Bridger Psychiatric Services

Thank you for choosing Bridger Psychiatric Services (BPS). It is our mission to provide the most comprehensive and effective care possible. A responsible partnership between the physician, staff and patient will ensure you receive the most accurate and efficient treatment possible.

The following is a patient contract meant to ensure you are appropriately acquainted with our office policies and practices. Review this contract carefully and discuss any questions you may have with staff.

Confidentiality/Privacy Practices:
BPS complies with HIPAA regulations regarding the disclosure of health care information. We are legally required to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this contract so long as it remains in effect. We reserve the right to change the terms of this contract, as necessary. You may receive a copy of any revised contracts in the office or by mail.

All records are strictly confidential and none of your records will be released to a third party without a written release of information. Exceptions to the rule of confidentiality include situations in which you may be deemed a serious threat to yourself or others, situations where there is suspicion of neglect or abuse of children, elder adults, or other vulnerable adults. If a serious threat of harm is present, your information will be released to the appropriate parties to protect yourself or others. Care details may also be shared as part of continuity of care among current providers. Patient records are maintained for seven years by BPS, after which time they are destroyed.

We are permitted by law to make certain other uses and disclosures of your personal health information without your consent or authorization.

- Any purpose required by law.
- Public Health activities such as required reporting of disease, injury, births, deaths, immunization information and for required public health investigations.
- If we suspect abuse or neglect of a child, elder adult, or other vulnerable adult.
- To the Food and Drug Administration if necessary to report adverse events, products, defects, or to participate in product recalls.
- If required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- If required to do so by a court or administrative ordered subpoena or discovery request; in most cases, you will have notice of such release.
- To law enforcement officials as required by law to report wounds, injuries, and crimes.
- If you are a member of the military as required by armed forces services, we may also release your personal health information if necessary for national security or intelligence activities.

Access to Your Personal Health Information:
You have the right to your personal health information. All requests for access must be completed in writing and signed by you or your representative. We will charge a fee if you request this information. You may obtain a record release form from our office.

You have the right to request that your personal health information to be amended or corrected. We are not obligated to make all requested amendments; however, we will give each request careful consideration. All amendment requests must be in writing and must state the reasons for the request.

Insurance/Billing:
It is your responsibility to contact your insurance company and verify your mental health benefits. We must have a copy of your current insurance card to process your claims correctly. You must keep BPS informed about changes in insurance. If the correct insurance information has not been provided to BPS, you are financially liable for all expenses, and it is your responsibility to submit any claims to the proper insurance company should you wish to do so.

You are authorizing BPS to contact your insurance company in reference to claims and to release documentation that is requested to process claims on your behalf.

We are in-network with **Medicare Part B, Montana Medicaid, and Mountain Health Co-Op.** BPS is not responsible for submitting to an out-of-network insurance company and has the right to refuse to do so. If we are not in network with your insurance, be prepared to pay for your office visits in full at the time of service.

If your insurance company rejects a claim for any reason, you are responsible for payment in full.

Any disputes regarding payment by your insurance are solely the responsibility of the patient and are to be resolved between the patient and insurance company.

I further agree and understand that claims will only be submitted that accurately reflect diagnosis(es) that are documented within my medical record, and that asking our clinic to otherwise is considered a fraudulent act.

I understand that there are some services and fees which are not covered by insurance, such services will be disclosed when relevant and detailed billing information will be provided.

If a third party is responsible for payment, you need to sign a release of information for that party to access detailed billing information.

We accept cash, checks, money orders and debit/credit cards. If we receive a returned check a fee will be added to your account for the returned check, and we may no longer accept your checks.

Failure to maintain a current balance may result in termination of services as well as collection activity. Our office will add a 30% fee for all accounts sent to a collection service, and you will be liable for this expense in addition to any fees accrued through the collections service.

If you have extenuating circumstances, please discuss payment options with the billing manager.

Appointments:
I agree to attend and be on time to all my scheduled appointments and understand that failing to do so will result in fees up to the full cost of the scheduled appointment. I understand that repeated offenses may result in being discharged from the practice. Cancellations must be made within 24 hours prior to the appointment time and understand that failure to do so will result in a late cancellation fee.

