New Patient Information

Patient Name: _____ DOB: _____ Age: _____
(Nombre de Paciente) (Fecha de Nacimiento) (Edad)

Address: _____ City: _____ ST: _____ Zip_____
(Direccion) (Ciudad) (Estado) (Codigo)

SSN: _____-_____-_____ Home Phone#_____ Work: _____ Cell: _____
(Numero de seguro social) (Telefono de casa) (Telefono de Trabajo) (Telefono de cellular)

Employer: _____ Phone#: _____
(Nombre de Empleo) (Telefono de Empleo)

Spouse's Name: _____ DOB: _____ Age: _____
(Nombre de Esposo/a) (Fecha de Nacimento) (Edad)

Spouse's Employer: _____ SSN: _____-_____-_____
(Empleo de Esposo/a) (Numero de seguro social)

Insurance Information
(Informacion sobre su Aseguransa)

Primary Insurance: _____ Phone#: _____
(Nombre de Aseguransa Primaria) (Numero de Telefono)

Claims Address: _____ City: _____ ST: _____ Zip: _____
(Direccion) (Ciudad (Estado) (Codigo)

Insured's Name: _____ Group#_____
(Nombre de el persona que tienes el Aseguransa) (Numero de Grupo)

Member/ID#: _____ Policy#: _____
(Numero de miembro o ID) (Numero de Poliza)

Secondary Insurance
(Informacion sobre su Aseguransa Segundaria)

Secondary Insurance: _____ Phone#: _____
(Numero de Telefono)
(Nombre de Aseguransa)
Claims Address: _____ City: _____ ST: _____ Zip:
_____ Direccion) (Ciudad) (Estado) (Codigo)

Insured's Name: _____ Group# _____
(Nombre de el persona que tienes el Aseguransa) (Numero de Grupo)

Member/ID#: _____ Policy#: _____
(Numero de miembro o ID) (Numero de Poliza)

Attorney's Name: (Nombre de Abogado) _____ Phone#: _____
(Telefono de su Abogado)
Address_____ City: _____ ST: _____ Zip: _____
(Direccion) (Ciudad) (Estado) (Codigo)

Date of Injury: _____ Who may we thank for referring you to our office? _____
Fecha que fue lastimado) (Aquien le debemos las gracias por su referencia?)

Patient's Signature: X_____ Date: _____
(Firma de Paciente) (Fecha)

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI) By Joseph J. Schifini, MD, LTD. (JJS)

Patient Name: _____
Last First M.I. (Previous or Other Names Used)

Address: _____

_____

Date of Birth: _____

If this Authorization is for any purpose other than the release of PHI for personal reasons, please state the purpose below:

I authorize the release of medical records from: Joseph J. Schifini, MD, LTD
8925 W. Russell Road
Suite 200
Las Vegas, NV 89148

Please release requested medical records to:

Name: _____
Address: _____
City: _____
State: _____
ZIP: _____
Telephone Number: ( ) -
Fax Number: ( ) -

I specifically authorize the use and disclosure of the following PHI: **(Please provide a detailed description of the particular data and period of time you are requesting)**

- □ Emergency Records
- □ Clinic Records
- □ Lab Reports
- □ Shot Records
- □ Slides
- □ Hospital Records
- □ Radiology Reports
- □ Radiology Films
- □ Pathology Reports
- □ Other _____

This authorization will expire on the 180th day of the signing unless a lesser date is specified below:

By signing this Authorization Form, I understand that I am giving my authorization for JJS to use and/or disclose my protected health information (PHI) as described above. The information to be used or disclosed pursuant to this authorization form may include information relating to: (1) Acquired immunodeficiency syndrome (AIDS) or (2) human immunodeficiency virus (HIV) infection, treatment for drug or alcohol abuse, or (3) mental or behavioral health or psychiatric care. If you are requesting psychotherapy session notes maintained by a mental health provider, a separate authorization form must be completed. I understand that I may revoke this authorization at any time by notifying JJS in writing to Joseph J. Schifini, MD, LTD Health Information Management Department, 8925 W. Russell Road, Suite 200, Las Vegas, Nevada 89148 of my intent to revoke this authorization. I understand that such a revocation will not have any effect on any information already used or disclosed by JJS before JJS received my written notice of revocation. If neither federal nor Nevada privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Nevada privacy laws. This Authorization is voluntary and I may refuse to sign this Authorization Form. I understand that I am not required to sign this Authorization Form in exchange for the patient receiving treatment from JJS.

