Woodnote Therapy, PLLC.

1913 S. Washington St, Ste C
Grand Forks, ND 58201
Phone: (701)757-1425
Fax: (701)299-0695

January 19, 2022

Welcome to Woodnote Therapy. We are a new psychotherapy practice located in Grand Forks, ND providing individual in-person and telehealth mental health services. Current providers are Winonah Monette, MSW, LCSW, LAC, and Erica Cerda, MSW, LCSW. We are pleased to partner with you or continue with you on your therapy journey.

To get on the schedule you must first complete the enclosed intake packet and mail it back in or bring it to your first session. Please complete the forms and/or sign date on pages 2, 7, 8 (if needed), 9, 10, 14, and 15 (if needed), complete the assessments (pages 16-20), and send in a copy of a form of identification (government ID, passport, tribal ID), and a copy of your health insurance card. Please fill out any releases of information you feel would be beneficial for your therapy. Enclosed is a pre-stamped envelope.

Sincerely,

Winonah and Erica of Woodnote Therapy

Woodnote Therapy, PLLC.

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INITIAL INTAKE/DEMOGRAPHIC FORM			
Today's Date		Referred By	
Client Name			
Preferred Name			
Birthdate		Age	
Address			
Parent(s)/Guardian(s) Name			
Mobile Phone			
2nd Phone			
Email Address			
Gender Identity			
Preferred Pronouns			
Sexual Orientation			
Race			
Languages			
Marital Status			
Employment			
Insurance Provider		Co-Pay	
Insurance Phone #		Group #	
Insurance ID		Plan Code	
Subscriber's Name		Subscriber's Employer	
Subscriber's Address if different than patients		City, State, Zip	
Effective Date		Expiration Date	
Total # Session per yr benefit		Subscriber's Birthdate	
Secondary Insurance Provider		2nd Co-Pay	
Secondary Insurance Phone #		2nd Group #	
Secondary Insurance ID		2nd Plan Code	
Secondary Subscriber's Name		2nd Subsribers Employer	
Secondary Subscriber's Address if different than patients		City, State, Zip	
2nd Effective Date		2nd Expiration Date	

I herby authorize by my signature that:

As insured or authorized person, I hereby assign any insurance benefits to Woodnote Therapy, PLLC, and authorize them to furnish any necessary information needed to submit and process claims to my insurance company(ies).

Client Signature	
Legal Guardian/Subscriber's Signature	
Date:	

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CONSENT FOR SERVICES

This form is called a Consent for Services (the "Consent"). Your therapist, counselor, psychologist, doctor, or other health professional ("Provider") has asked you to read and sign this Consent before you start therapy. Please review the information. If you have any questions, contact your Provider.

THE THERAPY PROCESS

Therapy is a collaborative process where you and your Provider will work together on equal footing to achieve goals that you define. This means that you will follow a defined process supported by scientific evidence, where you and your Provider have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their Provider. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit.

Therapy begins with the intake process. First, you will review your Provider's policies and procedures, talk about fees, identify emergency contacts, and decide if you want health insurance to pay your fees depending on your plan's benefits. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your Provider is practicing under the supervision of another professional, your Provider will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often you will attend therapy, your short- and long-term goals, and the steps you will take to achieve them. Over time, you and your Provider may edit your treatment plan to be sure it describes your goals and steps you need to take. After intake, you will attend regular therapy sessions at your Provider's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time. At some point, you will achieve your goals. At this time, you will review your progress, identify supports that will help you maintain your progress, and discuss how to return to therapy if you need it in the future.

IN-PERSON VISITS & SARS-CoV-2 ("COVID-19")

When guidance from public health authorities allows and your Provider offers, you can meet in-person.
If you attend therapy in-person, you understand:

-You can only attend if you are symptom-free (For symptoms, see: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html);

-If you are experiencing symptoms, you can switch to a telehealth appointment or cancel. If you need to cancel, you will not be charged a late cancellation fee.

You must follow all safety protocols established by the practice, including:

-Following the check-in procedure;

-Washing or sanitizing your hands upon entering the practice;

-Adhering to appropriate social distancing measures;

-Wearing a mask, if required;

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-Telling your Provider if you have a high risk of exposure to COVID-19, such as through school, work, or commuting; and

-Telling your Provider if you or someone in your home tests positive for COVID-19.