You are required to schedule and maintain regular follow-up visits per physician's instructions of the effectiveness of medication. Failing to make and keep follow-up appointments could result in lapses in medication and possible discharge from the clinic.

Telehealth:
The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. By agreeing to use these telehealth/telemedicine services, I understand, agree, and expressly consent to BPS obtaining, using, storing, and disseminating to necessary third parties, information about me, as necessary to provide the telehealth/telemedicine services and for billing purposes.

I understand that if I am utilizing insurance to cover telehealth/telemedicine services that the telehealth/telemedicine services may not be covered by my insurance plan, and it is my responsibility to look into my insurance coverage guidelines. I understand that I am financially liable for any outstanding balances not covered by my insurance.

I understand that when agreeing to telehealth/telemedicine services I am required to do so within a quiet and confidential space with secure and reliable service connection. If I am unable to do so, services may not be completed at that time and there may be associated fees. I understand that this is to protect my privacy and to create the optimal space for effective treatment.

Professional Fees:
Fees are listed on the Cost of Services Document. In addition to regular appointments, it is policy to charge the psychiatric hourly rate on a prorated basis for other professional services required. Other services include report

writing, letter writing, telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals which have been authorized, preparation of records or treatment summaries, and time spent performing any other professional service.

Our providers find that it is often unhelpful to participate in legal proceedings related to mental health and will decline to participate if asked to take part in any legal or court proceedings. If it becomes necessary for one of our providers to participate in a legal or court proceeding, there is a $350.00 per hour fee. You will be charged this rate for travel time, waiting time, preparation, and appearance time. Fees are due a week in advance of appearance, with any remaining fees to be billed upon completion of appearance.

Medication:
There is a 48-hour turnaround time for all prescription refills. Requests made over the weekend, or on holidays may take additional time. Refill requests made with less than 48-hour notice will not be filled immediately and may result in lapses in medication.

- I will take medications as prescribed by the physician.
- I will not misuse, change medication, or change doses of medications without first consulting with my physician.
- I will not sell, share, or give any of my medications to another person.
- I will inform my physician of all medications I am taking including those prescribed by other physicians as well as any over-the-counter medications or herbal remedies.
- I will inform my physician of any side effects or adverse reactions I may be having immediately.
- I understand that abruptly discontinuing my medications without the physician's knowledge may result in mild to severe withdrawal symptoms.
- I understand that combining alcohol, or other substances, with certain medications can promote depression and can cause sleep disturbances as well as other adverse reactions. Such substance use may also result in discontinuation of the prescribed medication.
- I agree to abstain from illegal substances and any other addictive substances that my doctor recommends be avoided, and to be open and honest about any use that occurs.
- I understand that I may be randomly evaluated for medication adherence or misuse at any time by oral swab or urinalysis.
- I agree that it is my responsibility to keep my medication in a safe and secure place. I further understand that if a medication is lost or stolen it may not be replaced, at the discretion of my provider.

I understand that failure to meet these guidelines may result in termination of services.

I understand that controlled substances cannot be sent across state lines by my provider and that I may only fill my medications within the state of Montana. I recognize that this means if I require any early or extended fills for travel it is my sole responsibility to work with my provider to obtain these fills with at least a week's notice prior to needing the fill. I also recognize that due to the nature of controlled substances early or extended fills may be denied by my provider, may not be covered by my insurance, and may also be denied being filled by my pharmacy.

Drug Screening:
I acknowledge that as part of my treatment I may be asked to complete an oral swab or urinalysis at random to monitor medication compliance as well as substance use. I understand that I may refuse to complete these screenings, however, doing so may impact my medication fills or my status as patient with BPS.

I understand that I am liable for any expenses incurred from such drug screening.

Conduct:
I agree to conduct myself in a courteous manner with physicians, staff members, and other patients in the office and on the phone. I understand that failure to do so may result in termination from the clinic.

I agree not to conduct any illegal or disruptive activities at BPS. I understand that any illegal or disruptive behaviors/activities observed, or suspected, by office staff or the employees of my pharmacy will be reported to my provider and could result in termination of services.

