



GYNECOLOGY PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE: HOME _____ CELL _____ WORK _____
EMAIL ADDRESS (for patient portal access): _____
EMPLOYER _____ OCCUPATION _____

RACE:

- | | | |
|---|---|---|
| <input type="radio"/> White | <input type="radio"/> Asian | <input type="radio"/> Other |
| <input type="radio"/> Black/African American | <input type="radio"/> Hispanic or Latino (no race info available) | <input type="radio"/> Decline to Report |
| <input type="radio"/> American Indian or Alaskan Native | <input type="radio"/> Native Hawaiian or Pacific Islander | |

ETHNICITY:

| | | |
|---|---|--|
| <input type="radio"/> No, not Spanish/Hispanic/Latino | <input type="radio"/> Decline to Answer | <input type="radio"/> Unknown |
| <input type="radio"/> Yes/Cuban <input type="radio"/> Yes/Puerto Rican | <input type="radio"/> Yes, Mexican, American, Chicano | <input type="radio"/> Yes, Other Hispanic <input type="radio"/> (Specify) _____ |

PREFERRED LANGUAGE:

| | | | | | |
|----------------------------------|----------------------------------|--------------------------------|----------------------------------|--------------------------------|------------------------------|
| <input type="radio"/> English | <input type="radio"/> Spanish | <input type="radio"/> Japanese | <input type="radio"/> Chinese | <input type="radio"/> Italian | <input type="radio"/> Hindi |
| <input type="radio"/> Portuguese | <input type="radio"/> Russian | <input type="radio"/> French | <input type="radio"/> Guatemalan | <input type="radio"/> Tagalog | <input type="radio"/> Arabic |
| <input type="radio"/> Bosnian | <input type="radio"/> Vietnamese | <input type="radio"/> Laotian | <input type="radio"/> German | <input type="radio"/> Gujarati | |

INSURANCE INFORMATION

****please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section****

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER _____ PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY _____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____

SECONDARY INSURANCE INFORMATION (if applicable)

****please be sure to provide information for the PRIMARY POLICY HOLDER when completing this section****

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ GENDER _____ SOCIAL SECURITY NUMBER _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE NUMBER _____ PATIENT'S RELATIONSHIP TO POLICY HOLDER _____
INSURANCE COMPANY _____
GROUP NUMBER _____ POLICY NUMBER _____
CLAIMS MAILING ADDRESS: _____
(usually found on back of card) _____

PATIENT NAME (please print) _____ DATE OF BIRTH _____



SPOUSE/SIGNIFICANT OTHER

NAME: LAST _____ FIRST _____ MIDDLE _____
DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____
PHONE: HOME _____ CELL _____ WORK _____
EMPLOYER _____ OCCUPATION _____

PARENT/GUARDIAN (if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ RELATIONSHIP TO PATIENT _____

ALTERNATIVE CONTACT (other than spouse/significant other – if applicable)

NAME: LAST _____ FIRST _____ MIDDLE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ RELATIONSHIP TO PATIENT _____

PREFERRED PHARMACY

NAME _____ LOCATION _____

PREFERRED LAB

We send all lab work to LabCorp. Your insurance provider may require the use of a different lab. Please select:

LabCorp Other (specify): _____

LIVING WILL

Do you have a living will?

| | | |
|---------------------------|--------------------------|---|
| <input type="radio"/> Yes | <input type="radio"/> No | <input type="radio"/> I'd like information about establishing a living will |
|---------------------------|--------------------------|---|

PATIENT SIGNATURE _____ DATE _____

PRIVACY NOTICE

This privacy notice describes how your medical information may be disclosed and used by this practice. This notice also discusses your rights to access your medical information.

The HIPAA Privacy Rule allows your health information to be disclosed to carry out treatment, payment, and other healthcare operations. We are required to abide by the information outlined in this privacy notice. We reserve the right to update this policy as changes occur in the HIPAA Privacy Rule. HIPAA grants you the right to access and control your health information.