-Your Provider may be mandated to report to public health authorities if you have been in the office and have tested positive for infection. If so, your Provider may make the report without your permission, but will only share necessary information. Your Provider will never share details about your visit. Because the COVID-19 pandemic is ongoing, your ability to meet in person could change with minimal or no notice. By signing this Consent, you understand that you could be exposed to COVID-19 if you attend in-person sessions. If a member of the practice tests positive for COVID-19, you will be notified. If you have any questions, or if you want a copy of this policy, please ask.

CONFIDENTIALITY

Your Provider will not disclose your personal information without your permission unless required by law. If your Provider must disclose your personal information without your permission, your Provider will only disclose the minimum necessary to satisfy the obligation. However, there are a few exceptions.

-Your Provider may speak to other healthcare providers involved in your care.

-Your Provider may speak to emergency personnel.

-If you report that another healthcare provider is engaging in inappropriate behavior, your Provider may be required to report this information to the appropriate licensing board. Your Provider will discuss making this report with you first, and will only share the minimum information needed while making a report. If your Provider must share your personal information without getting your permission first, they will only share the minimum information needed. There are a few times that your Provider may not keep your personal information confidential.

-If your Provider believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your Provider can explain more if you have questions.

-If your Provider has reason to believe a minor or elderly individual is a victim of abuse or neglect, they are required by law to contact the appropriate authorities.

RECORD KEEPING

Your Provider is required to keep records about your treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services you receive meet the appropriate standards of care. Your records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect your personal information, including advanced encryption techniques to make your personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all log-ins and actions within the system.

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COMMUNICATION

You decide how to communicate with your Provider outside of your sessions. You have several options:

Texting/Email

-Texting and email are not secure methods of communication and should not be used to communicate personal information. You may choose to receive appointment reminders via text message or email. You should carefully consider who may have access to your text messages or emails before choosing to communicate via either method.

Secure Communication

-Secure communications are the best way to communicate personal information, though no method is entirely without risk. Your Provider will discuss options available to you. If you decide to be contacted via non-secure methods, your Provider will document this in your record.

Social Media/Review Websites

-If you try to communicate with your Provider via these methods, they will not respond. This includes any form of friend or contact request, @mention, direct message, wall post, and so on. This is to protect your confidentiality and ensure appropriate boundaries in therapy.

-Your provider may publish content on various social media websites or blogs. There is no expectation that you will follow, comment on, or otherwise engage with any content. If you do choose to follow your Provider on any platform, they will not follow you back.

-If you see your Provider on any form of review website, it is not a solicitation for a review. Many such sites scrape business listings and may automatically include your Provider. If you choose to leave a review of your Provider on any website, they will not respond. While you are always free to express yourself in the manner you choose, please be aware of the potential impact on your confidentiality prior to leaving a review. It is often impossible to remove reviews later, and some sites aggregate reviews from several platforms leading to your review appearing other places without your knowledge.

FEES AND PAYMENT FOR SERVICES

You may be required to pay for services and other fees. You will be provided with these costs prior to beginning therapy, and should confirm with your insurance if part or all of these fees may be covered. You should also know about the following:

-No-Show and Late Cancellation Fees: If you are unable to attend therapy, you must contact your Provider before your session. Otherwise, you may subject to fees outlined in your fee agreement. Insurance does not cover these fees.

-Balance Accrual: Full payment is due at the time of your session. If you are unable to pay, tell your Provider. Your Provider may offer payment plans or a sliding scale. If not, your Provider may refer you to other low- or no-cost services. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.

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ADMINISTRATIVE FEES

-Your Provider may charge administrative fees for writing a letter or report at your request; consulting with another healthcare provider or other professional outside of normal case management practices; or for preparation, travel, and attendance at a court appearance. These fees are listed in the fee agreement. Payment is due in advance.

