AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH**_____

DATE(S) OF TREATMENT:_____

I HEREBY AUTHORIZE: *David Cantu, LCSW* **TO DISCLOSE RECORDS OBTAINED IN THE COURSE OF MY EVALUATION AND/OR TREATMENT TO:**

NAME:_____

ADDRESS:_____

THE FOLLOWING INFORMATION IS TO BE RELEASED: **Medical Records**

I UNDERSTAND THAT I HAVE THE RIGHT TO LIMIT THE TYPE OF INFORMATION RELEASED. IF I CHOOSE TO LIMIT THE INFORMATION RELEASED, I UNDERSTAND THAT IT MAY BE NECESSARY FOR THE ABOVE NAMED PROVIDER TO INFORM THE REQUESTOR THAT PORTIONS OF THE RECORD HAVE BEEN WITHHELD. I ACKNOWLEDGE THAT THE INFORMATION MAY BE SUBJECT TO REDISCLOSURE AND NO LONGER PROTECTED BY THIS RULE. I UNDERSTAND THE ABILITY OR INABILITY TO CONDITION TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS ON THE INDIVIDUAL'S SIGNING THE AUTHORIZATION. I UNDERSTAND EITHER DIRECT OR INDIRECT, IF THE ENTITY IS TO RECEIVE SUCH REMUNERATION FOR A USE OR DISCLOSURE FOR MARKETING PURPOSES.

MY SIGNATURE AUTHORIZES THE RELEASE OF MEDICAL INFORMATION WITHOUT EXCEPTION, INCLUDING ANY INFORMATION CONCERNING AIDS OR RESULTS OF HIV TESTING, PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT, AND/OR ALCOHOL DRUG ABUSE UNLESS OTHER WISE INDICATED HERE:

_____

_____

_____ **INITIALS:** _____

THIS CONSENT FOR IS SUBJECT TO WRITTEN REVOCATION BY THE UNDERSIGNED AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN AND IF NOT EARLIER REVOKED. THIS CONSENT SHALL BECOME INVALID SIX MONTHS FROM THE DATE OF SIGNATURE.

I HEREBY RELEASE ALL PARTIES FROM ANY/ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THIS INFORMATION TO THE PARTY NAMED ABOVE.

SIGNATURE _____ **DATE**_____

SIGNATURE OF PATIENT SPOUSE:PARENT:GUARDIAN:CONSERVATOR:LEGAL REPRESENTATIVE

IF SIGNED BY OTHER THAN THE PATIENT, INDICATE RELATIONSHIP_____

*AUTHORIZED REPRESENTATIVE MUST SUBMIT COPIES OF LEGAL DOCUMENTS SUPPORTING ASSIGNMENT OF THIS AUTHORITY.

General Consent for Treatment
And
Release of Information

I, _____ am legally empowered and competent to give consent for diagnostic procedures and treatment that is to include any procedures deemed necessary by the referring physician, the mental health provider, and/or which had been requested by a third party, such as an insurance carrier. I understand that diagnostic procedures may include but are not limited to tests of intelligence, memory, psychosocial functioning and personality. Further, I understand that treatment may consist of, but is not limited to individual therapy, psychophysiological therapies such as biofeedback and deep relaxation, and education as to the nature of the injury or dysfunction.

I have been informed that a Licensed Psychologist and/or Licensed Professional Counselors may administer the diagnostics and treatment provided me. I know that I have the right to refuse diagnostics, and/or treatment or ask for another therapist to administer these. I understand that the progress of my treatment will be discussed with my referring physician, and summaries may be sent to the insurance carrier and referring physician. **I hereby grant permission to Comfort in Counseling its agents and psychotherapists, to divulge and release information concerning my evaluation and/or treatment with Comfort in Counseling and its agents/psychotherapists/qualified mental health providers, to my treating doctor, and his/her agents, as well as to health insurance carriers or providers who may be responsible for payment of services rendered to me by Comfort in Counseling and its agents/psychotherapists. I hereby grant permission to Comfort in Counseling to use any clinical information pertaining to my treatment for research and/or publishing purpose. I understand that no identifiable information will be used.**

I understand that the staff of Comfort in Counseling may not intentionally reveal information about me without my written authorization, or without a proper court order, or unless a State or federal statute requires it. The provisions of all state and federal laws that require Comfort in Counseling to reveal information bind Comfort in Counseling Raw data and protocols belong to Comfort in Counseling and are not a matter of public record. Raw data and protocols may be available only to another qualified mental health practitioner as long as proper authorization is received from the patient/client.

