
- ◯ No

46. Age at time of death?

47. Is your father still alive?

Choose one.

- ◯ Yes
- ◯ No

48. Age at time of death:

49. Do you have any history of being abused emotionally, physically, sexually or have you been neglected? Please include the amount of detail you are comfortable providing. (Please answer "none" if none.)

50. Which options best describes your relationship with your mother?

Check all that apply.

- ☐ healthy & connected
- ☐ unhealthy & connected
- ☐ distant
- ☐ absent
- ☐ Other

51. Comments / other details for: Which options best describes your relationship with your mother?

52. Which options best describes your relationship with your father?

Check all that apply.

- ☐ healthy & connected
- ☐ unhealthy & connected
- ☐ distant
- ☐ absent
- ☐ Other

53. Comments / other details for: Which options best describes your relationship with your father?

54. Which options best describes your relationship with your significant other?

Check all that apply.

- ☐ healthy & connected
- ☐ unhealthy & connected
- ☐ high conflict
- ☐ distant
- ☐ absent
- ☐ Other

55. Comments / other details for: Which options best describes your relationship with your significant other?

56. If applicable, which options best describes your relationship with your children?

Check all that apply.

- ☐ healthy & connected
- ☐ unhealthy & connected
- ☐ high conflict
- ☐ distant
- ☐ absent
- ☐ Other

57. Comments / other details for: If applicable, which options best describes your relationship with your children?

58. What gender do you identify as?

Check all that apply.

- ☐ Male
- ☐ Female
- ☐ Nonbinary
- ☐ Other

59. Comments / other details for: What gender do you identify as?

60. Preferred pronouns:

Check all that apply.

- ☐ She / Her
- ☐ He / Him
- ☐ They / Them
- ☐ Other

61. Comments / other details for: Preferred pronouns:

62. What is your sexual orientation?

Check all that apply.

- ☐ heterosexual
- ☐ homosexual
- ☐ bisexual
- ☐ asexual
- ☐ unsure
- ☐ rather not discuss
- ☐ Other

63. Comments / other details for: What is your sexual orientation?

64. Relationship Status

Check all that apply.

- ☐ single
- ☐ partnered
- ☐ polyamorous
- ☐ married
- ☐ separated
- ☐ divorced
- ☐ widowed

65. Please select who you live with:

Check all that apply.

- ☐ alone
- ☐ parent(s)
- ☐ family
- ☐ spouse
- ☐ child/children (includes stepchildren)
- ☐ friends / roommate
- ☐ Other

66. Comments / other details for: Please select who you live with:

67. Employment Status:

Check all that apply.

- ☐ unemployed voluntarily
- ☐ unemployed involuntarily
- ☐ employed part time
- ☐ employed full time
- ☐ stay at home parent / spouse
- ☐ student
- ☐ retired
- ☐ disabled
- ☐ & satisfied
- ☐ & dissatisfied
- ☐ Other

68. Comments / other details for: Employment Status:

69. If you are employed, what is your job?

70. Highest level of education completed:

Check all that apply.

- ☐ Middle School
- ☐ Some High School
- ☐ GED
- ☐ High School
- ☐ Some College
- ☐ College
- ☐ Graduate School
- ☐ Other

71. Comments / other details for: Highest level of education completed:

72. If you are currently in school, what are you studying & where do you attend school?

73. Military affiliation:

Check all that apply.

- ☐ none
- ☐ dependent
- ☐ spouse
- ☐ active duty
- ☐ retired
- ☐ veteran
- ☐ honorable discharge
- ☐ dishonorable discharge
- ☐ Other

74. Comments / other details for: Military affiliation:

75. How often do you exercise?

Check all that apply.

- ☐ never
- ☐ rarely
- ☐ 1-2 times per week
- ☐ 3-5 times per week
- ☐ >6 times per week
- ☐ Other

76. Comments / other details for: How often do you exercise?

77. Which option most closely reflects your dietary choices?

Check all that apply.

- ☐ eat whatever I want, whenever I want
- ☐ I want to eat better, but I'm unable
- ☐ everything in moderation, I keep a close eye on my eating
- ☐ I count all macros & calories every day
- ☐ Other

78. Comments / other details for: Which option most closely reflects your dietary choices?

79. How much caffeine do you consume?

Check all that apply.

