MIND MOOD PAIN
Interventional Pain & Psychiatry

Mind Mood Pain New Ketamine or Spravato Intake

Thank you for your interest in Ketamine Infusion Therapy or SPRAVATO (Esketamine) nasal spray for Treatment Resistant Depression. Before we can move forward, we need to collect some basic information. Please complete the information below, all information will be kept confidential. Our staff will review the information and be in touch with you as soon as possible. We look forward to being part of your care. **We know that this is a lot of information. You will only have to complete this once. This will allow us to best evaluate if you qualify for ketamine and/or SPRAVATO (Esketamine).**

Name_____ DOB_____
Address_____City_____State_____Zip_____
Phone (____)_____ Best contact method: [ ] Phone call [ ] Text [ ] Email
Email_____Best time to contact_____
SSN_____-_____-_____Student Status_____
Employment Status_____Employer_____
Employer Address_____
Primary Care Physician_____Psychiatrist_____
Therapist_____Referring Physician_____
Emergency Contact_____Relationship_____
Address_____Phone (_____)_____
How did you hear about Mind Mood Pain? _____
Would you like us to update your mental health provider after treatment? ◯ Yes ◯ No

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT COMPLETE THIS SECTION

Name of responsible party_____Relationship_____
Address_____Phone (_____)_____
Employed by_____Phone (_____)_____
Employer's Address_____

MEDICAL INSURANCE INFORMATION

Primary Insurance Name & Address_____
Policy number_____Group number_____Office visit co-pay_____
Policyholder _____Policyholder Date of Birth_____
Secondary Insurance Name & Address_____
Policy number_____Group number_____
Policyholder_____Policyholder Date of Birth_____
Race (please circle): Asian Native Hawaiian or other Pacific Islander Black or African American White Other
Ethnicity (please circle): Hispanic or Latino Not Hispanic or Latino Primary Language: _____
Local Pharmacy (Name & Address)_____
Mail Order Pharmacy (Name & Address) _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Expanded Authorization Option:
Please list any persons you would like to authorize to have access to your billing, appointment, or health information* such as your spouse, caretaker, or other family member:

Name: **Relationship:**

_____

_____

*With the exclusion of information that is protected under State and Federal Law.

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices but was unable to do so as documented below.

Date:	Initials:	Reason:

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What have you been diagnosed with? Please write the approximate date of diagnosis.

- ☐ Major Depressive Disorder: _____
- ☐ Suicidal Ideation*: _____
- ☐ Bipolar Depression: _____
- ☐ Premenstrual Dysphoric Disorder: _____
- ☐ Postpartum Depression: _____ Date of Delivery: _____
- ☐ Generalized Anxiety Disorder: _____
- ☐ Obsessive Compulsive Disorder: _____
- ☐ Post-Traumatic Stress Disorder: _____
- ☐ Other: _____

***If you are having thoughts of harming yourself, please call 911 or go to the nearest emergency department immediately.**

Which treatment are you interested in? (*Please circle)* **ketamine** **Spravato** **Undecided**

Which location would you like to be seen at? (*Please circle)* **Moore** **Edmond**

Are you currently taking an oral antidepressant? [ ] Yes [ ] No

Please list the antidepressant, dose, how often you take it and when you began this medication.
Medication:_____Dose:_____Frequency: _____ Approximate Date Started: _____

Are you currently taking, or have you ever taken any medication for a seizure disorder? [ ]Yes [ ] No

If so, what medication: _____Start date: _____Stop date: _____

Other Current Medications and Supplements:

Name	Dose/Frequency	Reason	Start Date

Allergies:	Reaction

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Medical History Height _____Weight_____lbs

[ ]Abnormal MRI	[ ]Eating Disorder	[ ]Interstitial Cystitis	[ ]Aneurysm	[ ]Restless Leg Syndrome
[ ]Anemia	[ ]Epilepsy	[ ]Raised intracranial pressure	[ ]Bipolar Mania	[ ]Alcohol Dependence
[ ]Asthma	[ ]Chronic Fatigue	[ ]Raised intraocular pressure	[ ]Nausea	[ ]Psychosis
[ ]Autoimmune Disorder	[ ]Fibromyalgia	[ ]Kidney Disease	[ ]Dizziness	[ ]Arteriovenous Malformation
[ ]Blood Clots	[ ]Head trauma| concussions	[ ]Liver Disease	[ ]Motion Sickness	[ ]Brain Tumor(s)
[ ]Bladder Issues	[ ]Headaches	[ ]Migraine	[ ]Eye Pain	[ ]Schizophrenia
[ ]Cancer	[ ]Heart Disease	[ ]Seizure	[ ]Toothache	[ ]Active Substance Abuse
[ ]Chronic Pain	[ ]High Blood Pressure	[ ]Stomach problems	[ ]Hearing Loss	
[ ]Diabetes Mellitus	[ ]High cholesterol	[ ]Stroke	[ ]Ringing in Ears	
[ ]Drug Abuse	[ ]Hyperthyroid	[ ]Thyroid Disease	[ ]Claustrophobia	

