Maggie T. Ankeny, PMHNP

1925 Empire Park Drive
Eugene, OR 97402
PH: 541-543-4638 Fax: 541-543-2573

Today's Date:	Primary Care Provider (PCP): Name of Clinic:

PATIENT CONFIDENTIAL INFORMATION

Name:	Ethnicity:	Marital status:

Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Preferred name:	Birth date:	Age:	Gender:

Address:

Social Security no.:	Primary phone no.: Okay to leave message? YES NO	Secondary phone no.: Okay to leave message? YES NO
Driver's License State and #: Expiration Date:	Occupation: Employer:	Email (optional):

Name of counselor/therapist (if applicable): Address:
Phone:

Chose clinic because/referred to clinic by:

RESPONSIBLE PARTY/GUARDIAN INFORMATION

(Please bring your insurance card to your initial appointment)

Responsible Party Name: Check here if self: _______	Primary phone no.: Secondary phone no.:	Address (if different than above):	SSN: Driver's license State and #:
Employer:	Relationship to patient:	Are you patient's legal guardian?	If custody is shared, other responsible party's name and phone:

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the nurse practitioner. I understand that I am financially responsible for any balance. I also authorize Maggie T. Ankeny, PMHNP or insurance company to release any information required to process my claims.

______________________________ ______________
Patient/Guardian signature Date

____
Patient/Guardian printed name

Maggie T. Ankeny, PMHNP

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Billing Information and Financial Agreement

Patient: ______________________________ Date of Birth: ________________________

Check One:

_____ **Self-pay:** I will pay fees without insurance at the time service is provided.

_____ **Use my insurance:** My provider's office will bill my insurance for me. However, I understand if **Maggie T. Ankeny, PMHNP is *not* an in-network provider with my insurance company, I must pay in full at the time service is provided.** A Medical Claim Form will be submitted to my insurance company and any reimbursement will be sent directly to me (the patient or responsible party). If the Medical Claim Form is unavailable, I will be directed to my insurance company for assistance with reimbursement. It is my responsibility to find out whether my provider is in or out of network, what my insurance will pay and whether preauthorization is needed before scheduling an appointment.

INSURANCE INFORMATION

Please list ALL health insurance you have, even if you do not intend to use it, as this may affect how we bill you.

Primary Insurance: _________________________ Member ID #: ____________________________

Secondary Insurance: _______________________ Member ID #: ____________________________

Other Insurance: ___________________________ Member ID #: ____________________________

BACKUP PAYMENT (Required for all patients)

Our office uses a secure credit card payment system. We accept Mastercard, Visa, and Discover.

Name as it appears on credit card: ________________________

Card type: (check one): ______Mastercard _____Visa _______Discover

Card Number: _________________________ Expiration Date: __________________

Please Initial _____ I understand and agree that the card provided above will be charged for all fees at time of service unless an acceptable alternative form of payment is provided at the time of the appointment. Checks returned by the bank for insufficient funds are subject to a fee of $35 and I agree to pay this fee if applicable.

NOTICE TO PATIENTS WITH INSURANCE

Your insurance is NOT an automatic guarantee of payment. All fees and expenses incurred by the patient in this office are solely the responsibility of the patient (or parent/legal guardian, if patient is a minor). As a courtesy, we will complete and submit your insurance claim unless we are unable to access the necessary forms, in which case we will direct you to your insurance company for assistance. In many cases, we accept what the insurance company pays as payment in full, but this may or may not apply in your case. Please feel free to ask us any questions you have regarding billing. You should also contact your insurance company for specific information on what your policy covers before you make an appointment.