INSURANCE BENEFITS

-Before starting therapy, you should confirm with your insurance company if:

-Your benefits cover the type of therapy you will receive;

-Your benefits cover in-person and telehealth sessions;

-You may be responsible for any portion of the payment; and

-Your Provider is in-network or out-of-network

-Sharing Information with Insurance Companies

-If you choose to use insurance benefits to pay for services, you will be required to share personal information with your insurance company. Insurance companies keep personal information confidential unless they must share to act on your behalf, comply with federal or state law, or complete administrative work.

COVERED AND NON-COVERED SERVICES

-When your Provider is in-network, they have a contract with your insurance company. Your insurance plan may cover all or part of the cost of therapy. You are responsible for any part of this cost not covered by insurance, such as deductibles, copays, or coinsurance. You may also be responsible for any services not covered by your insurance.

-When your Provider is out-of-network, they do not have a contract with your insurance company. You can still choose to see your Provider; however, all fees will be due at the time of your session to your Provider. Your Provider will tell you if they can help you file for reimbursement from your insurance company. If your insurance company decides that they will not reimburse you, you are still responsible for the full amount.

PAYMENT METHODS

-The practice requires that you keep a valid credit or debit card on file. This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

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COMPLAINTS

If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

Client signature _____Date_____

Guardian signature_____Date_____

Provider signature _____Date _____

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RELEASE OF INFORMATION

I, _____[Insert Name of Patient/Client], whose Date of Birth is _____, authorize _____to disclose to and/or obtain from: _____ the following information:

Description of Information to be Disclosed/Obtained (Patient/Client should initial each item to be disclosed):

_____Assessment _____ Diagnosis _____ Psychosocial Evaluation _____ Psychological Evaluation_____ Treatment Plan or Summary _____ Current Treatment Update ____Discharge/Transfer Summary _____Continuing Care Plan _____ Progress in Treatment _____ Demographic Information _____Psychotherapy Notes* (*Cannot be combined with any other disclosure) _____Other_____

Purpose

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations. If the purpose is other than as specified above, please specify:

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Expiration Unless sooner revoked, this authorization expires on the following date: _____or as otherwise indicated:_____

Conditions

I further understand that [Insert Name of Mental Health Counseling Organization] will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:
_____

Page 2 of 2 Form of Disclosure Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections. I will be given a copy of this authorization for my records.

Signature of Patient/Client_____Date_____

Signature of Parent, Guardian or Personal Representative _____Date_____
If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

Signature of Staff Witness_____ Date_____

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INDEPENDENT PRACTIONER ACKNOWLEDGMENT

Woodnote Therapy PLLC is a group of independent mental health professionals. This group is an association of independently practicing professionals which share certain expenses and administrative functions. While the members share a name and office space, your provider is completely independent in providing you with clinical services and they are fully responsible for those services. Your provider's professional records are separately maintained, and no member of the group can have access to them without your specific, written permission.

Woodnote Therapy, PLLC is a Professional Limited Liability Corporation which provides administrative and management services to mental health professionals. As an independent practitioner, your provider is solely responsible for all matters concerning your clinical care and all questions about that care should be addressed to him or her.

Signature of Patient or Authorized Representative Date

Woodnote Therapy Witness Signature Date

Patient Name (Printed)

Authorized Representative Name (Printed) Relationship to Client

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO THE PAYER AND ASSIGNMENT OF BENEFITS TO THE PROVIDER

I authorize Woodnote Therapy, PLLC to release any medical or other information necessary to my commercial or government insurance carrier(s) or to Center for Medicare and Medicaid Services and its agents in order to process claims for services provided to me or on my behalf.

I authorize the assignment of benefits otherwise payable to me for all government and commercial medical benefits are made to Woodnote Therapy PLLC for services provided to me or on my behalf.

You should also be aware that your contract with your health insurance company requires that I provide them with information relevant to services that I provide for you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that I can provide requested information to your carrier.

Signature of Patient or Authorized Representative Date

Woodnote Therapy Witness Signature Date

Patient Name (Printed)

Authorized Representative Name (Printed) Relationship to Client

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PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Woodnote Therapy, PLLC is committed to protecting your privacy. The Practice is required by federal law to maintain the privacy of Protected Health Information ("PHI"), which is information that identifies or could be used to identify you. The Practice is required to provide you with this Notice of Privacy Practices (this "Notice"), which explains the Practice's legal duties and privacy practices and your rights regarding PHI that we collect and maintain.