_____ _____
Signature of Patient or Authorized Personal Representative **Date**

_____ _____
Relationship to the Patient (If signed by a Personal Representative) **Date**

HIPAA Notice of Privacy Practices

This notice was published and becomes effective on/or before **April 14, 2003**.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature	Date

Joseph J. Schifini, M.D. **DATE** ___/___/___

PLEASE FILL OUT THIS FORM *COMPLETELY* SO WE CAN HELP YOU WITH YOUR PAINFUL CONDITION.

NAME:_____ **AGE:**____ **SEX:** M / F **HEIGHT** __'__" **WEIGHT**____**lbs**
OCCUPATION:_____ **DATE LAST WORKED**___/___/___

CC: **WHY** WERE YOU REFERRED TO OUR CLINIC?_____

HPI: PLEASE **DESCRIBE YOUR PAIN** BY ***SHADING*** IN THE AFFECTED AREAS AND ***PLACING AN 'X'*** ON THE AREA THAT HURTS THE MOST. ***CIRCLE*** ALL APPLICABLE DESCRIPTIVE WORDS.

CONSTANT TEMPORARY

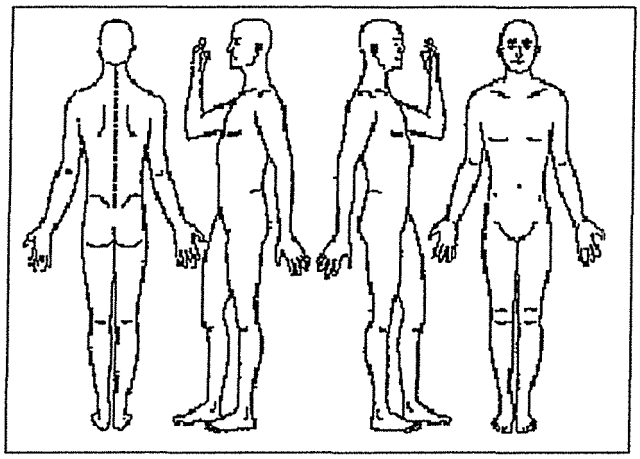
DAILY OCCASIONAL

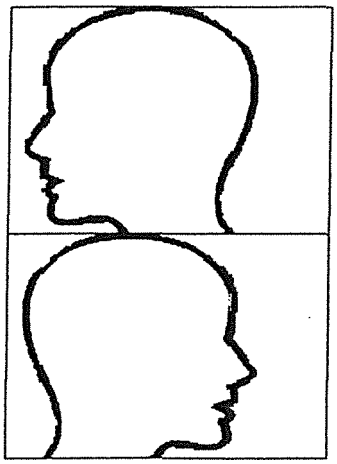
ACHING SHOOTING

BURNING STABBING

NUMBING TINGLING

PINS/NEEDLES





PLEASE ATTEMPT TO QUANTIFY YOUR PAIN USING PERCENTAGES. YOUR TOTAL PAIN SHOULD ADD UP TO 100%. (*EXAMPLE:* 20% LOW BACK PAIN AND 80% RIGHT LEG PAIN = 100%.)