Emergency Contact Information:

If there is a medical emergency that demands immediate attention, call 911 or go to the nearest emergency room.

For all other emergencies direct your phone calls to our office at (406) 586-5511.

If it is after normal business hours (Monday - Thursday 8:00am-5:00 pm and Friday 8:00 am-12:00pm) please call the **Help Center at (406) 586-3333** and have Dr. Olson paged.

I have read and fully understand all the information contained in the treatment contract. Failure to comply with the treatment contract may result in my being discharged from the clinic.

Printed Patient Name	Patient Signature	Date

Printed Patient Guardian Name (If Applicable)	Guardian Signature	Date

Patient Demographics

Patient Information

Name: _____ Date of birth: _____
First Middle Last

Telephone Number: (home)_____ (cell) _____ (work):_____

Physical address:_____
Street City State Zip

Mailing address:_____
Street City State Zip

Social Security Number:_____

Emergency Contact Information

Name: _____Phone:_____Realtionship:_____

Address:_____
Street City State Zip

Employment Information

Employer: _____ Phone: _____

Address: _____
Street City State Zip

Insurance Information

Name of Insurance:_____

ID Number: _____Group number:_____ Date coverage began:_____

Subscriber's name:_____ Subscriber's date of birth:_____

*****Please Present Any Insurance Cards You Have to the Front Desk**

Preferred Pharmacy:

_____
Street City State Zip

Adult Intake Questionnaire

In order for us to be able to fully evaluate you, please fill out the following questionnaire to the best of your ability. We realize there may be information that you do not remember or have access to, do the best you can. Thank you!

WHY DID YOU SEEK EVALUATION AT THIS TIME? (Include anything that is stressful for you, examples include relationships, job, school, finances, children)

_____
_____
_____
_____

WHAT IDEAS DO YOU HAVE ABOUT WHAT NEEDS TO HAPPEN FOR IMPROVEMENT TO OCCUR? (Often people have a good idea about what is causing the problem, and what they feel will resolve it.)

_____
_____
_____
_____
_____

WHAT HAVE YOU TRIED TO HELP THE PROBLEM OR SITUATION SO FAR? DID IT HELP? IF SO, HOW DID IT HELP? IF NOT, WHY DIDN'T IT HELP?

_____
_____

WHAT STRENGTHS DO YOU POSSESS THAT HAVE HELPED YOU IN THE PAST AND WILL CONTINUE TO FACILITATE YOUR IMPROVEMENT AFTER TODAY? (Strengths may include such things as; hobbies or activities, relationships, and/or personality traits).

_____
_____
_____
_____

WHAT DO YOU HOPE TO GAIN FROM TODAY'S CONSULTATION?

_____
_____
_____

PRIOR PSYCHIATRIC HISTORY (Please include contact with other professionals and reason for treatment, medication, types of treatment, etc).

_____
_____
_____

MEDICAL HISTORY

PRESENT HEIGHT: _____ PRESENT WEIGHT: _____

Current medical problems (Include abnormal lab tests, X-rays, EEG, etc.) and medications:

_____
_____
_____

PRIMARY CARE PHYSICAN/OTHER DOCTORS/CLINICS SEEN REGULARLY:

_____
_____

HISTORY OF HEAD TRAUMA, SEIZURES, OR SEIZURE LIKE ACTIVITY, PERIODS OF SPACINESS OF CONFUSION? (Please circle all that apply to you and describe in the space below).

_____
_____
_____

PRIOR HOSPITALIZATIONS (Place, Cause, Date, and Outcome).

_____
_____
_____

ALLERGIES/DRUG INTOLERANCES (Please Describe):

_____
_____
_____

FAMILY HISTORY

FAMILY STRUCTURE (Who do you currently live with, add other information as necessary):
_____
_____
_____

SIGNIFICANT DEVELOPMENTAL EVENTS (Include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.):
_____
_____
_____

CURRENT MARITAL OR RELATIONAL SITUATION/SATISFACTION:
_____
_____

EDUCATIONAL HISTORY

Last grade completed _____

Average grades received_____

Any academic problems?
_____

Learning Strengths:
_____
_____

Any behavior problems in school?
_____
_____

What would your teachers have said about you?
_____
_____
_____

NATURAL MOTHER'S HISTORY: Age_____ Occupation_____
School: Highest grade completed_____
Learning Problems_____
Behavior Problems_____
Medical Problems_____

Mother's childhood atmosphere (family position, abuse, illnesses, etc)

_____

_____

Has your mother ever sought psychiatric treatment? (Please circle) YES NO
If yes, for what purpose?