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Billing Information and Financial Agreement
(continued)

ASSIGNMENT OF INSURANCE BENEFITS
By signing below, I authorize **Maggie T. Ankeny, PMHNP** to furnish my third-party payor all relevant information which may be requested regarding my claim, including activities involved in determining eligibility, diagnosis, review of health care services for medical necessity, precertification and preauthorization, releasing **Maggie T. Ankeny, PMHNP** from any liability for furnishing such information. I assign all payments to which I am entitled for expenses related to the services performed to **Maggie T. Ankeny, PMHNP**, except as described below. Any money received from the insurance company over and above the amount I owe will be refunded after my bill is paid in full. I understand that I may be billed for lengthy telephone consultations and reports, which may not be reimbursable by insurance. I understand that I am financially responsible for all fees regardless of insurance coverage and, I am required to keep a valid credit or debit card on file which will be billed accordingly for co-pays, fees and any outstanding charges on my account.

APPOINTMENT POLICY
By signing below, I agree that if I cannot make it to a scheduled appointment, I must call and cancel the appointment 24 to 48 hours in advance. I understand I am responsible for paying for any missed appointments or appointments which are cancelled less than 24 hours in advance. I understand that if I do not follow this agreement, **Maggie T. Ankeny, PMHNP** reserves the right to deny services. I understand that failing to attend, or late cancellation of, three scheduled appointments may result in being dismissed as a client. Please note that "24-hour notice" means calling by 9 am Tuesday to cancel an appointment for 9 am Wednesday. This will allow our office the option of giving your appointment to someone else.

By signing below, I accept financial responsibility for all deductible/copays/coinsurance and fees incurred by the above-named patient, and certify that I am legally qualified and able to do so. I give permission for **Maggie T. Ankeny, PMHNP** to charge my credit or debit card for any copays, coinsurance, missed appointments, late cancellations, deductible payments, and other outstanding charges and agree to keep my credit/debit card information current. I also agree to pay all outstanding balances on the patient's account within 30 days if for any reason there are charges that cannot be or have not been billed to the card on file.

This authorization will remain in effect for the duration of the above-named patient's treatment at **Maggie T. Ankeny, PMHNP**, and may be revoked by me at any time. The request must be submitted in writing and will take effect within 30 days of receipt of the written request.

Date: ________________

Signature of Patient/Financially Responsible Party: ______________________________

Print Full Name: ______________________________

Address: ______________________________ City, State, Zip: ______________________

Phone: ______________________ Relationship to Patient: ______________________

Maggie T. Ankeny, PMHNP

1925 Empire Park Drive

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Patient Rights and Responsibilities

While you are a patient at Maggie T. Ankeny, PMHNP you have the right to:

- Considerate and respectful care.
- Be well-informed about your illness, possible treatments and likely outcomes and to discuss this information with your healthcare provider.
- You have the right to consent to or refuse a treatment as permitted by law. If you refuse a recommended treatment, you will receive other needed and available care.
- You have the right to privacy. Our office will protect your privacy as much as possible.
- You have the right to expect a timely response to questions regarding medications and side effects.
- You have the right to expect that treatment records are confidential unless you have given permission to release information or reporting is required or permitted by law. There are some instances, such as when a person has been or is at risk of being harmed, when we are required by law to report it without your consent.
- You have the right to expect that we will give you necessary health services to the best of our ability. Treatment, referral or transfer may be recommended. If transfer is recommended, you will be informed of risks, benefits and alternatives.

Our Patients Have the Responsibility To:

- Arrive on time for appointments. Patients who arrive more than a few minutes late may not be seen, as having the full time allotted is necessary for your provider to give you adequate care. Maggie will determine availability and if she cannot see you at your originally scheduled time, she will ask you to reschedule.
- Provide 24 to 48 hours' notice of cancellation (for example, calling no later than 9am Tuesday to cancel an appointment scheduled for 9am Wednesday). This allows us time to give your appointment to another patient.
- Display appropriate conduct while in the office, including silencing cell phones, monitoring children, and being courteous toward your nurse practitioner and other patients. In addition, no weapons, alcohol or street drugs are allowed on the premises.
- Provide truthful and accurate information to the best of your ability when filling out required patient forms or in response to questions asked by your nurse practitioner during appointment sessions. It is very important to be truthful about your medical and mental health history, substance use, side effects and other information necessary for your nurse practitioner to treat your condition.
- Take medications as prescribed and not share, give or sell prescribed medications to others.
- Not seek, obtain or fill prescriptions for controlled substances from multiple providers at the same time.
- Ask questions and let your provider know if you do not understand information or instructions. If you believe you cannot follow through with your treatment, you are responsible for telling your provider.
- Let us know if you are dissatisfied with services so that we may attempt to resolve the problem.
- Let us know of any changes in address, phone number, billing or other requested information as soon as possible.
- Take financial responsibility for payment of all charges as described in the Financial Agreement.
- Understand how lifestyle choices affect your mental health.