USES AND DISCLOSURES

Treatment: Your health information will be disclosed to provide, coordinate, and manage your healthcare. All of the providers in our practice may have access to your medical records. Additionally, our medical consultants and ultrasonographer review some records to assist us with your care. Your health information may be disclosed to any other physician or healthcare provider that may become involved in your care.

Healthcare Operations: Your health information will be used to support the business activities of the practice. Examples include, but are not limited to: quality assessment, employee reviews, nursing and midwifery student training, licensing, and other business activities. Health information may be shared in our group prenatal sessions.

Payment: Your health information will be used to obtain payment for services provided by this practice. Disclosures may be given to health plans, insurance providers, and collection agencies.

Business Associates: Your health information may be shared with third party business associates. Examples include billing and legal services. We have established written contracts that contain the terms that will protect your health information with all third-party business associates. All business associates must comply with HIPAA guidelines.

Disclosures Required by Law and Workers Compensation: We are permitted to disclose your health information to comply with workers compensation laws and legal proceedings. If required, you will be notified of disclosure. The protected health information of members of the armed forces may be disclosed to authorized federal officials, under certain circumstances.

Abuse or Neglect: We may disclose your protected health information to the appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence.

Emergencies: If you are incapacitated, we may use our best judgement to disclose information that is only directly relevant to your care.

Research and Health Oversight: We are permitted to disclose your information to researchers with an institutional review board has reviewed a research proposal and established protocols to ensure your health information will be kept confidential. We are permitted to disclose your health information to a health oversight agency for activities authorized by law. Examples include: audits, investigations, and inspections.

Written Authorization: Unless not required by law, your written authorization will be required for all disclosures of your protected health information. You can revoke authorization at any time via written request. It is important to note that we are unable to undo any disclosures previously made with your authorization.

Voicemail: Employees may only leave detailed voicemail messages if the greeting appropriately identifies the patient or another person who is authorized to receive information regarding the patient. If there is not appropriate identification, only the minimum necessary information will be left. This includes the caller's name, practice name, and a contact number. Patients have the right to opt out of voicemail messages.

PATIENT RIGHTS

You have the right to inspect and copy your protected health information. You may obtain your medical record that contains medical and billing information. As permitted by federal or state law, we may charge you a reasonable copy fee to provide a copy of your records. You may request an amendment of your protected health information. We reserve the right to deny your request. If we deny your request for amendment, you have the right to file a statement of disagreement. We may provide you with a copy of any rebuttal. Federal law prohibits you from inspecting or copying psychotherapy notes and information compiled in reasonable anticipation of, or use of, civil or criminal proceedings, or administrative actions or proceedings.

PRIVACY COMPLAINTS/ CLIENT GRIEVANCES

Should you believe that your privacy rights have been violated, and wish to file a complaint, you may contact us by calling our office at (912)629-6262 and asking to speak with our privacy officer. The director or her designee will personally respond within 10 business days to any complaint registered by a client about any aspect of Family Health and Birth Center. You may also contact our accrediting organization, The Commission for the Accreditation of Birth Centers at 240 Independence Drive, Hamburg, PA 19526, phone number 1-877-241-0262. Unresolved complaints may be directed to the Georgia Department of Community Health, Health Facilities Regulation Division, Attention: Complaints, 2 Peachtree Street NW, Atlanta, GA 30303-3142, phone: 1-800-878-6442.



DISCLOSURE OF CONFIDENTIAL INFORMATION (select one)

| | |
|---|--|
| <input type="radio"/> I choose to have voicemail left with minimally necessary information. In the event that I am not available, you may leave a message | <input type="radio"/> I choose to opt-out of voicemail messages. |
|---|--|

I authorize you to disclose information about my care and allow the following individual/s to schedule, reschedule, and cancel appointments on my behalf:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

PATIENT SIGNATURE _____ DATE _____

CONFIDENTIALITY AGREEMENT FOR PARTICIPATION IN GROUP PRENATAL CARE (for pregnant patients only)

You have the right to expect what is said in class to remain private and confidential. Along with our commitment to maintain your privacy, you also have a responsibility to respect and protect each other's privacy. If you have any questions about this policy, you may ask our HIPAA compliance officer.