_____

_____

Mother's alcohol/drug history_____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Please specify)

_____

_____

_____

NATURAL FATHER'S HISTORY: Age_____ Occupation_____
School: Highest grade completed_____
Learning Problems_____
Behavior Problems_____
Medical Problems_____
Father's childhood atmosphere (family position, abuse, illnesses, etc)

_____

_____

Has your father ever sought psychiatric treatment? (Please circle) YES NO
If yes, for what purpose?

_____

_____

Father's alcohol/drug history_____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Please specify)

_____

_____

_____

SIBLINGS (Names, ages, problems, strengths, quality of relationship with you):

_____

_____

_____

CHILDREN: (Names, ages, problems, strengths)

EMPLOYMENT HISTORY (Summarize jobs you've had, list most favorite and least favorite)

What would your employers or supervisors have said about you?

DESCRIBE YOUR RELATIONSHIPS WITH FRIENDS:

MILITARY HISTORY:

LEGAL PROBLEMS (Current and Past):

PLEASE LIST AND DESCRIBE ANY INFORMATION THAT HAS NOT BEEN ADDRESSED ABOVE THAT YOU BELIEVE IS IMPORTANT FOR TODAY'S EVALUATION

MEDICAL REVIEW OF SYSTEMS (Please check all that apply)

GENERAL

- ☐ Poor appetite
- ☐ Abnormal sensitivity to cold
- ☐ Cold sweats during the day
- ☐ Decreased sexual interest
- ☐ Tired or worn out
- ☐ Hot or cold spells
- ☐ Abnormal sensitivity to heat
- ☐ Increased appetite
- ☐ Excessive sleeping
- ☐ Increased sexual interest
- ☐ Difficulty sleeping
- ☐ Lowered resistance to infection
- ☐ Flu-like or vague sick feeling
- ☐ Sweating excessively at night
- ☐ Being overweight
- ☐ Excessive daytime sweating
- ☐ Urinating excessively
- ☐ Excessive thirst
- ☐ Weight gain
- ☐ Weight loss

NEUROLOGICAL

- ☐ Pacing due to muscle restlessness
- ☐ Decreased movement
- ☐ Forgotten periods of time
- ☐ Emotion causes brief paralysis
- ☐ Disorientation
- ☐ Dizziness
- ☐ Drowsiness
- ☐ Muscle spasms or tremors
- ☐ Excessive clumsiness
- ☐ Impaired ability to think
- ☐ Passing out
- ☐ Impaired ability to remember
- ☐ Muscle stiffness
- ☐ Other_____
  _____
- ☐ "Tics"
- ☐ Nightmares
- ☐ Numbness
- ☐ Paralysis
- ☐ Tingling or "burning" feeling
- ☐ Convulsions/fits
- ☐ Slurred speech
- ☐ Speech Problem (other)_____
- ☐ Fainting
- ☐ Shaking
- ☐ Spinning feeling
- ☐ Weakness (localized)
- ☐ Weakness (generalized)

RESPIRATORY

- ☐ Asthma
- ☐ Cough
- ☐ Shortness of breath
- ☐ Coughing up blood
- ☐ Other_____
  _____
- ☐ Rapid breathing
- ☐ Coughing up sputum
- ☐ Repeated nose or chest colds
- ☐ Wheezing

HEAD, EYE, EAR, NOSE, & THROAT

- ☐ Facial pain
- ☐ Headache
- ☐ Head injury
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Neck swelling
- ☐ Pain behind ear
- ☐ Pain from jaw movement
- ☐ Pain in temple
- ☐ Scalp itching
- ☐ Trouble swallowing
- ☐ Other:_____
  _____

GASTROINTESTINAL AND HEPATIC

- ☐ Abdominal (stomach/belly pain)
- ☐ Anal (or rectal) pain
- ☐ Infrequent bowel movements
- ☐ Other_____
  _____