Further, I acknowledge that the nature and anticipated course of therapy, fees, and confidentiality and its limits have been discussed with me. I understand that all reasonable efforts will be made in answering my questions and to avoid apparent misunderstandings about my therapy, fees, and confidentiality, and that written information will be provided to me in Layman's terms and language.

I understand that records of my treatment will be maintained with appropriate confidentiality in reading, storing, transferring and disposing of my records, whether these are written, automated, or in any other medium. Comfort in Counseling maintains and disposes of records in accordance with the law and in a manner that permits compliance with the requirements of the ethics code.
Having the capacity to consent to treatment and having been informed of significant information about the procedures, I now feel and without undue influence express my consent to undergo treatment and/or diagnostic procedures. I also understand the limits of confidentiality as explained herein, and consent to the release of information as provided for hereinabove.

_____ _____

Signature/Date Therapist

PI Psychological Evaluation Questionnaire

Referring Treating Doctor	Dx Code	Name of Interviewer	Date

PATIENT INFORMATION (DEMOGRAPHICS)

Last name:	**First:**	**Middle:**		**Date of Injury:**
Street address:	**City:**		**State:**	**Zip Code:**
Date of Birth: / /	**Age:**	**Sex:** ❑ M ❑ F	**Social Security Number:** ___-___-___	**Phone Number:** (___) ___-___	**E-Mail**

History of Injury

Description of how injury occurred: (What caused your pain? When pain started?)

_____

_____

_____

_____

_____

Have you returned to work since the date of your injury? ☐ Yes ☐ No

If yes, Explain:

Work Status: ☐ Employed ☐ Unemployed

If employed, are you employed by the same company that the injury occurred at? ☐ Yes ☐ No

Medical Clinics/Doctors seen for this injury:

Pain Symptoms

Where do you feel the pain from your injury?

Does the pain radiate (spread out)? ☐ Yes ☐ No

If yes, where: _____

Does the pain move around or change location? ☐ Yes ☐ No

If yes, where: _____

Treatments

Have you had any of the following treatments? Check boxes

☑ X Ray	☐ Physical Therapy	☐ Aquatic Therapy
☐ MRI	☐ TENS Unit	☐ Spinal Cord Stimulator
☐ EMG, (Nerve Conduction Test)	☐ Medication Pain Management	☐ Surgery
☐ C/T Scan	☐ Pain Injections	
☐ Acupuncture	☐ Individual Counseling	
☐ Chiropractic	☐ Bio-Feedback	

Enter number below:

What is your pain level on average?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your pain level when you feel the worst?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
What is your pain level when you feel the best?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Timing

Is the pain:

☐ Constant ☐ Comes and Goes ☐ After Exertion ☐ During Exertion ☐ During Movement

How often is there pain?

- ☐ Continuous
- ☐ Several Times Per Week
- ☑ Once a Week
- ☐ Several Times Per Day
- ☐ Never

How long does pain last?

- ☐ Continuous
- ☐ Days
- ☐ Less than 1time/week
- ☐ Lasts for hours
- ☐ Lasts for minutes
- ☐ Lasts for seconds
- ☐ None

Check boxes

In the past year, has your pain become:

☐ Better ☐ Worse ☐ Stayed the Same

Is your pain affected by: Check boxes

- ☐ Certain Positions
- ☐ Evening
- ☐ Exertion
- ☐ Morning
- ☐ Weather changes
- ☐ Other: _____

Describe how your pain feels: Check boxes

- ☐ Aching
- ☐ Pressure-like
- ☐ Stabbing
- ☐ Burning
- ☐ Dull
- ☐ Sharp
- ☐ Throbbing
- ☐ Shooting
- ☐ Cramp-like
- ☐ Numbness
- ☐ Pins and Needles
- ☐ Tingling
- ☐ Splitting
- ☐ Sickening
- ☐ Tender
- ☐ Tearing-Exhausting

Activities that increase pain:

- ☐ Bending
- ☐ Cleaning House
- ☐ Taking Baths
- ☐ Sitting
- ☐ Driving
- ☐ Walking
- ☐ Yard Work
- ☐ Sex with partner
- ☐ Lying Down
- ☐ Coughing/Sneezing
- ☐ Standing
- ☐ Grocery Shopping
- ☐ Playing with children
- ☐ Going Up and Down Stairs
- ☐ Other: _____

Treatments that relieve your pain:

- ☐ Anti-Depressant Medication
- ☐ Exercise
- ☐ Chiropractic Care
- ☐ Lying Down
- ☐ Physical Therapy
- ☐ TENS Therapy
- ☐ Massage
- ☐ Taking Pain Medication
- ☐ Hot/Cold Shower
- ☐ Bio-Freeze
- ☐ Relaxation Therapy
- ☐ Hot/Cold Compress

Daily Functioning

Please check any that describe what your days feel like.