I have read the Privacy Notice and understand these policies.

PATIENT SIGNATURE _____ DATE _____



OUR FINANCIAL POLICY / RELEASE AND ASSIGNMENT

Full payment is due at the time of service. We accept cash, checks, and credit cards. Our practice is committed to providing the best treatment for our clients, and our charges are reasonable and customary for our area.

I am responsible for payment regardless of the insurance company's arbitrary determination of reasonable and customary rates or decisions regarding non-covered services. I agree to pay collection fees associated with any outstanding balance on my account.

I hereby authorize The Midwife Group and Birth Center/Family Health and Birth Center, Inc. to release any of my medical records deemed necessary to process my insurance claim. I authorize payment of medical benefits to The Midwife Group/Family Health and Birth Center Inc., or its providers for services rendered to me. I fully understand that I am responsible for all charges incurred as a result of services rendered to me and any balance remaining after my insurance pays. I, the undersigned, a patient at this facility, hereby authorize the providers (and whomever they may designate as their assistants) to administer treatment as necessary. I hereby certify that I have read and fully understand this authorization for medical treatment. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

PATIENT SIGNATURE _____ DATE _____

OR SIGNED FOR PATIENT BY _____ RELATIONSHIP _____



HIV TESTING IN PREGNANCY (for pregnant patients only)

The HIV test is a routine screening in pregnancy. While I do have the right to refuse HIV testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to HIV testing and understand that the result will become a part of my medical record.

PATIENT SIGNATURE _____ DATE _____

DRUG TESTING IN PREGNANCY (for pregnant patients only)

Because the use of illegal drugs/substances is potentially harmful for me and my fetus, drug screening is a routine screening in pregnancy. While I do have the right to refuse drug testing, I understand that doing so may eliminate me from being eligible for care at The Midwife Group and Birth Center. I consent to drug testing and understand that the results will become a part of my medical record.

PATIENT SIGNATURE _____ DATE _____

NO SHOW FEE

We understand that there are times when you may miss an appointment due to emergency or unexpected obligations for work or family, however, when you do not call to cancel your appointment in a timely manner, you may be preventing another patient from getting an appointment. If an appointment is not cancelled at least 24 hours in advance, you may be charged a \$40 fee. This fee will not be covered by your insurance company.

PATIENT SIGNATURE _____ DATE _____

PARTICIPATION IN EDUCATION

I hereby give my permission for the participation of students in my care. Students will always be supervised by a Certified Nurse Midwife, Nurse Practitioner, Medical Doctor, Radiologic Technologist, or Registered Diagnostic Medical Sonographer. I may refuse student involvement at any time.

PATIENT SIGNATURE _____ DATE _____

AABC PERINATAL DATA REGISTRY (for pregnant patients only)

The purpose of this data registry is to help improve and maintain quality of care of childbearing families, provide for ongoing and systematic collection of data on normal birth, and facilitate research on maternity care practices that support optimal birth. By consenting to participate in this registry I understand that all information about me and my pregnancy will be kept confidential. As required by HIPAA, no identifying information will be seen by those conducting the project except for my date of birth and zip code. Statistical data will be kept on file and may be used later by other researchers who are studying specific parts of birth center or midwifery care. I freely consent to participate, and also give permission for data about my newborn to be used.

PATIENT SIGNATURE _____ DATE _____

PRINTED PATIENT NAME _____

DEFINITION OF A WELL-CARE VISIT

The focus of a well-care visit is preventive care. **If tests or services beyond the scope of a well-care visit are provided, then additional charges may be incurred for those services.** The choice to address both well-care and medical issues may be offered during the same visit for convenience, if the provider's schedule will allow. This is up to your provider so that they may stay on schedule and keep other scheduled patients from waiting. Although our office will assist you with your insurance processing, it is the patient's responsibility to understand their insurance benefits.

| What is a Well-Care Visit? | |
|---|--|
| YES | NO |
| A review of your current health and medical history | Treatment or consultation for a specific medical condition |
| Counseling about ways to improve your health | Any service not considered part of a well-care visit |
| A physical exam tailored to your preventive care needs | |
| Referral or performance of screening tests, if needed (billed separately by providers who perform the service) | |