HEAD____%	NECK____%	RIGHT ARM____%	LEFT ARM____%
CHEST____%	ABDOMEN____%	UPPER BACK____%	MID BACK____%
LOWER BACK____%	HIPS/BUTTOCKS____%	RIGHT LEG____%	LEFT LEG____%

CIRCLE THE ACTIVITIES WHICH TEND TO ***INCREASE*** YOUR PAIN:

WALKING LIFTING BENDING TWISTING STANDING SITTING

FILL IN ACTIVITIES WHICH ***DECREASE*** YOUR PAIN:_____

DOES THIS PAIN AFFECT YOUR **SLEEP?** YES / NO

CURRENT ***PAIN*** MEDICATIONS:_____PRESCRIBED BY **DR.**_____

MARK YOUR *AVERAGE* PAIN SCORE:
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10

MARK YOUR *WORST* PAIN SCORE:
0----------1----------2----------3----------4----------5----------6----------7----------8----------9----------10
NOTE: (*ZERO* EQUALS *NO PAIN* AND *TEN* EQUALS YOUR *WORST* IMAGINABLE PAIN)

***WHEN* DID THIS PAIN BEGIN?**_____ (SPONTANEOUS/ INJURY/ ACCIDENT/ SURGERY/ OTHER)
PLEASE ***DESCRIBE*** **HOW** IT BEGAN:

_____

_____

_____

_____

HAVE YOU EVER HAD ANY ACCIDENTS OR INJURIES AFFECTING THESE SAME AREAS BEFORE? YES / NO
IF YES, WHEN?_____

TREATMENT: WHICH TYPES OF TREATMENT HAVE YOU HAD IN THE PAST TO TREAT YOUR CURRENT PAIN. PLEASE *CIRCLE* ALL THAT APPLY.

PAIN CLINIC PHYSICAL THERAPY MASSAGE CHIROPRACTIC INJECTIONS SURGERY

ACUPUNCTURE MAGNETS HERBS OTHER:_____

PLEASE *LIST* ALL TREATMENT BELOW:

HEALTH CARE PROFESSIONAL	APPROXIMATE DATES	DIAGNOSIS	TREATMENT/ MEDICATIONS

DIAGNOSTIC EXAMINATIONS: PLEASE *CIRCLE* ALL THAT APPLY

XRAY CT-SCAN MRI MYELOGRAM EMG/NCV OTHER_____

PAST/CURRENT MEDICAL HISTORY: PLEASE *CIRCLE* ALL THAT APPLY:

ARTHRITIS ASTHMA BLEEDING PROBLEMS CANCER CIRRHOSIS COLITIS DIABETES EMPHYSEMA
HEART TROUBLE HEPATITIS / JAUNDICE HIGH BLOOD PRESSURE HIV / AIDS KIDNEY DISEASE
MURMUR SEIZURE STROKE THYROID TROUBLE URINATING ULCER VASCULAR DISEASE
ARE YOU TAKING ANY **BLOOD THINNERS** SUCH AS **COUMADIN, WARFARIN, PLAVIX, OR TICLID?** YES / NO
LIST ALL CURRENT **MEDICATIONS:**_____

ALLERGIES TO **MEDICATIONS:**_____

PAST SURGICAL HISTORY: (PLEASE *LIST* **ALL OPERATIONS** YOU HAVE HAD)_____
_____

SH: SINGLE____ MARRIED____ DIVORCED____ SEPARATED____ WIDOWED____ # OF CHILDREN____

PACKS OF **CIGARETTES** SMOKED/DAY_____ # OF **ALCOHOLIC** BEVERAGES/DAY_____
HISTORY OF **SUBSTANCE ABUSE** YES / NO IF YES, WHAT TYPE?_____

FH: *LIST* **ANY ILLNESSES** WHICH RUN IN YOUR **FAMILY:**_____

ROS: PLEASE *CIRCLE* ALL **SYMPTOMS** YOU MAY CURRENTLY HAVE: CHANGE IN VISION CHEST PAIN
COUGH DIARRHEA / CONSTIPATION DIZZINESS EASY BLEEDING FAINTING FEVER ITCHING
SHORTNESS OF BREATH STOMACH PROBLEMS URINARY PROBLEMS WEIGHT LOSS / WEIGHT GAIN

WHO IS YOUR CURRENT **PRIMARY CARE PHYSICIAN / PROVIDER?**_____

Name_____

Date_____

Joseph J. Schifini, M.D., Ltd
Diplomate of American Board of Anesthesiology
Practice of Anesthesiology and Pain Medicine

CONTROLLED SUBSTANCE PATIENT AGREEMENT FORM

We want to ensure that patients and caregivers have clear communication and safe, effective procedures when patients use opioids. For the purposes of this document "I" will be synonymous with the patient receiving one or more controlled substances, and "provider" will be considered synonymous with the prescriber of these medications.