Do you have any of the following?

Pacemaker		[ ] Yes [ ] No	
Hearing aids		[ ] Yes [ ] No	Removable? [ ] Yes [ ] No
Implantable Cardiac Defibrillator (ICD)		[ ] Yes [ ] No	
Wearable Cardiac Defibrillator (WCD)		[ ] Yes [ ] No	
Vagus Nerve Stimulator		[ ] Yes [ ] No	
Have you ever had a Vagus Nerve Stimulator?		[ ] Yes [ ] No	
Spinal cord stimulator		[ ] Yes [ ] No	
Implantable medication pump		[ ] Yes [ ] No	
Insulin pump		[ ] Yes [ ] No	
Piercings	Removable? [ ] Yes [ ] No	[ ] Yes [ ] No	If yes, where?
Plates		[ ] Yes [ ] No	If yes, where?
Screws/staples		[ ] Yes [ ] No	If yes, where?
Stents		[ ] Yes [ ] No	If yes, where?
Dental Implants		[ ] Yes [ ] No	If yes, where?
Bullet Fragments		[ ] Yes [ ] No	If yes, where?
Shrapnel fragments		[ ] Yes [ ] No	If yes, where?
Aneurysm clips or coils		[ ] Yes [ ] No	If yes, where?
Cochlear implants		[ ] Yes [ ] No	If yes, where?
Ocular implants		[ ] Yes [ ] No	If yes, where?
Deep brain stimulation device		[ ] Yes [ ] No	If yes, where?
Do you have anything not listed above implanted in the head area?		[ ] Yes [ ] No	If yes, where?
			Removable? [ ] Yes [ ] No

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Have you ever been a machinist, welder, or metal worker? [ ] Yes [ ] No
Have you ever had a facial injury from metal and/or metal removed from your eyes? [ ] Yes [ ] No
Have you ever had complications from an MRI? [ ] Yes [ ] No

Surgeries (list all, include dates):

_____
_____
_____
_____

Hospitalizations (include dates):

_____
_____
_____
_____
_____

Pregnancy History (female patients)

Are you or could you be pregnant? [ ] Yes [ ] No
Method of Birth Control: _____
Date of last menstrual period: _____
Number of pregnancies: _____ Number of children: _____
Last Pap Smear: _____ Last Mammogram: _____
Are you currently breastfeeding? [ ] Yes [ ] No
Are you planning to become pregnant in the next 6 months? [ ] Yes [ ] No

Review of Systems

<u>General/Constitutional</u>			<u>Gastrointestinal</u>		
Trouble falling asleep	[ ] Yes	[ ] No	Constipation	[ ] Yes	[ ] No
Trouble staying asleep	[ ] Yes	[ ] No	Diarrhea	[ ] Yes	[ ] No
Pregnant	[ ] Yes	[ ] No	Nausea	[ ] Yes	[ ] No
Breastfeeding	[ ] Yes	[ ] No	Vomiting	[ ] Yes	[ ] No
Weight change	[ ] Yes	[ ] No	<u>Musculoskeletal</u>		
<u>Endocrine</u>			Joint stiffness	[ ] Yes	[ ] No
Cold intolerance	[ ] Yes	[ ] No	Painful joints	[ ] Yes	[ ] No
Excessive thirst	[ ] Yes	[ ] No	<u>Neurologic</u>		
Heat intolerance	[ ] Yes	[ ] No	Weakness	[ ] Yes	[ ] No
<u>Respiratory</u>			Dizziness	[ ] Yes	[ ] No
Cough	[ ] Yes	[ ] No	Headache	[ ] Yes	[ ] No
Shortness of breath	[ ] Yes	[ ] No	Memory loss	[ ] Yes	[ ] No
<u>Cardiovascular</u>			Seizures	[ ] Yes	[ ] No
Chest pain	[ ] Yes	[ ] No	Tingling/Numbness	[ ] Yes	[ ] No
Palpitations	[ ] Yes	[ ] No			