Your scheduled appointment day is for an Annual Exam which is a well-care visit. Each insurance company has different contracts regarding group and individual coverage for well-care (preventive care) benefits. We do not know your contract so we cannot tell you if your insurance company is going to cover the charge for a well exam. Insurance plans typically do not pay for this service twice in less than one year regardless of where you have it done. If there is any question about when your last well-woman exam was, please contact the office where you last had one to ensure you have been scheduled appropriately with us. If your last well-woman exam was at our office, we can find the date of your last exam for you. If tests or services beyond the scope of a well-care visit are provided, then you may be required to pay a co-pay and may incur additional charges.

PATIENT SIGNATURE: _____ DATE: _____



GYN HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record. Please complete **ENTIRE** form.

| | | | |
|---|--|--|--|
| Name (<i>Last, First, M.I.</i>): | | DOB: | |
| Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | | | |
| Significant other name: | | | |
| Highest level of education: | | Employed: | |
| Who do you live with? | | | |
| What are your living arrangements? <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Mobile Home <input type="checkbox"/> Other | | | |
| PERSONAL MEDICAL, SURGICAL HISTORY AND SOCIAL HISTORIES: | | | |
| Please complete this portion of your health history in the patient portal PRIOR to your appointment. This is a very important part of your care and we want to make the most of your visit with the midwife by having the most updated and complete information. <u>If the patient portal is not completed, we may be required to reschedule, or have you return for an additional visit to complete the appointment.</u> | | | |
| Have you had any recent hospitalizations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when why? _____ | | | |
| | | | |
| Do you have any allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list allergies: _____ | | | |
| | | | |
| FAMILY HEALTH HISTORY: | | | |
| Your family history is very important for certain health screening as well as anticipating your health care needs. Please ensure you complete this section in the patient portal PRIOR to your appointment. | | | |
| OB/GYN HEALTH HISTORY | | | |
| Pregnancy History: | | Total # pregnancy: ____ # Premature births ____ #miscarriages/ abortions: ____ # term births? ____ | |
| Please answer all the questions below and write in any explanations or comments in the space provided | | | |
| Last Menstrual Period: | | | |
| Last pap test: | | Have you ever had an abnormal Pap test? | |
| Age period began? | | Length of periods? | #days between periods? |
| Are you sexually Active? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> One partner <input type="checkbox"/> more than one partner <input type="checkbox"/> Heterosexual <input type="checkbox"/> Homosexual <input type="checkbox"/> Bisexual |
| Any history of Sexually Transmitted infection | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Trichomonas <input type="checkbox"/> HPV <input type="checkbox"/> Syphilis <input type="checkbox"/> HIV |
| Do you or your partner have a history of herpes? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any recent changes in your periods? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you use birth control? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any history of pelvic or vaginal infections? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| NAME: | | | |
| Any problems with intercourse? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | | | |
|--|------------------------------|-----------------------------|--|
| Any abnormal vaginal bleeding or vaginal discharge? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Any uterine abnormality? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Any history of endometriosis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Any history of infertility? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Any history of polycystic ovarian syndrome? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Any menopause symptoms? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Do you do regular self-breast exams? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Do you have any history of physical or sexual abuse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |

| | | | | | | | |
|-----------------|---|--|-------------------------------------|-----------------------|------------|------------------------------|-----------------------------|
| Exercise | Do you exercise? Yes <input type="checkbox"/> No <input type="checkbox"/> | | What type of exercise do you enjoy? | | How often? | | |
| | | | | | | | |
| Diet | Are you on any special diet or have dietary restrictions? If so what? | | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you eat three meals a day? If no, how many? | | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have a working stove? | | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you have running hot and cold water? | | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | Do you receive WIC? | | | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | #meals you eat in an average day. | | | How much water a day? | | How much caffeine a day? | |

