Bracken Psychiatric Services
3200 Southern Dr. #107 Garland, TX 75043
PH: (972) 278-5385 Fax: (972) 692-8687
e-mail: admin@brackenmentalhealth.com www.brackenmentalhealth.com

ADULT REGISTRATION FORM

Please note that we require:

1. All social security numbers requested in the registration form.
2. A copy of the patient or guardian valid Texas I.D.
3. A copy of the insurance card front and back.
4. Proof of guardianship if applicable.

Please fax, e-mail; mail or bring your registration form to our office. We require 1 week to process your **complete** information. **Make sure you call us** after 1 week to schedule your appointment.

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Adult Registration Form

Patient Last Name	First Name	Middle Name	Maiden Name	
Address (Street)		City	State	Zip
Home Phone #	Work Phone #	Cell Phone #		
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Valid TX I.D.#
Marital Status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed			Spouse's Name (if applicable)	
Employer Name			Employer Address	

Responsible Party/Legal Guardian Last Name	First Name	Middle Name	Maiden Name	
Address (Street)		City	State	Zip
Home Phone #	Work Phone #	Cell Phone #		
Sex (check one) ☐ Male ☐ Female	Date of Birth	Age	Social Security #	Valid TX I.D.#
Employer Name			Employer Address	

Primary Insurance Company		Effective Date	**Secondary** Insurance Company		Effective Date
Claims Mailing Address (Street)			Claims Mailing Address (Street)		
City	State	Zip	City	State	Zip
Policy ID Number	Group ID Number		Policy ID Number	Group ID Number	
Subscriber Name (policy holder)	Date of Birth		Subscriber Name (policy holder)	Date of Birth	
Subscriber Social Security #	Relationship to Patient		Subscriber Social Security #	Relationship to Patient	
Subscriber Employer	Work Phone #		Subscriber Employer	Work Phone #	
Subscriber Employer Address (Street)			Subscriber Employer Address (Street)		
City	State	Zip	City	State	Zip

Signature of Patient, Parent, or Legal Guardian **Date**

Private Pay Agreement

Please complete the Private Pay Agreement if you have Medicaid as a secondary insurance.

I understand that Bracken Psychiatric Services is accepting

patient name:_____ as a private pay patient for the period of 1 year from today's date and as such I will be responsible for paying at the time of services for any services and fees I receive. I understand that the provider will not file a claim to Medicaid for services provided to the patient.
I understand that I may receive services from another provider at no cost using my Medicaid but I am choosing to pay privately so that the patient may receive services at Bracken Psychiatric Services.

Patient Name:_____ DOB:_____

Patient Signature:_____ Date:_____

Guardian Name:_____

Guardian Signature: _____ Date:_____

Consent to Treat and Financial Responsibility

I hereby authorize employees and agents of **Bracken Psychiatric Services** to render psychiatric evaluations including: medication management, psychotherapy and all usual practices of psychiatry to the patient indicated below.
The duration of this consent is indefinite and continues until revoked in writing.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

I hereby authorize payment of medical benefits directly to **Bracken Psychiatric Services** and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process or complete the patient's medical insurance claim and/or medication prior authorization.
I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV") as well as mental health and psychiatric protected health information.

I understand that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to **Bracken Psychiatric Services**. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of **Bracken Psychiatric Services**, if any.

The duration of this authorization is indefinite and continues until revoked in writing.

_____
Patient Name (please print)

_____ _____
Signature of Patient, Parent, or Legal Guardian **Date**

What language do you feel most comfortable speaking with your doctor?

- ☐ English
- ☐ Spanish
- ☐ Other _____

Patient Privacy Directive

Patient Last Name: _____ First Name: _____

In our efforts to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please provide us with the phone number(s) that we or an automated service may leave messages regarding appointments:

_____ _____

Please provide us with the phone number(s) that we or an automated service may leave messages regarding treatments and/or medication information:

_____ _____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your appointments:

_____ _____

_____ _____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your/your child's treatments and/or medications.

_____ _____

Please provide us with the name(s) and phone number(s) that we may talk to regarding your billing:

_____ _____

_____ _____

Please provide an email address that we may use to communicate protected health information.
(Employee email is subject to the conditions set forth by the employer and may not be private.)