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Family History

Father	Mother	Siblings
[ ] Diabetes	[ ] Diabetes	[ ] Diabetes
[ ] Cancer	[ ] Cancer	[ ] Cancer
Type: _____	Type: _____	Type: _____
[ ] Cardiovascular Disease	[ ] Cardiovascular Disease	[ ] Cardiovascular Disease
[ ] High blood pressure	[ ] High blood pressure	[ ] High blood pressure
[ ] Mental illness	[ ] Mental illness	[ ] Mental illness
[ ] Obesity	[ ] Obesity	[ ] Obesity
[ ] Other: _____	[ ] Other: _____	[ ] Other: _____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

[ ] alcohol abuse	[ ] depression	[ ] post-traumatic stress
[ ] anger	[ ] eating disorder	[ ] substance abuse
[ ] anxiety	[ ] insomnia	[ ] suicide attempts
[ ] bipolar disorder	[ ] personality disorders	[ ] violence

Are you able to attend treatment appointments twice a week for the first 4 weeks of treatment and then weekly to monthly for maintenance? [ ] Yes [ ] No

Do you have reliable transportation for ketamine/Spravato (Esketamine) treatment? [ ] Yes [ ] No

At what age were you initially diagnosed with depression (estimate): _____

Have you ever experienced a poor response to oral antidepressants? _____

Have you experienced intolerable side effects to antidepressants in the past? _____

Have you ever had a reaction to ketamine or Esketamine? [ ] Yes [ ] No
IF yes, list reaction or symptoms:_____

Have you ever been in remission from depression? [ ] Yes [ ] No
If so, during what time frame? _____

Have you participated in: [ ] Inpatient Psychiatric Hospitalization
[ ] Psychiatric Partial Hospitalization Program
[ ] Intensive Outpatient Psychiatric Program
Date(s): _____ Facility(ies): _____
Reason: _____

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Have you failed treatment with: [ ]ECT [ ]TMS [ ]Psychotherapy

If you have previously had TMS, which TMS device was used? _____
Date: _____ Facility: _____

If you have previously had ECT, what was the outcome? _____
[ ] Unilateral [ ] Bilateral Date: _____ Facility: _____

What hand do you use primarily? [ ] Left [ ] Right [ ] Both
If you are LEFT-handed, are you exclusively left-handed? [ ] Yes [ ] No

What types of psychotherapy have you tried in the past or are you currently in?
[ ] Talk Therapy [ ] Cognitive Behavioral Therapy [ ] Client-Centered Therapy
[ ] Existential Therapy [ ] Extended Visits with Psychiatrist [ ] Group Therapy
[ ] Dialectical Behavioral Therapy [ ] Interpersonal Therapy [ ] Mindfulness Therapy
[ ] Psychoanalytic or Psychodynamic Therapy
[ ] Other: _____

General/Lifestyle History
Highest educational level or degree: [ ] high school diploma/GED [ ] college degree [ ] graduate degree
Are you currently working: [ ] working [ ] not working by choice [ ] unemployed [ ] disabled [ ] retired
How long have you been in your present position? [ ] 1-3 months [ ] 6-12 months [ ] 1-3 years
[ ]6-10 years [ ] 10+ years
What is/was your occupation: _____
Do you exercise regularly: [ ] Yes [ ] No
Number of days per week: [ ] 1-2 days [ ] 3-4 days [ ] 5-6 days [ ] 7 days
Type(s): [ ] high impact [ ] low impact [ ] weight training

Do you smoke? [ ] Never [ ] Former smoker [ ] Current smoker
If current smoker, how many cigarettes do you smoke a day? _____
Are you interested in quitting? [ ]Yes [ ] No
Do you drink alcohol? [ ] Yes [ ] No
If yes, how often do you drink? _____

Do you have a diagnosis of Substance Use Disorder? [ ] Yes [ ] No
Type: _____
Onset: _____ Date of Sobriety: _____

Current substance abuse or dependence can complicate treatment with Spravato (Esketamine) and ketamine. A history of substance abuse increases the risk of abusing ketamine recreationally. The following questions help us determine if treatment is appropriate for you at this time.

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Have you used any of the following substances in the last 6 months?
If yes, please list how often you use them and the last date of use.

