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| --- | --- |
|  | **Monarch Rehabilitation & Sports Wellness Center**  Our mission is to provide excellence in rehabilitation services to enhance overall physical health, fitness, and quality of life by providing educational classes, work hardening / conditioning programs, and individualized treatment programs.  facebook.com/MonarchRehab e-mail: [monarch.rehab@gmail.com](mailto:monarch.rehab@gmail.com) |

PATIENT INFORMATION

PATIENT

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (1): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (2): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER

Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TREATING PHYSICIAN

Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

1. I do not feel sad.
2. I feel sad.
3. I am sad all the time and I cannot snap out of it.
4. I am so sad and unhappy that I cannot stand it.

2.

1. I am not particularly discouraged about the future.
2. I feel discouraged about the future.
3. I feel I have nothing to look forward to.
4. I feel the future is hopeless and that things cannot improve.

3.

1. I do not feel like a failure.
2. I feel I have failed more than the average person.
3. As I look back on my life, all I can see is a lot of failures.
4. I feel I am a complete failure as a person.

4.

1. I get as much satisfaction out of things as I used to.
2. I do not enjoy things the way I used to.
3. I do not get real satisfaction out of anything anymore.

3 I am dissatisfied or bored with everything.

5.

0 I do not feel particularly guilty.

1 I feel guilty a good part of the time.

1. I feel quite guilty most of the time.
2. I feel guilty all of the time.

6.

1. I do not feel I am being punished.
2. I feel I may be punished.
3. I expect to be punished.
4. I feel I am being punished.

7.

1. I do not feel disappointed in myself.
2. I am disappointed in myself.
3. I am disgusted with myself.
4. I hate myself.

8.

1. I do not feel I am any worse than anybody else.
2. I am critical of myself for my weaknesses or mistakes.
3. I blame myself all the time for my faults.
4. I blame myself for everything bad that happens.

9.

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

10.

1. I do not cry any more than usual.
2. I cry more now than I used to.
3. I cry all the time now.
4. I used to be able to cry, but now I cannot cry even though I want to.

11.

1. I am no more irritated by things than I ever was.
2. I am slightly more irritated now than usual.
3. I am quite annoyed or irritated a good deal of the time.
4. I feel irritated all the time.

12.

1. I have not lost interest in other people.
2. I am less interested in other people than I used to be.
3. I have lost most of my interest in other people.
4. I have lost all of my interest in other people.

13.

1. I make decisions about as well as I ever could.
2. I put off making decisions more than I used to.
3. I have greater difficulty in making decisions more than I used to.
4. I cannot make decisions at all anymore.

14.

1. I do not feel that I look any worse than I used to.
2. I am worried that I am looking old or unattractive.
3. I feel there are permanent changes in my appearance that make me look unattractive.
4. I believe that I look ugly.

15.

1. I can work about as well as before.
2. It takes an extra effort to get started at doing something.
3. I have to push myself extremely hard to do anything.
4. I cannot do any work at all.

16.

1. I can sleep as well as usual.
2. I do not sleep as well as I used to.
3. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
4. I wake up several hours earlier than I used to and cannot get back to sleep.

17.

1. I do not get more tired than usual.
2. I get tired more easily than I used to.
3. I get tired from doing almost anything.
4. I am too tired to do anything.

18.

1. My appetite is no worse than usual.
2. My appetite is not as good as it used to be.
3. My appetite is much worse now.
4. I have no appetite at all anymore.

19.

1. I have not lost much weight, if any, lately.
2. I have lost more than five pounds.
3. I have lost more than ten pounds.
4. I have lost more than fifteen pounds.

20.

1. I am no more worried about my health than usual.
2. I am worried about physical problems like aches, pains, upset stomach, or constipation.
3. I am very worried about physical problems and it is hard to think of much else.
4. I am so worried about my physical problems that I cannot think of anything else.

21.

1. I have not noticed any recent change in my interest in sex.
2. I am less interested in sex than I used to be.
3. I have almost no interest in sex.
4. I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Levels of Depression

1-10\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_These ups and downs are considered normal.

11-16\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mild mood disturbance

17-20\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Borderline clinical depression

21-30\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Moderate depression 31-40\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Severe depression over 40\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Extreme depression

# 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 did not bother me much** | **Moderately – it was not 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 |
| Faint / lightheaded | 0 | 1 | 2 | 3 |
| Face flushed | 0 | 1 | 2 | 3 |
| Hot / cold sweats | 0 | 1 | 2 | 3 |

Patient Record of Disclosure

In general, the HIPAA privacy rule gives the individual the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondences to the individual’s office instead of the individual’s home.

I wish to be contacted in the following manner (check all that apply):

* Home Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + OK to leave a message with detailed information.
  + Leave message with call-back number only.
* Work Telephone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + OK to leave a message with detailed information.
  + Leave message with call-back number only.
* Written Communication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + OK to email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  + OK to mail to my home address on file.
  + OK to fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Patient Cancellation Policy

We take great pride in the TIME and SERVICE we provide to our patients. We take your time very seriously and are committed to serving you with the highest level of respect, integrity and in the most cost-effective manner. While come patient cancellations are inevitable, cancellations with less than 24-hours’ notice, missed appointments (no-shows) or being late for an appointment have unfortunately become a great expense to our organization.

As a result, we are instituting the following cancellation policy:

* There will be a $25.00 charge for each cancellation / no-show without a 24-hour notice.
* There will be a $25.00 charge for each 15 minutes a patient is late for an appointment.

I have read and understand the above Cancellation Policy. As an active patient here at Monarch Rehabilitation and Sports Wellness Center, I will adhere to this policy and acknowledge that I will be financially responsible for any fees incurred as a result of this policy due to my non-compliance.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
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Consent for Evaluation and Treatment

I understand that Monarch Rehabilitation and Sports Wellness Center, and its licensed clinicians, have been contracted by my Treating Physician to conduct clinical evaluations and subsequent treatment of my person. The clinicians will perform evaluations with the possibility of providing counseling and/or other clinical services.

The evaluation will consist of one or more of the following: an interview, psychological testing, biofeedback, individual counseling and/or vocational rehab. The report will focus on my current level of psychological functioning and on making recommendations regarding treatment needs and case management.

Having been given the opportunity to ask questions of the evaluator, I believe I understand the purpose of the evaluation.

* I agree to participate.
* I do not agree to participate.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_