Maggie T. Ankeny, PMHNP

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Office Policy Statement

Contact Information: Maggie's office is open 130- 500 PM Fridays and 0900-1200 AM on Saturdays. Maggie may make exceptions to these times if she has availability. Your call may be answered by voicemail if Maggie is unable to answer during business hours. Voicemail is *not* for psychiatric or medical emergencies. If you are unable to reach Maggie and cannot wait for her to return your call, please contact your primary care provider, go to the nearest emergency room, or dial 911. You may also call White Bird Crisis Line at (541) 687-4000 for an adult mental health crisis or the Crisis Response Program at (888) 989-9990 for a crisis involving a child. Both hotlines are answered 24 hours a day, seven days per week.

Appointments: It is your responsibility to attend appointments as scheduled. If you do not show for three scheduled appointments, or you cancel three scheduled appointments less than 24 hours in advance in a one-year period (except in verifiable emergencies), you may be dismissed as a client. You may also be billed for missed appointments. Please note that "24-hour notice" means calling by 9 am Tuesday to cancel an appointment for 9 am Wednesday. This will allow us time to give your appointment to someone else.

Medication Refills: At each appointment, Maggie will prescribe enough medication to last until your next appointment. As long as you are coming to appointments as scheduled, you should not need to call the office for refills. However, if this does happen, contact your pharmacy directly 72 hours in advance. Refills will only be authorized during normal business hours.

Psychiatric Fees: You may be charged for other services such as phone calls, after-hours contacts, reports, and consultations with other professionals. Your insurance company will be billed for covered services; however, you will be expected to pay for any fees not covered by insurance. If you are a self-pay or private insurance client, your card on file will be billed for any co-pays and fees at the time of the appointment. Please feel free to discuss charges or fees with us.

Treatment Plan: You have the right to participate in developing your treatment plan and to ask why any form of treatment is recommended. You may at any time refuse treatment or request a change in the treatment approach.

Provider Responsibility Disclaimer: Many insurance companies now require preauthorization for mental health services. It is your responsibility to notify our office if your insurance changes, or if your insurance requires preauthorization. If your insurance plan does require preauthorization, it is your responsibility to know what the requirements are and to obtain the necessary approvals before seeking treatment. It is also your responsibility to be aware if your policy has plan limitations. Authorization for sessions does not guarantee available benefits. If benefits exhaust or preexisting conditions apply, you will be responsible for the bill.

Grievance Procedures: If you feel your rights have been violated, please discuss this with us. If we are not able to resolve the issue, you may contact the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Patient Privacy Notice

We are required by law to protect the privacy of your personal health information and to provide you with this Notice describing how medical information about you may be used/disclosed and how you can access this information.

• We are required by law to have your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, receiving payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

• We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

• As our patient, you have important rights related to inspecting and receiving a copy of your medical information that we maintain: amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information and registering a complaint if you think your rights have been violated.

• We have a detailed Notice of Privacy Practices, included as part of the welcome packet, which fully explains your rights and our obligations under the law. We may revise our Notice periodically. The Notice's effective date is listed on the front page.

• You have the right to receive a copy of our most current Notice in effect. If you have not yet received a copy of our current Notice, please ask your provider and we will provide you with a copy.

• If you have any questions, concerns or complaints about the Notice or your medical information, please contact your provider.

I acknowledge, understand and agree to comply with the above policies.