- ☐ Because of this, I am under a great deal of pressure from my own self to recover as successfully as possible and return to work as soon as I can fulfill my necessary work responsibilities.
- ☐ I am in so much pain and I am not regularly working it is difficult to remain positive.
- ☐ I am in so much pain it is difficult being motivated to perform the necessary exercises, actions for a successful recovery.
- ☐ My pain limits my ability to participate in activities with my family.
- ☐ My constant physical and emotional pain has created problems with my family and friends, without help my bad choices, behaviors and feelings will only continue.
- ☐ My pain causes me to always be angry; I can't seem to have a civil conversation with anyone anymore.
- ☐ My pain affects my ability to do routine home maintenance like, changing a light bulb, mowing the lawn, or minor home repairs.
- ☐ The stress causes my pain to increase; I have difficulty maintaining my levels of pain low enough, for a period of time, so that I can productively function.
- ☐ Since my injury and then my pain, I am no longer the person I used to be.
- ☐ My pain affects my ability to do self-care activities such as bathing/showering and getting dressed.
- ☐ I am in so much pain and I am not regularly working, it is difficult structuring time in my life.
- ☐ Some of my stressors include my lack of financial stability.
- ☑ My pain prevents me from having a normal sex life.

☐ Describe a typical day at home with chronic pain _____

What do you worry about the most? _____

_____

_____

What percentage of your previous activities are you now able to handle? _____%
List a percent: 0% (none of them) – 100% (all of them)

If List any other medical history (surgeries, hospitalizations, etc) we should know about? ☑ Yes ☑ No

_____

_____

Current Pain Medications (Analgesic): *Please identify prescribed pain medication and dosage*

Opioids: ☐ Not taking pain medication

- ☐ Fentanyl
  - ○ Actiq
  - ○ Fentora
  - ○ Duragesic
- ☑ Demerol
- ☐ Hydrocodone
  - ○ Lortab
  - ○ Narco
  - ○ Vicodin
  - ○ Vicoprofen
- ☐ Tramadol
  - ○ Ultram
  - ○ Ultram ER
- ☐ Oxydodone
  - ○ Oxycontin
  - ○ Percocet
- ☐ Tapentadol
  - ○ Nucynta
- ☐ Propoxyphene
  - ○ Darvocet
  - ○ Darvon
- ☐ Codeine

Anti-Inflammatory & Tylenol:

- ☐ Meloxicam
  - ○ Mobic
- ☐ Nabumetone
  - ○ Relafen
- ☐ Aspirin
- ☐ Indomethacin
  - ○ Ultram
- ☐ Ibuprofen
  - ○ Motrin
  - ○ Advil
- ☐ Acetaminophen
  - ○ Tylenol
- ☐ Celecoxib
  - ○ Clelebrex
- ☐ Etodolac
- ☐ Naproxen
  - ○ Naprosyn
- ☐ Flector patch
- ☐ Other

Muscle Relaxants:

- ☐ Baclofen
- ☐ Methocarbamol
  - ○ Robaxin
- ☐ Carisoprodol
  - ○ Soma
- ☐ Cyclobenzaprine
  - ○ Flexeril
- ☐ Metaxalone
  - ○ Skelaxin
- ☐ Tizanidine
  - ○ Zanaflex

Please check the item or items that reflect how you feel about your medication.

- ☑ I find my medications to be fairly effective most of the time.
- ☑ I seem to need more and more medication to get any relief.
- ☑ No matter how much medication I take, I get no relief.
- ☑ I am concerned about the side effects caused by my medications.
- ☑ At times, it is necessary to take more medication than my doctor prescribes.
- ☑ I don't like taking any type of medication and use as little as possible.
- ☑ I need more medication or stronger medication to deal with my pain.
- ☑ I am concerned that I am misusing my medications.