EFFECTIVENESS: For most patients and pain conditions, opioids are effective pain-relieving medications. However, it is possible opioids will not work well for you and your pain.

SAFETY: Most people can take these drugs safely, but some people do experience side effects. (See below.)

SIDE EFFECTS: Most patients do not have serious side effects or drug interactions. Unfortunately, some do experience side effects and must stop the medication(s). Common side effects include constipation, itching, nausea, vomiting, sedation or lightheadedness. Uncommon reactions include swelling in the legs, water on the lungs, trouble breathing (especially if you have emphysema/COPD or are on other narcotics), mental slowing and loss of coordination, lowering of sex drive, decreased testosterone (male sex hormone) and addiction. Note: Pregnant women using opioids could make their newborn child dependent upon opioids. If you are pregnant, you need to alert your health care provider.

DEPENDENCE: Dependence is not the same as addiction. Many people who take opioids daily will become dependent on them. Dependence is when your body adapts to the medication and then experiences withdrawal if the medication is stopped or lowered too quickly. Withdrawal symptoms include moodiness, aches and pains, sweating, diarrhea, abdominal pain and even seizures.

ADDICTION: Addiction is not the same as dependence. While many people become dependent on daily opioids, only a small percentage of these people will become addicted. Addiction is characterized by behaviors such as loss of control of drug use, compulsive use and craving, and continued use despite harm or risk to the person. When people are addicted, they are not taking opioids simply to treat the pain.

GOALS: The goals of chronic pain management are to:

1. Improve your ability to function in your daily life,
2. Lower your pain.

TREATMENT OPTIONS :

1. Medications,
2. Counseling, relaxation training, hypnosis and meditation,
3. Chiropractic care, massage, acupuncture and physical therapy,
4. Surgery and spinal or other type of injections.

WHAT YOU NEED TO DO :

1. Realize that opioid therapy is only one part of treatment.
2. Remain active every day and try to increase activity a little bit at a time.
3. Use your medications ONLY as directed by your provider.
4. Work with your provider and follow treatment recommendations in addition to taking prescribed medications.

Dr. Schifini and staff have explained the risks and benefits of chronic opioid therapy for my pain.

I,_____, understand that I must comply with the following rules or I will not be given opioids.

I will fill the prescription at one and only one pharmacy.

Pharmacy name_____Phone _____

I will take the medication(s) listed in my charts as they were prescribed and intended and only in that manner.

continued on page 2 of 2 >-

8925 W. Russell Road, Suite 200 Las Vegas, NV 89148
Phone: (702) 870-0011 Fax: (702) 870-1144

Name_____

Date_____

Joseph J. Schifini, M.D., Ltd
Diplomate of American Board of Anesthesiology
Practice of Anesthesiology and Pain Medicine

*Initial in each box below.

_____I will not increase the dose or stop the medication unless asked to do so by my provider or my provider's partner. I will report any worrisome side effect soon after it begins.

_____I will follow through on appointments that may help me with chronic pain and functioning. These may include physical and occupational therapy, counseling and other mental health practices, neurosurgery, neurology and orthopedics. Consistent failure to keep these appointments and therapies may result in the stopping of the opioid medications.

_____If prescribed, I will use medications other than opioids to control pain.

_____I will accept opioids for chronic pain from my provider only.

_____I will not share, exchange or sell my opioids, as the law prohibits those actions. I understand that my provider will report serious concerns of drug misuse to any and all authorities for investigation.

_____I will not use illegal/street drugs (this includes marijuana). I will not use narcotic medications unless provided to me from my provider.

_____I agree to provide samples for random drug testing when asked. If I fail to provide the sample when asked or if the results are unsatisfactory, I may forfeit the right to continue receiving the medication.