______________________________________ ___________________________

Signature of Patient/Legal Guardian Date

____

Printed

Maggie T. Ankeny, PMHNP

1925 Empire Park Drive

Eugene, OR 97402

PH: 541-543-4638 Fax: 541-543-2573

Patient Consent and Release Form

Yes **No** **CONSENT FOR TREATMENT:** I consent to and authorize Maggie T. Ankeny, PMHNP to examine and treat me. I understand that this could include lab tests, education, or other diagnostic procedures. I understand that Maggie is available to explain the purpose of the procedures and treatment, and that I have the right to refuse the recommended treatment.

Yes **No** **RELEASE OF MEDICAL RECORDS FOR RESEARCH:** State law requires us to inform you that your medical records may be released for research purposes unless you object. Occasionally, Maggie T. Ankeny, PMHNP may receive a request from medical or scientific researchers for a copy of our patient records in order to conduct a research study. These requests would be evaluated to ensure that the release of patient records is necessary to accomplish the research purpose. The researchers cannot use patient names or other identifying characteristics when reporting any results of their research. By indicating "Yes", you authorize this release, but may also revoke authorization any time by notifying us in writing.

Yes **No** **INSURANCE BILLING AUTHORIZATION:** I authorize Maggie T. Ankeny, PMHNP to release requested medical information to my insurance company to collect payment for any charges incurred.

Yes **No** **INSURANCE ASSIGNMENT OF BENEFITS:** I request that payment of insurance benefits be made directly to Maggie T. Ankeny, PMHNP on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges relating to the service(s) rendered. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay my portion promptly.

Yes **No** **VOICE AND EMAIL COMMUNICATION:** I authorize Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner to contact me or leave messages for me via telephone or email, with the following limitations:

____

DISCLOSURE OF PRESENCE: I understand that during my visit my friends, family, employers or others may call to inquire about my presence at the office of Maggie T. Ankeny. I authorize you to disclose information about my presence at the office to the following people:

Name	Phone #	Name	Phone #

FAMILY/CAREGIVER COMMUNICATION: I authorize Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner to communicate regarding my care with:

Name	Phone #	Name	Phone #

Patient Name (Print) ______________________ Date of Birth ________________

Signature: ______________________________ Date: ________________

Maggie T. Ankeny, PMHNP

1925 Empire Park Drive
Eugene, OR 97402
PH: 541-543-4638 Fax: 541-543-2573

Authorization for Release of Confidential Information

Patient: ______________________________ Date of Birth: ______________

I hereby authorize the release and sharing of information which pertains to my medical history, mental or physical condition or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment *between the following parties*:

Maggie T. Ankeny, PMHNP
1925 Empire Park Dr. Eugene, OR 97402
Phone (541) 543-4638
Fax (541) 543-2573

AND

Name: ______________________ Phone: ______________________

Clinic: ______________________ Fax: ______________________

Address: ____

The information to be disclosed is needed for diagnosis and evaluation, treatment planning, and/or continuity of care, and I specifically authorize this disclosure.

Providers: Please fax the following information to (541) 543-2573:

__X___ Diagnostic Evaluations
__X___ Progress/Chart Notes **Last 4**
__X___ Psychological Testing
__X___ Laboratory Reports/**GeneSight Testing**
__X___ Verbal Information
_____ Complete Medical Record – Dates:
__X___ Drug and Alcohol Treatment
__X___ Medication List
_____ Educational Records
_____ Other:

Please Initial:

_____ I acknowledge that records to be requested may include information related to diagnosis or treatment of mental health conditions, and I specifically authorize the release of this information.

_____ I acknowledge that records to be requested may include information related to drug and/or alcohol treatment, and I specifically authorize the release of this information.

_____ I acknowledge that records to be requested may include information related to treatment of HIV/AIDS and/or sexually transmitted diseases, and I specifically authorize the release of this information.