Are these pain medications taken as prescribed: ☐ Yes ☐ No

Do you take more medication or use additional medications other than what your doctor prescribed? ☐ Yes ☐ No

Doctor prescribing pain medication:

Dr. _____ Phone #: _____

Dr. _____ Phone #: _____

Psychological History

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, when and explain the circumstances: _____

Within the past six months, have you had any thoughts of attempting to harm yourself or someone else?

Thoughts of suicide? ☐ Yes ☐ No Any intent? ☐ Yes ☐ No Any plan? ☐ Yes ☐ No

Any existing or previous psychiatric treatments or problems? ❑ Yes ❑ No

If yes, what type and what was the diagnosis?

Any psychological inpatient therapy or outpatient mental health therapy? ❑ Yes ❑ No

If yes, was the therapy before or following the injury? ❑ Before Injury ❑ Following the Injury

Location and length of therapy?

Family Psychological History

Any family history of psychiatric treatment or problems? ☐ Yes ☐ No
Who and what type? _____
Has any relative attempted or committed suicide? ☐ Yes ☐ No **If yes, who?** _____

Anti-Depressant Medications

Anti-Depressants: *Please identify prescribed medication and **dosage**.*

- ☐ **Cymbalta**
- ☐ **Effexor**
- ☐ **Amitriptyline**
  - ○ **Elavil**
- **Nortriptyline**
  - ○ **Pamelor**
- **Paxil**
- **Lexapro**
- ☐ **Not taking anti-depressants**
- **Welbutrin**
- **Zoloft**
- **Fluoxetine**
  - ○ **Prozac**

Are medications taken as prescribed? ☐ Yes ☐ No
Any adverse reactions to these medications? ☐ Yes ☐ No
If yes, what type of reaction: _____
Are you ok with being prescribed Anti-Depressants or Anti-Anxiety medication? ☐ Yes ☐ No
If yes, explain:

Please circle any feelings that you are experiencing:

Anxious	Choking Sensations	Dizziness	Muscular Tension	Startle Response
Autonomic	Confusion	Embarrassment	Burning/Itching /Tingling/Prickling	Unusual Sweating
Avoidance	Disconnected from self	Fear of losing control of life	Phobias	Trembling and Shaking Nervousness
Blushing	Loss of reality & Surroundings	Heart Symptoms	Restlessness	Worry about physical health
Chest Pain	Diarrhea	Overly concerned of surroundings	Shortness of Breath	Panic Attacks
Chills	Difficulty Concentrating	Reminders/Avoid Remembering Event	Detachment	Stressed when around other people
Replaying Injury /Accident over & over	Dreams / Nightmares / Flashbacks	Fatigue	Memory Loss	Future Limited
Acting Out	Appetite (increase/decrease)	Guilt	Sadness/Down	Thinking
Decreased energy	Deciding	Irritability/ Short temper	Sociability	Worthlessness
Anger	Excessive Worrying	Decreased Sex Drive	Sleep (increase/decrease)	Hopelessness
No pleasure	Crying Episodes	Boredom	Discourage about the Future	Helplessness
Increased sensitivity of emotions	Increase pain when emotionally upset	Decreased Motivation	Headaches	Fear Re-Injury
Difficulty adjusting to injury	Increase pain when emotionally upset	Decreased Motivation	Headaches	Lack of restroom control Urine/Stool

How long after the injury did any of these feelings start?

Health & Behavior

Weight:

Have you had any weight/loss gain since the date of your injury? ☐ Yes ☐ No

If yes: nn.nmm, **(number of pounds)** mmmmmm ☐ **Gained weight** ☐ **Weight lost**

Substance Use:

Do you use tobacco? ☐ Yes ☐ No

If yes, how often?

- ☐ < 1 pack/day
- ☐ 1 pack/day
- ☐ 2 packs/day
- ☑ > 2 packs/day
- ☐ Former tobacco user

Do you drink alcohol? ☐ Yes ☐ No

If yes, how often?

☐ Little/No Alcohol ☐ Moderate Alcohol Intake ☐ Excessive Alcohol Intake

Do you drink caffeine? ☐ Yes ☐ No

If yes, how many cups per day? _____

Do you use any recreational drugs? ☐ Yes ☐ No

If so, what types and how much? _____

Sexual Functioning:

Has your sex life been affected by your injury? ☐ Yes ☐ No

If yes, please explain: _____

Sleep:

How much time do you spend resting or napping during the day? _____ **Minutes/Hours**

How many hours of sleep do you average each night? _____

Do you suffer from any of the following problems?