Email: _____ Confirm Email: _____

Please provide us with the name and number of your emergency contact:

_____ _____

You must inform us in writing of any changes in your directives. I acknowledge that everything above is accurate.

_____ _____

Signature *Printed Name & Date*

I acknowledge I have seen or been offered a copy of the "Notice of Privacy Practices"

_____ _____

Signature *Printed Name & Date*

_____ _____

Relationship If Patient Representative *Physician Office Representative*

Continuity and Coordination of Care
Authorization and Release of Information

Communication between and among your **behavioral health care providers**, your **primary care physician** and/or your **pain management providers** is important for you to receive comprehensive and quality healthcare. We are requesting that you authorize and consent to the exchange of health information between your **health care providers** identified below.

_____ _____, _____

Patient First Name Print *Patient Last Name Print* *Patient DOB*

I authorize the **health care providers** identified below to exchange information related to my/child's physical and behavioral health evaluations and treatment plans:

Jill Bracken D.O. Bracken Psychiatric Services	**Phone #:** (972) 278-5385
Address: 3200 Southern Dr. #107 Garland, TX 75043	**Fax #:** (972) 692-8687
www.BrackenMentalHealth.com	admin@brackenmentalhealth.com

Primary Care Provider Name:	**Phone #:**
Address:	**Fax #:**

Pain Management Provider Name:	**Phone #:**
Address:	**Fax #:**

	Phone #:
Address:	**Fax #:**

I, the undersigned, understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke this authorization I must send a written request to:

Privacy Officer at Bracken Psychiatric Services 3200 Southern Dr. #107 Garland, TX 75043.

This authorization expires **twelve (12) months** from the date of signature.

This information is being disclosed on the condition that it not be re-disclosed except as authorized or permitted by applicable Federal or State laws, including the Federal Privacy Regulations. I understand that information disclosed pursuant to this authorization may, in some instances, no longer be protected by the Privacy Regulations. Re-disclosure may occur in situations such as if my provider's care is reviewed by a State or Federal agency, a court orders the disclosure of information, or if I sue my provider and my provider needs the information to defend himself/herself.

Please initial to authorize:

☐ I give my authorization to release to, obtain from, and discuss with the identified health care provider(s) the following information**:** Medical information**,** HIV status, Substance abuse information and Behavioral health information, excluding "psychotherapy notes" as defined by HIPAA

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____ _____ _____

Printed Name of Patient/Guardian/Representative Signature of Patient/Guardian/Representative Date

_____

Relation to Patient

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Financial Obligation Letter

Dear Patient:

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost-effective psychiatric care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan and our office.

Payment Guidelines:

- You must pay any copayments, coinsurance and/or deductibles at the time of service.
- We accept cash, checks, money orders and credit cards (MasterCard and Visa).
- We charge a $30.00 fee for all returned checks. (We accept cash, credit card, money order or cashier's check only as payment for returned checks and fees.)
- We will file your insurance carrier as a courtesy.
- ***If you receive payment from the insurance company, please forward the payment (and all other papers you received) to our office. Please do not send the payment back to the insurance company.***

When do you present your insurance card?

Please present your insurance card at EACH VISIT. If there has been a change in your insurance we require a minimum of 48 business hours notice of the change**. If you cannot provide us the change of information within 48 business hours of your next appointment we will see you as a self-pay and you will be charged the self-pay rate for that visit.** If you come in to your appointment with new insurance and have not submitted the information to us 48 hours prior, we consider it as your intention of not using your benefits for that visit and your willingness to pay the self-pay rate. Bringing your change of insurance information to the appointment without prior notice is considered your omission of using your benefits for that visit and expectation of paying the full self-pay rate at the time of the visit. The missed appointment fee will apply if there is a cancelation with less than 24 business hours notice. Please visit www.brackenmentalhealth.com for the change of insurance form. Once we are able to get the benefits and bill the insurance and the visit is paid we will promptly refund your self-payment.

What happens if the insurance company denies payment?

Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

- You have not met your deductible for the calendar year.
- This type of psychiatric service is not covered. The insurance was not in effect at the time of service.
- You have other insurance which must be filed first.
- You have exceeded your maximum dollar/visit amount; and/or
- You did not have a referral number for your visit/service.

If your insurance denies your claim for any of the above or other reasons, our office cannot be responsible for the bill. It is your responsibility to pay the denied amounts in full.