YOUR RIGHTS

Your rights regarding PHI are explained below. To exercise these rights, please submit a written request to the Practice at the address noted below.

To inspect and copy PHI.

-You can ask for an electronic or paper copy of PHI. The Practice may charge you a reasonable fee.

-The Practice may deny your request if it believes the disclosure will endanger your life or another person's life. You may have a right to have this decision reviewed.

To amend PHI.

-You can ask to correct PHI you believe is incorrect or incomplete. The Practice may require you to make your request in writing and provide a reason for the request.

-The Practice may deny your request. The Practice will send a written explanation for the denial and allow you to submit a written statement of disagreement.

To request confidential communications.

-You can ask the Practice to contact you in a specific way. The Practice will say "yes" to all reasonable requests.

To limit what is used or shared.

-You can ask the Practice not to use or share PHI for treatment, payment, or business operations. The Practice is not required to agree if it would affect your care.

-If you pay for a service or health care item out-of-pocket in full, you can ask the Practice not to share PHI with your health insurer.

-You can ask for the Practice not to share your PHI with family members or friends by stating the specific restriction requested and to whom you want the restriction to apply.

To obtain a list of those with whom your PHI has been shared.

-can ask for a list, called an accounting, of the times your health information has been shared. You can receive one accounting every 12 months at no charge, but you may be charged a reasonable fee if you ask for one more frequently.

To receive a copy of this Notice.

-You can ask for a paper copy of this Notice, even if you agreed to receive the Notice electronically.

To choose someone to act for you.

-If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights.

To file a complaint if you feel your rights are violated.

-You can file a complaint by contacting the Practice using the following information:

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-You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

-The Practice will not retaliate against you for filing a complaint.

To opt out of receiving fundraising communications.

-The Practice may contact you for fundraising efforts, but you can ask not to be contacted again.

OUR USES AND DISCLOSURES

1. Routine Uses and Disclosures of PHI

The Practice is permitted under federal law to use and disclose PHI, without your written authorization, for certain routine uses and disclosures, such as those made for treatment, payment, and the operation of our business. The Practice typically uses or shares your health information in the following ways:

To treat you.

- The Practice can use and share PHI with other professionals who are treating you.
- Example: Your primary care doctor asks about your mental health treatment.

To run the health care operations.

-The Practice can use and share PHI to run the business, improve your care, and contact you.

-Example: The Practice uses PHI to send you appointment reminders if you choose.

To bill for your services.

-The Practice can use and share PHI to bill and get payment from health plans or other entities.

-Example: The Practice gives PHI to your health insurance plan so it will pay for your services.

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2. Uses and Disclosures of PHI That May Be Made Without Your Authorization or Opportunity to Object

The Practice may use or disclose PHI without your authorization or an opportunity for you to object, including:

To help with public health and safety issues

-Public health: To prevent the spread of disease, assist in product recalls, and report adverse reactions to medication.

-Required by the Secretary of Health and Human Services: We may be required to disclose your PHI to the Secretary of Health and Human Services to investigate or determine our compliance with the requirements of the final rule on Standards for Privacy of Individually Identifiable Health Information.

-Health oversight: For audits, investigations, and inspections by government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

-Serious threat to health or safety: To prevent a serious and imminent threat.

-Abuse or Neglect: To report abuse, neglect, or domestic violence.

To comply with law, law enforcement, or other government requests

-Required by law: If required by federal, state or local law.

- Judicial and administrative proceedings: To respond to a court order, subpoena, or discovery request.

-Law enforcement: For law locate and identify you or disclose information about a victim of a crime.

-Government Functions: For military or national security concerns, including intelligence, protective services for heads of state, or your security clearance.

-National security and intelligence activities: For intelligence, counterintelligence, protection of the President, other authorized persons or foreign heads of state, for purpose of determining your own security clearance and other national security activities authorized by law.

-Workers' Compensation: To comply with workers' compensation laws or support claims.

To comply with other requests

-Coroners and Funeral Directors: To perform their legally authorized duties.

-Organ Donation: For organ donation or transplantation.

-Research: For research that has been approved by an institutional review board.