EYE

- ☐ Blindness
- ☐ Blurred vision
- ☐ Bloodshot or red eye
- ☐ Double vision
- ☐ Feels something in eye
- ☐ Eye pain
- ☐ Farsightedness
- ☐ Other_____
  _____
- ☐ Increased tearing
- ☐ Itching of eyes
- ☐ Loss of vision from the side
- ☐ Nearsightedness
- ☐ Night blindness
- ☐ Overly sensitive to light
- ☐ Spots before eyes

EAR

- ☐ Hearing loss in both ears
- ☐ Ear discharge
- ☐ Ear pain
- ☐ Feeling of fullness in ear
- ☐ Other_____
  _____
- ☐ Ear itching
- ☐ Ear ringing
- ☐ Hearing loss in one ear

NOSE

- ☐ Disturbances in smell
- ☐ Nosebleeds
- ☐ Nose stuffiness
- ☐ Other_____
  _____
- ☐ Nose itchiness
- ☐ Runny nose
- ☐ Sneezing

MOUTH

- ☐ Dental (tooth or gum problems)
- ☐ Dry mouth
- ☐ Hoarseness
- ☐ Too much saliva in mouth
- ☐ Painful throat muscle spasms
- ☐ Other_____
  _____
- ☐ Sore throat
- ☐ Sore tongue
- ☐ Taste alteration
- ☐ Tickling feeling in throat

CHEST AND CARDIOVASCULAR

- ☐ Ankle swelling
- ☐ Rapid-irregular pulse
- ☐ Breast swelling
- ☐ Breast mass
- ☐ Breast tenderness
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Nipple leaking milk
- ☐ Nipple bleeding
- ☐ Nipple discharge
- ☐ Breastbone tenderness
- ☐ Other:_____
  _____

RECTAL HEALTH

- ☐ Painful bowel movements
- ☐ Discharge/leakage near anus
- ☐ Anal itching
- ☐ Rectal bleeding (red blood)
- ☐ Return of food into mouth
- ☐ Loss of bowel control
- ☐ Frequent belching or gas
- ☐ Frequent solid bowel movements
- ☐ Heartburn (acid up to mouth)
- ☐ Vomiting blood
- ☐ Jaundice (yellowing of skin)
- ☐ Nausea (sick to stomach)
- ☐ Other_____
  _____
- ☐ Black bowel movements
- ☐ Bulky, foul-smelling stools
- ☐ Mucus in stools
- ☐ Pencil thin stools
- ☐ Pus in stools
- ☐ Vomiting (throwing up)

MALE GENITOURINARY

- ☐ Itchy privates or genitals
- ☐ Painful urination
- ☐ Groin pain
- ☐ Blood in urine
- ☐ Impotence (weak male erection)
- ☐ Inability to ejaculate
- ☐ Frequent urination at night
- ☐ Insufficient urination
- ☐ Other_____
  _____
- ☐ Pus in urine
- ☐ Testicular (ball) swelling
- ☐ Scrotal (ball) pain
- ☐ Pain above pubic hair area
- ☐ Abnormal penis discharge
- ☐ Excessive urination
- ☐ Accidental wetting of self
- ☐ Difficulty in starting urine
- ☐ Excessive urgency to urinate

FEMALE GENITOURINARY

- ☐ No menstrual period
- ☐ Itchy privates or genitals
- ☐ Vaginal bleeding with sex
- ☐ Painful menstrual periods
- ☐ Painful intercourse or sex
- ☐ Painful urination
- ☐ Groin pain
- ☐ Blood in urine
- ☐ Sterility infertility
- ☐ Menstrual irregularity
- ☐ Frequent urination at night
- ☐ Insufficient urination
- ☐ Other_____
  _____
- ☐ Nonvaginal pain between thighs
- ☐ Severe premenstrual discomfort
- ☐ Pus in urine
- ☐ Pain above pubic hair area
- ☐ Excessive urination
- ☐ Accidental wetting of self
- ☐ Difficulty in starting urine
- ☐ Excessive urgency to urinate
- ☐ Vaginal pain (not with sex)
- ☐ Abnormal vaginal discharge
- ☐ Vaginal bleeding between periods
  Date of last menstrual period _____