| How often do you eat: | Never | 2-3 times/month | Once/week | 2-3 times/week | Once/day | 2-3 times/day |
|---|-------|-----------------|-----------|----------------|----------|---------------|
| Fast/restaurant food | | | | | | |
| Frozen meals | | | | | | |
| Home-cooked meals | | | | | | |
| Beef | | | | | | |
| Chicken/Turkey | | | | | | |
| Pork | | | | | | |
| Fish, Type? | | | | | | |
| Deli meat | | | | | | |
| Beans | | | | | | |
| Cookies/Cakes/Muffins | | | | | | |
| Other refined grains (white bread, white rice, white pasta) | | | | | | |
| Whole grains | | | | | | |
| Vegetables (fresh, frozen) | | | | | | |
| Fruit (Fresh, frozen) | | | | | | |



1692 Chatham Parkway
Savannah, GA 31405
www.themidwifegroup.com

| How often do you eat: | Never | 2-3 times/month | Once/week | 2-3 times/week | Once/day | 2-3 times/day |
|-------------------------------------|--------------|------------------------|------------------|-----------------------|-----------------|----------------------|
| Dairy (milk yogurt, cheese, butter) | | | | | | |
| Artificial sweetener | | | | | | |
| Meal replacement bars or shakes | | | | | | |

Date: _____

Name: _____

DRUG USE QUESTIONNAIRE (DAST-10)

The following questions concern information about your potential involvement with drugs (excluding alcohol and tobacco) during the past 12 months. Carefully read each statement and decide if your answer is “no” or “yes,” then fill in the appropriate box beside the question.

When the words “drug abuse” are used, they mean the use of prescribed or over-the-counter in excess of the directions, and any non-medical use of drugs. The various classes of drugs may include: cannabis (marijuana, hashish), solvents (e.g., paint thinners), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD), or narcotics (e.g., heroin). Remember, the questions do not include alcohol or tobacco.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

- | | | | | |
|---|--------------------------|-----|--------------------------|----|
| 1. Have you used drugs other than those required for medical reasons? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 2. Do you abuse more than one drug at a time? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 3. Are you always able to stop using drugs when you want to? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 4. Have you had “blackouts” or “flashbacks” as a result of drug use? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 5. Do you ever feel bad or guilty about your drug use? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 6. Does your partner (or parents) ever complain about your involvement with drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 7. Have you neglected your family because of your use of drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 8. Have you engaged in illegal activities in order to obtain drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| 10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |

----- *for office use only* -----

DAST Score: _____

Plan of Care: _____

Reviewed by: _____

Hurt, Insulted, Threatened with Harm and Screaming (HITS)

Domestic Violence Screening Tool

Name: _____ Date: _____

| How often does your partner? | Never | Rarely | Sometimes | Fairly Often | Frequently |
|-------------------------------|-------|--------|-----------|--------------|------------|
| 1. Physically hurt you? | | | | | |
| 2. Insult or talk down to you | | | | | |
| 3. Threaten you with harm? | | | | | |
| 4. Scream or curse at you | | | | | |
| | 1 | 2 | 3 | 4 | 5 |
| Total Score: | | | | | |

Reviewed by: _____

Each item is score from 1-5. Range between 4-20. A score greater than 10 signifies that you are at risk of domestic violence abuse and should seek counseling or help from a domestic violence resource center.

Sherin, K. et.al. *HITS: A Short Domestic Violence Screening Tool for Use in a Family Practice Setting*, Family Medicine 1998;30(7):508-12.)

National Hotlines can connect clients to local resources and provide support.

For Free help 24 hours a day, call:

National Domestic Violence Hotline

1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224

Teen Dating Abuse Hotline

1-866-331-9474

Rape, Abuse, Incest, National Networks (RAINN)

1-800-656-HOPE (1-800-656-4673)

Georgia 24 Hour Statewide Domestic Violence Hotline

1-800-33HAVEN (1-800-334-2836) <https://gcadv.org/get-help/>



PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

| | Not at all | Several days | More than half the days | Nearly every day |
|---|------------|--------------|-------------------------|------------------|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |

add columns

_____ + _____ + _____

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

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____