Substances	Frequency	Last used	Prescribed
Opiates	[ ] Yes [ ] No		[ ] Yes [ ] No
ketamine	[ ] Yes [ ] No		[ ] Yes [ ] No
Cocaine	[ ] Yes [ ] No		
Alcohol	[ ] Yes [ ] No		
Tobacco	[ ] Yes [ ] No		
Vape	[ ] Yes [ ] No		
LSD (Lysergic Acid Diethylamide)	[ ] Yes [ ] No		
Psilocybin (magic mushrooms)	[ ] Yes [ ] No		

Have you used drugs other than those required for medical reasons? [ ] Yes [ ] No
Have you abused prescription drugs? [ ] Yes [ ] No
If yes, which ones and for how long? _____

Are you always able to stop drinking/using drugs when you want to? [ ] Yes [ ] No
Have you ever been in trouble because of alcohol/drug abuse? [ ] Yes [ ] No
Have you ever experienced withdrawal symptoms because of heavy alcohol/drug intake? [ ] Yes [ ] No
Have you ever been treated for alcohol or drug abuse? [ ] Yes [ ] No
Do you think you may have a problem with alcohol or drug use? [ ] Yes [ ] No

Social History

Do you have a good support system: [ ] Yes [ ] No
Are you married? [ ] Yes [ ] No How many years? _____
Are you: [ ] Divorced [ ] Single [ ] Widowed How many years? _____
If not married, are you currently in a relationship? [ ] Yes [ ] No How long? _____
Do you have children? [ ] Yes [ ] No If yes, list ages and gender:
_____
_____
_____

Have you ever been arrested? [ ] Yes [ ] No
Do you have any pending legal problems? [ ] Yes [ ] No
Have you traveled outside the US? [ ] Yes [ ] No
Do you have a history of being abused emotionally, sexually, physically or by neglect? [ ] Yes [ ] No
Do you belong to a particular religion or spiritual group? [ ] Yes [ ] No
If yes, do you find your involvement makes things more difficult or stressful? [ ] Yes [ ] No
If yes, do you find your involvement is helpful? [ ] Yes [ ] No

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Bipolar Mania and Psychosis are contraindications to treatment with Spravato (Esketamine) and ketamine. The following questions assess your recent mental status to ensure that you are not currently experiencing a manic or hypomanic episode or an episode of psychosis. Answer yes or no to the following questions.

If you have ever been diagnosed with Bipolar Mania, when is the last time you were manic? _____

Do you have thoughts that others think are bizarre or out of touch with reality? [ ] Yes [ ] No

Do you ever hear voices or see things that aren't there? [ ] Yes [ ] No

Do you ever feel paranoid or feel like others are out to get you? [ ] Yes [ ] No

Do you feel like others are sending you messages or controlling your mind or thoughts? [ ] Yes [ ] No

If Yes:_____

_____

Mark symptoms you've experienced in the past 2 weeks:

[ ] I feel happier or more cheerful than usual
[ ] I feel more self-confident than usual
[ ] I need less sleep than usual
[ ] I frequently talk more than usual
[ ] I have frequently been more active than usual

Past Psychiatric Medications: Have you ever taken any of the following medications?

Mood Stabilizers

[ ]Tegretol(carbamazepine)
[ ] Depakote (valproate)
[ ] Lamictal (lamotrigine)
[ ] Lithium
[ ] Trileptal(oxcarbazepine)
[ ] Other(s): _____

Antipsychotics/Mood Stabilizers

[ ] Abilify (aripiprazole)
[ ] Clozaril (clozapine)
[ ] Geodon (ziprasidone)
[ ] Latuda (lurasidone)
[ ] Risperdal (risperidone)
[ ] Saphris (asenapine)
[ ] Seroquel (quetiapine)
[ ] Zyprexa (olanzapine)
[ ] Other(s): _____

Sedative/Hypnotics

[ ] Ambien (zolpidem)
[ ] Desyrel (trazodone)
[ ] Lunesta (eszopiclone)
[ ] Restoril (temazepam)
[ ] Rozerem (ramelteon)
[ ] Sonata (zaleplon)
[ ] Other(s): _____

Anxiety medications

[ ] Ativan (lorazepam)
[ ] Buspar (buspirone)
[ ] Klonopin (clonazepam)
[ ] Tranxene (clorazepate)
[ ] Valium (diazepam)
[ ] Xanax (alprazolam)
[ ] Xanax XR
[ ] Other(s): _____

ADHD medications

[ ] Adderall (amphetamine)
[ ] Concerta (methylphenidate)
[ ] Ritalin (methylphenidate)
[ ] Strattera (atomoxetine)
[ ] Vyvanse (lisadexamfetamine)
[ ] Other(s): _____

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Past Psychiatric Medications Continued: Have you ever taken any of the following medications?