MUSCULOSKELETAL

- ☐ Back pain
- ☐ Back stiffness
- ☐ Bone pain
- ☐ Buttocks to ankle pain
- ☐ "Heavy" legs
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Leg pain
- ☐ Muscle cramps
- ☐ Muscle pain
- ☐ Repeated bone fractures
- ☐ Other:_____
  _____

SKIN, HAIR, AND LYMPH NODES

- ☐ Drying of hair
- ☐ Skin Swelling
- ☐ Dry skin
- ☐ Easy bruising
- ☐ Hair loss
- ☐ Increased perspiration
- ☐ Abnormal change in mole(s)
- ☐ Tender lymph nodes
- ☐ Skin rash due to sun exposure
- ☐ Itchy skin
- ☐ Other_____
  _____
- ☐ Skin sore not healing
- ☐ Skin rash
- ☐ Skin ulcer/open sore
- ☐ Skin bleeds easily
- ☐ Sweaty palms
- ☐ Thinning hair
- ☐ Hives

This questionnaire contains items about emotions, mood, thoughts, and behaviors. Please circle the corresponding number 1-4 that best describes the frequency you experience.

1-Rarely or never
2-Frequently
3-Often
4-Very often

During the past two weeks have you…

1 2 3 4 Felt sad or depressed?
1 2 3 4 Felt sad or depressed for most of the day, nearly every day ?
1 2 3 4 Got less joy or pleasure from almost all of the things you normally enjoy?
1 2 3 4 Been less interested in almost all of the activities you are usually interested in?
1 2 3 4 Had a significantly lower appetite than usual nearly every day?
1 2 3 4 Had a significantly greater appetite than usual nearly every day?
1 2 3 4 Slept at least 1-2 hours less than usual nearly every day?
1 2 3 4 Slept at least 1-2 hours more than usual nearly every day?
1 2 3 4 Felt very jumpy and physically restless and had a lot of trouble sitting calmly in a chair nearly every day?
1 2 3 4 Felt tired out nearly every day?
1 2 3 4 Frequently felt guilty about things you have done?
1 2 3 4 Put yourself down and had negative thoughts about yourself nearly every day?
1 2 3 4 Felt like a failure nearly every day?
1 2 3 4 Had problems concentrating nearly every day?
1 2 3 4 Had more difficulty making decisions nearly every day?
1 2 3 4 Frequently thought of dying in passive ways like going to sleep and not waking up?
1 2 3 4 Wished you were better off dead?
1 2 3 4 Thought you'd be better off dead?
1 2 3 4 Had thoughts of suicide, even though you would not really do it?
1 2 3 4 Seriously considered taking your life?
1 2 3 4 Thought about a specific way of taking your life?

During the past two years have you…

1 2 3 4 Felt sad or down on most days?
1 2 3 4 Had a poor appetite or overate on most days?
1 2 3 4 Had difficulty with not sleeping enough or oversleeping on most days?
1 2 3 4 Felt tired out on most days?
1 2 3 4 Had problems concentrating on making decisions on most days?
1 2 3 4 Had low self-esteem on most days?
1 2 3 4 Felt hopeless about the future on most days?

Have you ever experienced a traumatic event such as combat, rape, assault, sexual abuse or any other extremely upsetting event? Y N

Have you ever witnessed a traumatic event such as rape, assault, someone dying in an accident, or any other extremely upsetting event? Y N

How frequently do these symptoms occur?

1 2 3 4 Thoughts about a traumatic event frequently pop into your mind?
1 2 3 4 Getting upset because you were thinking about a traumatic event?
1 2 3 4 Bothered by memories or dreams of a traumatic event?
1 2 3 4 Reminders of a traumatic event cased you to feel intense distress?
1 2 3 4 Tried to block out thoughts or feelings related to a traumatic event?
1 2 3 4 Avoided activities, place, or people that reminded you of a traumatic event?
1 2 3 4 Had "flashbacks," where it felt like you were reliving a traumatic event?
1 2 3 4 Reminders of a traumatic event made you shake, break out into a sweat, or have a racing heart?
1 2 3 4 Felt distant or cutoff from other people because of having experienced a traumatic event?
1 2 3 4 Felt emotionally numb because of having experienced a traumatic event?
1 2 3 4 Did you give up on goals for the future because of having experienced a traumatic event?
1 2 3 4 Kept your guard up because of having experienced a traumatic event?
1 2 3 4 Were jumpy and easily startled because of having experienced a traumatic event?