- ☐ 0 servings per day
- ☐ 1-3 servings per day
- ☐ 3-6 servings per day
- ☐ >6 servings per day
- ☐ Other

80. Comments / other details for: How much caffeine do you consume?

81. Do you use tobacco products?

Check all that apply.

- ☐ never
- ☐ former use
- ☐ current use
- ☐ smoke cigarettes
- ☐ smokeless tobacco
- ☐ Other

82. Comments / other details for: Do you use tobacco products?

83. Frequency of alcohol use?

Check all that apply.

- ☐ never
- ☐ 0-1 days per week
- ☐ 2-4 days per week
- ☐ 5 or greater days per week
- ☐ Other

84. Comments / other details for: Frequency of alcohol use?

85. Any substance Use?

Check all that apply.

- ☐ no history of substance use, ever
- ☐ not actively using substances
- ☐ have experimented with substances in the past
- ☐ substances used in the last 90 days:
- ☐ Cannabis
- ☐ Methamphetamine
- ☐ Cocaine
- ☐ Heroin
- ☐ LSD, Mushrooms or Hallucinogens
- ☐ Prescription medication (not prescribed)
- ☐ Ecstasy / MDMA
- ☐ Other

86. Comments / other details for: Any substance Use?

87. Legal history:

Check all that apply.

- ☐ none
- ☐ <10 years ago
- ☐ >10 years ago
- ☐ current / pending
- ☐ Other

88. Comments / other details for: Legal history:

89. Any treatment for substance use in the past?

Check all that apply.

- ☐ none
- ☐ inpatient
- ☐ outpatient
- ☐ support meetings
- ☐ Other

90. Comments / other details for: Any treatment for substance use in the past?

91. What do you do for fun / self care / recreation / hobbies

Check all that apply.

- ☐ nothing
- ☐ gaming
- ☐ exercise / outdoor activities / sports
- ☐ cooking / baking
- ☐ crafting
- ☐ watch TV
- ☐ reading
- ☐ social media
- ☐ home projects
- ☐ volunteer work
- ☐ enjoy pets
- ☐ spend time with friends, family
- ☐ meditation
- ☐ art
- ☐ shopping
- ☐ Other

92. Comments / other details for: What do you do for fun / self care / recreation / hobbies

93. Who is your support system?

Check all that apply.

- ☐ none
- ☐ friends
- ☐ pet
- ☐ Other
- ☐ family
- ☐ significant other / partner
- ☐ therapist

94. Comments / other details for: Who is your support system?

95. Do you belong to a spiritual or religious group?

Choose one.

- ◯ Yes
- ◯ No

96. Comments / other details for: Do you belong to a spiritual or religious group?

97. Do you currently attend counseling?

Choose one.

- ◯ Yes
- ◯ No

98. Comments / other details for: Do you currently attend counseling?

99. Height:

100. Weight:

101. Is there anything else you feel is important to add? Please list here:

(PHQ-9) - Depression Severity Score

Over the last 2 weeks, how often have you been bothered by any of the following problems?

102. Little interest or pleasure in doing things
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

103. Feeling down, depressed, or hopeless
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

104. Trouble falling or staying asleep, or sleeping too much
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

105. Feeling tired or having little energy
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

106. Poor appetite or overeating
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

107. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

108. Trouble concentrating on things, such as reading the newspaper or watching television
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

109. 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
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

110. Thoughts that you would be better off dead or of hurting yourself in some way
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

111. 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?
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

112. Would you be interested in learning more about a safe, effective, non-drug treatment for depression?
Choose one.

- ◯ Yes
- ◯ No

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Over the last 2 weeks, how often have you been bothered by the following problems?

113. Feeling nervous, anxious or on edge
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

114. Not being able to stop or control worrying
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

115. Worrying too much about different things
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

116. Trouble relaxing
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

117. Being so restless that it is hard to sit still
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

118. Becoming easily annoyed or irritable
Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day

119. Feeling afraid as if something awful might happen

Choose one.

- ◯ Not at all
- ◯ Several days
- ◯ More than half the days
- ◯ Nearly every day