-Inmates: The Practice created or received your PHI in the course of providing care.

-Business Associates: To organizations that perform functions, activities or services on our behalf.

3. Uses and Disclosures of PHI That May Be Made With Your Authorization or Opportunity to Object

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Unless you object, the Practice may disclose PHI:

To your family, friends, or others if PHI directly relates to that person's involvement in your care.

If it is in your best interest because you are unable to state your preference.

4. Uses and Disclosures of PHI Based Upon Your Written Authorization

The Practice must obtain your written authorization to use and/or disclose PHI for the following purposes:

Marketing, sale of PHI, and psychotherapy notes.

You may revoke your authorization, at any time, by contacting the Practice in writing, using the information above. The Practice will not use or share PHI other than as described in Notice unless you give your permission in writing.

OUR RESPONSIBILITIES

-The Practice is required by law to maintain the privacy and security of PHI.

-The Practice is required to abide by the terms of this Notice currently in effect. Where more stringent state or federal law governs PHI, the Practice will abide by the more stringent law.

-The Practice reserves the right to amend Notice. All changes are applicable to PHI collected and maintained by the Practice. Should the Practice make changes, you may obtain a revised Notice by requesting a copy from the Practice, using the information above, or by viewing a copy on the website [WEB ADDRESS WHERE THIS NOTICE IS POSTED].

-The Practice will inform you if PHI is compromised in a breach.

This Notice is effective on _____

Client signature_____

Provider signature_____

Legal Guardian Signature_____

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TELEHEALTH SERVICE CONSENT

To use telehealth, you need an internet connection and a device with a camera for video. Your Provider can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your Provider will recommend a different option. There are some risks and benefits to using telehealth:

RISKS

-Privacy and Confidentiality. You may be asked to share personal information with the telehealth platform to create an account, such as your name, date of birth, location, and contact information. Your Provider carefully vets any telehealth platform to ensure your information is secured to the appropriate standards.

-Technology. At times, you could have problems with your internet, video, or sound. If you have issues during a session, your Provider will follow the backup plan that you agree to prior to sessions.

-Crisis Management. It may be difficult for your Provider to provide immediate support during an emergency or crisis. You and your Provider will develop a plan for emergencies or crises, such as choosing a local emergency contact, creating a communication plan, and making a list of local support, emergency, and crisis services.

BENEFITS

-Flexibility. You can attend therapy wherever is convenient for you.

-Ease of Access. You can attend telehealth sessions without worrying about traveling, meaning you can schedule less time per session and can attend therapy during inclement weather or illness.

-Recommendations

-Make sure that other people cannot hear your conversation or see your screen during sessions.

-Do not use video or audio to record your session unless you ask your Provider for their permission in advance.

-Make sure to let your Provider know if you are not in your usual location before starting any telehealth session.

Client Signature_____Date_____

Provider Signature_____Date_____

Legal Guardian Signature_____Date_____

Adverse Childhood Experience (ACE) Questionnaire

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While you were growing up, during your first 18 years of life:

l. Did a parent or other adult in the household often ...

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

Yes No If yes enter 1 _____

2. Did a parent or other adult in the household often . . .Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever...

Touch or fondle you or have you touch their body in a sexual way?

or

Try to or actually have oral, anal, or vaginal sex with you?

Yes No If yes enter I _____

4. Did you often feel that . . .No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No If yes enter 1 _____

5. Did you often feel that ...

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it? Yes No If yes enter I _____

6. Were your parents ever separated or divorced?

Yes No If yes enter I _____

7, Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or

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Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No If yes enter I _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Ycs No If yes enter I _____

9. Was a household member depressed or Inentally ill or did a household member attempt suicide? Yes No If yes enter 1 _____

10. Did a household member go to prison?

Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

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The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. **Have you felt you ought to cut down on your drinking or drug use?**
2. **Have people annoyed you by criticizing your drinking or drug use?**
3. **Have you felt bad or guilty about your drinking or drug use?**
4. **Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?**

Score: __ /4

2/4 or greater = positive CAGE, further evaluation is indicated

Source: **Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.**

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T____ = ____ + ____ + ____)*

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
⑤	⑤	⑤	⑤

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