What happens if my insurance is not active at the time of the appointment?

You are automatically a self-pay patient and all fees and charges will apply. If you are not eligible for your state insurance at the time of your visit and you do not intend to keep your appointment and pay the self-pay rate you must contact the office 24 business hours prior to your appointment to cancel.

We value you as a patient and are eager to serve you. Our first priority is to provide you with the best possible care,

If you would like to contact our office, you may call us at 972-278-5385.

Sincerely,
Bracken Psychiatric Services

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. Both Bracken Psychiatric Services and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my plan's guidelines.

I understand that I will be fully responsible for payment of any and all medical services denied by my insurance company as applicable by state and/or federal law.

_____

Patient Name (please print)

_____ _____

Signature of Patient, or Legal Guardian **Date**

Psychiatric and Controlled Substance Agreement
Missed Appointment Agreement

This is an agreement between you and the provider at Bracken Psychiatric Services
and is made in order for you to understand your personal responsibilities while you or your child are taking
one or more of the following prescriptions: benzodiazepine and/or antipsychotic, amphetamines, or stimulant medications.

Please read the agreement fully and ask any questions that you have prior to signing.

I understand that Bracken Psychiatric Services will be monitoring my or my child's use and response to this medication(s).
Additionally, my compliance with the following guidelines will be required:

1. I will need to have scheduled visits to this office to safely monitor my medication(s).
   The number of visits required will depend upon my progress.
2. I will be required to give a 48-business hour notice for medication refills.
3. I understand that I am responsible to notify my provider of any changes to my address and phone number.
4. If I or my child are experiencing any side effect(s) from medication(s), I will call the office immediately and notify of the specific symptoms being experienced. I understand that I may need to leave this information with the answering service if a staff member is not available to pick up in the office. I understand that if I do not provide enough information when my call is answered the first time I call, it may take longer to get a response from the doctor as someone will need to call me back for more details before the doctor can receive my message.
5. If I want to request a dosage change I will call the office to schedule an appointment.
6. I understand that I am responsible for taking my or giving my child's medication(s) as prescribed and I will not be provided new prescriptions before they are due. Exceptions may be made and would be on a case by case situation when deemed necessary.
7. I understand that I am responsible for safeguarding my or my child's supply (against theft, loss, unauthorized use by others, etc.) and will not receive early refills of my prescriptions.
8. I understand that controlled substance medication(s) is only part of my or my child's treatment. I know that there are other aspects of my or my child's treatment (for example, recommended counseling, various behavioral modification techniques or additional testing such as neuropsych, lab work, oral swab, and/or urine sample) that I or my child may be required to perform or participate in while I am taking a prescribed controlled substance. The decision as to whether the medication is providing sufficient therapeutic benefit to justify continued use is a medical determination that will be made only by my provider at B.P.S.
9. I will keep my or my child's appointments as scheduled. I will be respectful to all office staff persons. I will contact Bracken Psychiatric Services as soon as possible in the event I need to cancel or reschedule an appointment.
   If fail to show up at the time of a scheduled appointment it will be recorded in my chart as a "no show".
   If a behavioral appointment is missed or rescheduled at the last minute (less than 24-business hours);
   Bracken Psychiatric Services will make the necessary accommodations in the behavioral provider's schedule to get me or my child seen as soon as possible. If I am not able or willing to take the appointment time offered I understand that any delay in care is my choice and not that of the provider.
10. Beginning January 1st 2016 Bracken Psychiatric Services will allow 3 missed appointments per calendar year. A missed appointment is defined as (a.) appointment no show, (b.) arrival 15 minutes after follow up appointment time or (c.) appointment cancellation or rescheduling with less than 24 business hours' notice. Same day reschedules will not require a $75.00 missed appointment fee but will count against the 3 missed appointment per calendar year limit. After your 4th missed appointment in the calendar year, Bracken Psychiatric Services will notify you in writing that you or your child will be referred to another physician. Please contact us so that we may provide you or your child with medication to limit any interruption in care.
11. I agree to comply with the foregoing guidelines as a condition to the provision of services by the practice. I understand that any violation of the above guidelines or requirements may result in my or my child's controlled medication prescription not being refilled and my discharge from the practice.