_____If my provider is concerned that I might have a substance abuse problem, I must agree to an evaluation by a specialist in abuse/addiction. If the evaluation suggests I have a drug abuse problem, my provider may stop my medication in a way that does not cause withdrawal symptoms.

_____I will not get early refills unless something has dramatically changed and then only if my provider agrees.

_____I recognize that opioids by themselves, in combination with alcohol or in combination with other medications can result in unclear thinking and loss of coordination. I agree to contact my provider if these symptoms arise. I should not drive or operate equipment if I have these side effects.

_____It is my responsibility to keep my medications safe. If opioids are lost, damaged or stolen, the medication may or may not be refilled early. Each case will be looked at individually. If the medication is stolen, I must file a police report and submit the number for verification to my provider's office. Again, stolen medications may or may not be refilled. If a refill is given, it will be given only once.

_____If a new condition develops that causes acute pain, I have the right to expect appropriate treatment for that new condition from the provider treating me for the new condition. I should not be required to increase the use of my chronic pain medication for a serious and new pain.

_____I understand that if my provider does not feel I am following through adequately with the treatment plan, my provider may lower or stop the opioid altogether.

_____I understand that my provider may decide to stop the opioid if after increasing it adequately, my pain and function have not responded positively.

By signing this form, I authorize my provider's office to contact any and all groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies. This also gives these caregivers and pharmacies permission to share with my provider information about my past treatments and care.

_____

PATIENT SIGNATURE DATE

_____

HEALTH CARE PROVIDER DATE

8925 W. Russell Road, Suite 200 Las Vegas, NV 89148
Phone: (702) 870-0011 Fax: (702) 870-1144

_____

Patient's Name

Controlled Substance Questionnaire

	YES	NO	N/A
N/A means not applicable.			
Have you ever used a controlled substance in a way other than prescribed?	____	____	____
Have you ever diverted a controlled substance to another person?	____	____	____
Have you ever taken a controlled substance that did not have the desired effect?	____	____	____
Are you currently using any drugs, including alcohol or marijuana?	____	____	____
Are you using any drugs that may negatively interact with a controlled substance?	____	____	____
Are you using any drugs that were not prescribed by a practitioner that is treating you?	____	____	____
Have you ever attempted to obtain an early refill of a controlled substance?	____	____	____
Have you ever made a claim that a controlled substance was lost or stolen?	____	____	____
Have you ever been questioned about your pharmacy report or PMP report?	____	____	____
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	____	____	____
Have you ever been accused of inappropriate behavior or intoxication?	____	____	____
Have you ever increased the dose or frequency of meds without telling your provider?	____	____	____
Have you ever had difficulty with stopping the use of a controlled substance?	____	____	____
Have you ever demanded to be prescribed a controlled substance?	____	____	____
Have you ever refused to cooperate with any medical testing or examinations?	____	____	____
Have you ever had a history of substance abuse of any kind?	____	____	____
Has there been any change in your health that might affect your medications?	____	____	____
Have you misused or become addicted to a drug, or failed to comply with instructions?	____	____	____
Are there any other factors that your practitioner should consider before prescribing?	____	____	____

_____	_____	_____
Patient's Signature	Patient's Printed Name	Date
_____	_____	_____
Parent/Legal Guardian	Parent/Legal Guardian	Date

PRESCRIPTION OPIOID MISUSE INDEX

1. Do you ever use MORE of your medication, that is, take a higher dosage, than is prescribed for you? Yes No

2. Do you ever use your medication MORE OFTEN, that is, shorten the time between dosages? Yes No

3. Do you ever feel high or get a buzz after using your pain medication? Yes No

4. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain? Yes No

5. Have you ever gone to multiple physicians including emergency room doctors, seeking more of your pain medication? Yes No

6. Do you ever need early refills for your pain medication? Yes No

Name_____

Date_____

Name_____

Date_____

Beck's Depression Inventory

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

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.

Name_____

Date_____

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 of my 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.

Name_____

Date_____

20.

0 I am no more worried about my health than usual.

1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much 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.

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