During the past two weeks have you…

1 2 3 4 Gone on eating binges (eating a very large amount of food very quickly over a short period of time?
1 2 3 4 Felt you could not control how much you were eating during an eating binge?
1 2 3 4 Gone on eating binges during which you ate a large amount of food even when you didn't feel hungry?
1 2 3 4 Ate alone during an eating binge because you were embarrassed by how much you were eating?
1 2 3 4 Gone on eating binges and then felt disgusted with yourself after overeating?
1 2 3 4 Been upset with yourself because you were going on eating binges?

1 2 3 4 Gone on strict diets or exercised excessively to prevent weight gain?
1 2 3 4 Forced yourself to vomit or use laxative or water pills to prevent gaining weight from an eating binge?
1 2 3 4 Focused on your weight or body shape as the most important things that affected you opinion of yourself?

During the past two weeks have you…

1 2 3 4 Worried obsessively about dirt, germs, or chemicals?
1 2 3 4 Worried obsessively that something bad would happen because you forgot to do something important like locking the door or turning off the stove?
1 2 3 4 Felt compelled to do things over and over (for at least ½ hour per day) that you could not stop when you tried?
1 2 3 4 Felt compelled to do things over and over even though it interfered with getting other things done?
1 2 3 4 Washed and cleaned yourself or things around you obsessively and excessively?
1 2 3 4 Counted things obsessively or excessively?

During the past two weeks have you…

1 2 3 4 Been very scared because you heart was beating fast?
1 2 3 4 Been very scared because you were short of breath?
1 2 3 4 Been very scared because you were feeling shaky or faint?
1 2 3 4 Had sudden attacks of very intense anxiety or fear that came on from out of the blue, for no reason at all?
1 2 3 4 Had sudden attacks of very intense anxiety or fear during which you thought something terrible might happen, such as you might die, go crazy, or lose control?
1 2 3 4 Had sudden, unexpected attacks of anxiety during which you had 3 or more of the following symptoms: heart racing or pounding, sweating, shakiness, shortness of breath, nausea, dizziness, or feeling faint?
1 2 3 4 Worried a lot about having unexpected anxiety attacks?
1 2 3 4 Had attacks of anxiety that caused you to avoid certain situations or to change your behavior or normal routine?

During the past two weeks have you…

1 2 3 4 Felt excessively cheerful and happy, much more than usual, and the good mood lasted most of the day for at least several days?
1 2 3 4 Felt extremely self-confident, much more than usual?
1 2 3 4 Had so much positive energy that you needed less sleep than usual to feel rested?
1 2 3 4 Talked much more than usual, or felt a pressure to talk constantly?
1 2 3 4 Taken on new projects or responsibilities because you thought you could do everything?
1 2 3 4 Done impulsive things that are out of character for you like going on spending sprees, investing money, or doing things sexually that are unusual for you?

During the past two weeks have any of the following occurred…

1 2 3 4 Things happened that you knew were true, but other people told you were your imagination?
1 2 3 4 Thought that other people were watching you, talking about you, or spying on you?
1 2 3 4 Thought that you were in danger because someone was plotting to hurt you?
1 2 3 4 Thought that you were in danger because someone was plotting to hurt you?
1 2 3 4 Thought that you had special powers other people didn't have?
1 2 3 4 Thought that some force or power from the outside was controlling your body or mind?
1 2 3 4 Heard voices that other people didn't hear, or see things that other people didn't see.

During the past six months have you…

1 2 3 4 Worried a lot about embarrassing yourself in front of others?
1 2 3 4 Worried a lot that you might do something to make people thing that you were stupid or foolish?
1 2 3 4 Felt very nervous in situations where people might pay attention to you?
1 2 3 4 Been extremely nervous in social situations?
1 2 3 4 Regularly avoided situations because you were afraid you'd do or say something to embarrass yourself?
1 2 3 4 Worried a lot about doing or saying something to embarrass yourself in any of the following situations?