This portion needs to be filled out to the best of your knowledge in order to submit for approval. Estimated dates can be given.

Antidepressant	Circle Dose	Start Date *(ex: mm/dd/yy)*	Stop Date *(ex: mm/dd/yy)*	Reason for Discontinuation *(ex: weight gain, ineffective)*
[ ] Anafranil (clomipramine)	25mg 50mg 75mg			
[ ] Celexa (citalopram)	10mg 20mg 40mg			
[ ] Cymbalta (duloxetine)	20mg 30mg 40 mg 60mg			
[ ] Effexor (venlafaxine)	37.5mg 75mg 150mg			
[ ] Elavil (amitriptyline)	10mg 25mg 50mg 75mg 100mg 150mg			
[ ] Fetzima (levomilnacipran)	20mg 40mg 80mg 120mg			
[ ] Lexapro (escitalopram)	5mg 10mg 20mg			
[ ] Luvox (fluvoxamine)	25mg 50mg 100mg 150mg			
[ ] Pamelor (nortriptyline)	10mg 25mg 50mg 75mg			
[ ] Paxil (paroxetine)	10mg 20mg 30mg 40mg			
[ ] Pristiq (desvenlafaxine)	25mg 50mg 100mg			
[ ] Prozac (fluoxetine)	10mg 20mg 40mg 60mg			
[ ] Remeron (mirtazapine)	7.5mg 15mg 30mg 45mg			
[ ] Topamax (topiramate)	25mg 50mg 100mg 200mg			
[ ] Desyrel (trazadone)	25mg 50mg 100mg 150mg 300mg			
[ ] Trintellix (vortioxetine)	5mg 10mg 20mg			
[ ] Viibryd (vilazodone)	10mg 20mg 40mg			
[ ] Wellbutrin (bupropion)	75mg 100mg 150mg 200mg 300mg 450mg			
[ ] Zoloft (sertraline)	25mg 50mg 100mg			
O Other(s):				

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Beck Depression Inventory

Patient Name: _____ Date: _____ Score: _____

Scoring:
1-10 Normal
11-20 Mild depression
21-30 Moderate depression
31-40 Severe depression
>40 Extreme depression

1	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad and unhappy that I can't stand it.
2	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel the future is hopeless and that things cannot improve.
3	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6	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	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9	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	0	I don't cry any more than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.
11	0	I am no more irritated by things than I ever was.
	1	I am slightly more irritated now than usual.
	2	I am quite annoyed or irritated a good deal of the time.
	3	I feel irritated all the time.
12	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all interest in other people.
13	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions more than I used to.
	3	I can't make decisions at all anymore.
14	0	I don't feel that I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel there are permanent changes in my appearance that make me look unattractive.
	3	I believe that I look ugly.

15	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.
16	0	I can sleep as well as usual.
	1	I don't sleep as well as I used to.
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17	0	I don't get more tired than usual.
	1	I get tired more easily than I used to.
	2	I get tired from doing almost anything.
	3	I am too tired to do anything.
18	0	My appetite is no worse than usual.
	1	My appetite is not as good as it used to be.
	2	My appetite is much worse now.
	3	I have no appetite at all anymore.
19	0	I haven't lost much weight, if any, lately.
	1	I have lost more than five pounds.
	2	I have lost more than ten pounds.
	3	I have lost more than fifteen pounds.
20	0	I am no more worried about my health than usual.
	1	I am worried about my physical problems like aches, pains, upset stomach, or constipation.
	2	I am very worried about my physical problems and it's hard to think of anything else.
	3	I am so worried about my physical problems that I cannot think of anything else.
21	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 have almost no interest in sex.
	3	I have lost interest in sex completely.

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Patient Health Questionnaire 9 (PHQ-9)

NAME: _____ DATE: _____

Scoring:	**0-4**	**Minimal depression**
	5-9	**Mild depression**
	10-14	**Moderate depression**
	15-19	**Moderately severe depression**
	20-27	**Severe depression**

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle 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 ususal	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3

Total:

Updated 9/24/2020