I understand that information about my treatment is confidential and protected by state and federal law. I voluntarily consent to the release of the information described above. This authorization will remain in effect for the duration of my treatment at Maggie T. Ankeny, PMHNP This consent may be revoked by me at any time. The request must be submitted in writing and will not affect information previously released.

____

Signature of Patient or Legal Guardian Date

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.

Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

This notice is effective as of 3/10/2008.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT: We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.
PAYMENT: We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
WORKERS' COMPENSATION: We may disclose your health information as necessary to comply with State Workers' Compensation Laws.
EMERGENCIES: We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.
PUBLIC HEALTH: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
JUDICIAL AND ADMINISTRATIVE PROCEEDINGS: We may disclose your health information in the course of any administrative or judicial proceeding.
LAW ENFORCEMENT: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
DECEASED PERSONS: We may disclose your health information to coroners or medical examiners.
RESEARCH: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.
PUBLIC SAFETY: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.
MARKETING: We may contact you for marketing purposes or fund raising purposes.
CHANGE OF OWNERSHIP: In the event that Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner, as a practice, is sold or merged with another organization, your health information/record will become the property of the new owner.

YOUR HEALTH INFORMATION RIGHTS

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is not required to agree to the restriction that you requested.

YOUR HEALTH INFORMATION RIGHTS

- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method
- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner amend your protected health information. Please be advised, however, that Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is required by law to comply with this Notice. Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner here by calling the office at 541-543-4638. If Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

COMPLAINTS

Complaints about your Privacy rights, or how Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner has handled your health information should be directed to Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner by calling the office at 541-543-4638. If Maggie T. Ankeny, Psychiatric Mental Health Nurse Practitioner is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201.

[ ] Patient declined to sign this Privacy Notice.

I acknowledge receiving this Privacy Notice.

Signature ____________________ Date ____________

Maggie T. Ankeny, PMHNP

1925 Empire Park Drive

Eugene, OR 97402

PH: 541-543-4638 Fax: 541-543-2573

Symptom List

Below is a list of common problem areas. Please check all that you have experienced in the past month:

_____Problematic mood
(check those which apply)
- _____ Depression
- _____ Angry or hostile
- _____ Anxious, tense or worried
- _____ Fearful
- _____ Other _______________________________

_____Sleeping difficulties
(check those which apply)
- _____ Sleeping too much
- _____ Difficulty falling asleep
- _____ Frequent awakening during night
- _____ Early morning awakening

_____Change in appetite/eating
(check those which apply)
- _____ Loss of appetite or decrease
- _____ Overeating
- _____ Bingeing on food
- _____ Bowel problems
- _____ Stomach problems
- _____ Headaches
- _____ Purging food (vomiting, using laxatives)

_____Crying easily and often
(check those which apply)
- _____ Easily upset
- _____ Withdrawn
- _____ Hopeless/worthless feelings
- _____ Low self-esteem, self-critical
- _____ Loss of interest in activities
- _____ Loss of sexual interest/performance
- _____ Fatigue
- _____ Suicidal thoughts/statements

_____Suicidal actions

_____Homicidal thoughts/statements

_____Unusual noises or images

_____Feeling that your mind is "racing"

_____Difficulty completing thoughts

_____Obsessive thoughts

_____Compulsive behaviors

_____Fear of dying

_____Fearful dreams

_____Aggressive thoughts/statements

_____Anger/temper difficulties

_____Physically assaultive behaviors

_____Relationship conflicts/social problems

_____Feel unsafe in home

_____Concentration difficulties

_____Memory problems

_____Legal charges/difficulties (history of)

_____Unusual, troubling or inappropriate sexual interest

_____Other (please describe below)

_____Chronic (long standing) difficulties with:
(check those which apply)
- _____ Focusing
- _____ Staying on task
- _____ Being organized
- _____ Completing tasks
- _____ Academic/work performance

_____Substance Abuse
(check those which apply)
- _____ Alcohol
- _____ Marijuana
- _____ Other

____

Signature Patient/Person Authorized to Sign for Patient - Relationship Date/Time

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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 ________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.