Printed Patient Name _____

Signature of Patient _____ Date _____

Printed Guardian or Representative Name _____

Signature of Guardian or Representative _____ Date _____

Relationship to Patient _____

Acknowledgment of Review of Notice of Privacy Practices

Patient Name: _____ **Date of Birth:** _____

Bracken Psychiatric Services policy guide and privacy practices are available on our website: www.brackenmentalhealth.com and in our office.

I hereby acknowledge that I have received a copy of Bracken Psychiatric Services' Notice of Privacy Practices.

I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____ _____

Printed Patient Name | Signature | Date

_____

Printed Name of Patient's Representative

_____

Signature of Patient's Representative

Relationship to Patient (*if applicable*)

- ☐ Parent or guardian of unemancipated minor
- ☐ Court appointed guardian
- ☐ Executor or administrator of decedent's estate
- ☐ Power of Attorney

E-Prescribing/Medication History Consent Form

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an e-Prescribe program. These include:

- **Formulary and benefit transactions** - Gives the prescriber information about which drugs are covered by the drug benefit plan.
- **Medication history transactions** - Provides they physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- **Fill status notification** - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that **Bracken Psychiatric Services** can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

_____ _____ _____

Printed Patient Name | Signature | Date

_____ _____ _____

Printed Name of Patient's Representative | Signature of Patient's Representative | Date

Adult Patient History Questionnaire

Name:
Preferred Name:
Date of Birth:

Referred By:

What concerns or symptoms are you seeking treatment for? How long have you had them?

Please Circle All Symptoms That You Are Currently Experiencing:

Sad Mood	Racing Thoughts	Panic Attacks	Excessive Dieting
Low Energy/Fatigue	Concentration/Memory Difficulties	Fear of Leaving the House	Focused on Body Weight or Image
Hopelessness	Increased/Decreased Sexual Interest	Fear of Driving	Change in Weight
Guilt	Decreased Appetite	Fear of Specific Situations/Things	History of Trauma/Victim of Abuse
Worthlessness	Increased Appetite	Fear of Being in Public	Offender of Abuse
Crying Spells	Difficulty Falling Asleep	Upsetting Thoughts	Hearing Voices Others Do Not
Decreased Motivation	Excessive Sleeping	Repetitive Thoughts or Behaviors	Seeing Images Others Do Not
Loss of Interest in Usual Activities	Early Morning Waking	Excessively Orderly or Perfectionistic	Bizarre Ideas

Irritability	Suicidal Thoughts	Periods of "Lost" Time	Recent Upsetting Change or Loss
Hyperactivity	Thoughts of Harming Others	Excessive Anger / Aggressiveness	Alcohol Abuse
Impulsiveness	Self Harm/Cutting	Difficulty Trusting Others	Drug Abuse
Elevated Mood	Anxious/Worried	Binge Eating / Purging	Overuse of Prescription Medication

Medications: Please list all medications or supplements that you are **currently** taking. Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*
1.		
2.		
3.		
4.		
5.		
6.		

Have you experienced a head injury? If so, please explain what happened, your age, and if you were unconscious: _____

_____

Current Medical Diagnoses *i.e. asthma, diabetes, seizures, etc*	Treatment?
1.	
2.	
3.	
4.	

Previous Surgeries	Approximate Date	Location/Hospital
1.		
2.		
3.		

Previous Hospitalizations	Approximate Date	Location/Hospital
1.		
2.		
3.		

Medication Allergies:
Food Allergies:

Past Psychiatric History

Have you ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

Have you ever seen a psychologist?

Have you ever seen a therapist (*i.e. LMHC, LCSW, LMFT*)?

Have you ever been hospitalized for psychiatric reasons? If so, where and when?

Developmental History:

Any Learning Disabilities (*i.e. reading, dyslexia, writing, math, etc)*?:

Attended Special Education Classes?:

Received Any Developmental Services (*i.e. physical, speech, occupational therapy, etc*)?:

Social History:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Lives With (Name, Age, and Relation to Yourself):

Highest Grade Attended:

Occupation and Employment (*specialty, where you work, and how long*):

Military History:

Arrest History or Pending Legal Issues (*i.e. divorce, disability, bankruptcy, etc)*:

Family History: Please indicate if there is a family history of the following conditions and **WHO** is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Substance Abuse History: Please circle all that you have used in the past 2 years:

Alcohol Frequency of use:	Marijuana (weed) Frequency of use:
Cocaine (crack, coke) Frequency of use:	Tobacco Frequency of use:
Opiates (heroin, pain killers, methadone) Frequency of use:	Benzodiazepines (Xanax, Klonopin, Ativan, Valium) Frequency of use:
MDMA (ecstasy) Frequency of use:	LSD (acid, hallucinogens) Frequency of use:
Over the Counter (cough syrup, triple C's) Frequency of use:	Bath Salts, Spice, K2 Frequency of use:
Amphetamines (speed, Adderall, Ritalin) Frequency of use:	Inhalants (dusters, whip its) Frequency of use:
Other: Frequency of use:	Other: Frequency of use:

In the past two years, there have been one or more episodes of memory loss due to substance abuse? **Yes or No**

There are personality changes due to the use of substances. **Yes or No**

In the past 5 years, there has been one or more arrest due to substance or alcohol use? **Yes or No**

Someone close to you thinks you may have a serious substance abuse problem. **Yes or No**

There is a history of serious problems with the use of substances. **Yes or No**

There is a history of substance abuse treatment. **Yes or No**

Past Psychiatric Medication

Antidepressants	**Response (Good, Fair, Poor)**	**Antipsychotic**	**Response (Good, Fair, Poor)**
Amitriptyline (Elavil)		Olanzapine (Zyprexa)	
Bupropion (Wellbutrin)		Perphenazine (Trilafon)	
Citalopram (Celexa)		Pimozide (Orap)	
Clomipramine (Anafranil)		Quetiapine (Seroquel)	
Desipramine (Norpramin)		Risperidone (Risperdal)	
Doxepin (Sinequan)		Asenapine (Saphris)	
Escitalopram (Lexapro)		Thioridazine (Mellaril)	
Fluoxetine (Prozac)		Thiothixene (Navane)	
Fluvoxamine (Luvox)		Trifluperazine (Stelazine)	
Imipramine (Tofranil)			
Mitrazapine (Remeron)		**Mood Stabilizers**	
Nefazodone (Serzone)		Carbamazepine (Tegretol)	
Nortriptyline (Pamelor)		Gabapentin (Neurontin)	
Paroxetine (Paxil)		Lamotrigine (Lamictal)	
Phenelzine (Nardil)		Lithium (Lithobid, etc)	
Dexvenlafaxine (Pristiq)		Topiramate (Topamax)	
Sertraline (Zoloft)		Valproic Acid (Depakote, etc)	
Tranylcypromine (Parnate)			
Trazodone (Desyrel)		**ADHD Medications**	
Venlafaxine (Effexor)		Amphetemine salts (Adderall, etc)	
		Clonidine (Kapvay, Catapres)	
AntiAnxiety		Dexmethylphenidate (Focalin)	
Alprazolam (Xanax)		Guanfacine (Intuniv, Tenex)	
Buspirone (Buspar)		Methylphenidate (Ritalin, Concerta, Daytrana, etc)	
Chlordiazepoxide (Librium)		Strattera (Atomoxetine)	
Clonazepam (Klonopin)		Vyvanse (Lisdexamfetamine)	
Clorazepate (Tranxene)			
Diazepam (Valium)		**Miscellaneous**	
Flurazepam (Dalmane)		Thyroid (Synthroid, Cytomel)	
Hydroxyzine (Vistaril)		Dilantin (Phenytoin)	
Lorazepam (Ativan)		Propranolol (Inderal)	
Oxazepam (Serax)		Naltrexone (Revia)	
Temazepam (Restoril)		Benztropine (Cogentin)	
Triazolam (Halcion)		Trihexyphenidyl (Artane)	
Zolpidem (Ambien)		L-Dopa	
Antipsychotic			
Aripiprazade (Abilify)		**Other Medications**	
Fluphenazine (Prolixin)			
Haloperidol (Haldol)			
Lurasidone (Latuda)			

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**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. During the last 4 weeks, how much have you been bothered 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	☐	☐	☐	☐

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.	☐	☐	☐

		NO	YES
6. Questions about eating.			
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 unusually 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?	☐	☐

	NO	YES
7. In the last 3 months have you often done any of the following in order to avoid gaining weight?		
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?	☐	☐

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

		NO	YES
10. Have any of the following happened to you more than once in the last 6 months?			
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 any problems on this questionnaire, 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
☐	☐	☐	☐