- ☐ Insomnia
- ☐ Falling Asleep
- ☐ Wake Up Early
- ☐ Need Sleep Assistance
- ☐ Interrupted Sleep
- ☐ Racing Thoughts
- ☐ Staying Asleep
- ☐ Length of Sleep
- ☐ Nightmares
- ☐ Up and Down all night
- ☐ Unable to sleep in one position

Do you take any of the following sleep aids? ☐ Yes ☐ No

- ☐ Zolpidem
  - ○ Ambien
  - ○ Ambien CR
- ☐ Lunesta
- ☐ Rozerem
- ☐ Xyrem
- ☐ Restoril
- ☐ Sonata

Are you disabled in anyway? ☐ Yes ☐ No

If yes, please explain:

Are you able to care for yourself? ☐ Yes ☐ No

Explain: _____

Have you suffered from any personal loss or dangerous situations since the injury?

- ☐ Death
- ☐ Job Loss
- ☐ Financial Loss
- ☐ Divorce/Separation
- ☐ Disaster/Tragedy
- ☐ Violence towards others

Are there any weapons in your home? ☐ Yes ☑ No

If yes, are the weapons secured? Yes No

Would you say that your family is negative? ☐ Yes ☐ No

Marital/Relationship History

What is your current marital status? Single Married Divorced Separated Widow Partner

How many years have you been in your current relationship? _____

How would you describe your current relationship?

- ☐ Excellent
- ☐ Good/Supportive
- ☐ Tolerable
- ☐ Stable/Supportive
- ☐ Problematic/Divorce is Possible
- ☐ Chaotic/ Fights/ Separation

Number of children from current relationship: _____

Number of children from previous relationships: _____

Childhood Family History

Where were you born? _____

If born outside of the United States, when did you come to the U.S.? _____

☐ U.S. citizen ☐ Permanent Resident Alien

Who were you raised by? _____

Who do you currently live with? _____

Brothers & Sisters:

Patient is the _____ **child of** _____ **children.**

Number of brothers: _____ **Number of Sisters:** _____

Are any of your siblings deceased? ☐ Yes ☐ No

Relevant Details: _____

Parent Information (Primary Relationships):

Mother's age: _____ ☐ Deceased

Describe Relationship with your mother:

☐ Good ☐ Ok ☐ Bad ☐ Other: _____

Father's age: _____ ☐ Deceased

Describe Relationship with your father:

☐ Good ☐ Ok ☐ Bad ☐ Other: _____

Were parents divorced? ☐ Yes ☐ No ☐ N/A

How does your injury affect your family?

_____

_____

_____

Do you argue with your partner more now than before the injury? ☐ Yes ☐ No

_____

_____

Education History

High School Graduate? ☐ Yes ☐ No ☐ GED

Date of GED or HS Graduation: _____

Years Completed in School: _____

Any College Degrees or Certifications?

_____

_____

Religious & Cultural Beliefs

How would you describe your spirituality?

- ☐ Religious Beliefs
- ☐ Spiritual Beliefs
- ☐ Attend religious Services
- ☐ I do not believe in religion or spirituality

Cultural Problems?

- ☐ None
- ☐ Isolated from cultural community
- ☐ English is a second language
- ☐ Homesick
- ☐ Discriminated against

Current Employment

Current Employer Name:_____ **or** ☐ **Not Currently Employed**

Job Title: _____ **Last day you worked:** ____/____/____

How long have you been employed by this employer? _____ **years/months**

Please identify any volunteer work or interest.

_____

_____

Financial Information

What sources of income do you have right now?

_____

How you would you describe your financial situation?

☐ **Can't pay bills** ☐ **Live Paycheck to paycheck** ☐ **Stable** ☐ **Comfortable**

Is your financial situation a major stress factor at this time? ☐ **Yes** ☐ **No**

Please explain any stress factors related to your financial situation:

_____

Legal History

Have you gotten an attorney in the case related to your injury? ☐ **Yes** ☐ **No**

Name: _____

Phone Number_____

Military History

Military Service? ☐ **Yes** ☐ **No** **Branch:** _____

When? _____ **Type of discharge:** _____

Is there anything additional you would like to tell me?

_____

_____

_____

Thank you for filling out this questionnaire.

Circle the number below to indicate your current level of sadness/depression

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate				Severe		Most

Circle the number below to indicate your current level of nervousness/anxiety

0	1	2	3	4	5	6	7	8	9	10
None		Mild		Moderate				Severe		Most

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness Enter selected number

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry any more than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3