- ☐ Public speaking.
- ☐ Eating in front of other people.
- ☐ Using public restrooms.
- ☐ Writing in front of others
- ☐ Saying something stupid when you're with a group of people.
- ☐ Asking a question when in a group of people.
- ☐ Business meetings.
- ☐ Parties or other social gatherings.

1 2 3 4 Almost always been very anxious as soon as you were in any of the above situations?

1 2 3 4 Avoided any of the above situations because they made you feel anxious or fearful?

During the past six months have you…

1 2 3 4 Thought that you were drinking too much?
1 2 3 4 Had someone in your family think or say that you were drinking too much, or that you had an alcohol problem?
1 2 3 4 Had friends, a doctor, or anyone else think or say that you were drinking too much?
1 2 3 4 Thought about cutting down or limiting your drinking?
1 2 3 4 Thought you had a drug problem?
1 2 3 4 Had problems in you marriage, job, with your friends or family, doing household chores, or in any other important area of your life because of your drinking?

During the past six months have you…

1 2 3 4 Thought that you were using drugs too much?
1 2 3 4 Had anyone in your family think or say that you were using drugs too much?
1 2 3 4 Had friends, a doctor, or anyone else think or say that you were using drugs too much?
1 2 3 4 Thought about cutting down or limiting your drug use?
1 2 3 4 Thought you had a drug problem?
1 2 3 4 Had problems in your marriage, your job, with your friends or family, doing household chores, or in any other important area of your life?

During the past six months have you…

1 2 3 4 Been nervous on most days of the past 6 months?
1 2 3 4 Worried a lot that bad things might happen to you or someone close to you?
1 2 3 4 Worried about things that other people said you shouldn't worry about?
1 2 3 4 Been worried or anxious about a number of things in you daily life on most days?
1 2 3 4 Felt restless or on edge because you were worrying?
1 2 3 4 Had problems falling asleep because you were worrying about things?
1 2 3 4 Felt tension in you muscles because of anxiety or fear?
1 2 3 4 Experienced difficulty concentrating because your mind was on your worries?
1 2 3 4 Been snappy or irritable because you were worrying or feelings stressed out?
1 2 3 4 Had difficulty controlling or stopping your worrying on most days of the past 6 months?

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1 2 3 4 Has your physical health has been poor most of your life?

During the past six months have you…

1 2 3 4 Had stomach and intestinal problems such as nausea, vomiting, excessive gas, stomach bloating, or diarrhea?
1 2 3 4 Been bothered by aches and pains in many different parts of your body?
1 2 3 4 Been sick more than most people?
1 2 3 4 Had doctors that are usually unable to find a physical cause for your physical symptoms?

During the past six months have you…

1 2 3 4 Often worried that you might have a serious physical illness?
1 2 3 4 Found it hard to stop worrying that you have a serious physical illness?
1 2 3 4 Had difficulty stopping thoughts that you had a serious illness even though your doctor said you didn't have one?
1 2 3 4 Worried so much about having a serious illness that it interfered with your activities?
1 2 3 4 Visited the doctor a lot because you were worried that you had a serious physical illness?

How frequently do you experience these symptoms?
0-Never
1-Rarely
2-Sometimes
3-Often
4-Very Often

0 1 2 3 4 Make careless mistakes when you have to work on a boring or difficult project?
0 1 2 3 4 Experience difficulty keeping your attention when you are doing boring or repetitive work?
0 1 2 3 4 Experience difficulty concentrating on what people say to you even when they are speaking to you directly?
0 1 2 3 4 Have trouble wrapping up the final details of a project, once the challenging parts have been done?
0 1 2 3 4 Have difficulty getting things in order when you have to do a task that requires organization?
0 1 2 3 4 Delay getting started when you have a task that requires a lot of thought?
0 1 2 3 4 Misplace or have difficulty finding things at home or at work?
0 1 2 3 4 Distracted by activity or noise around you?
0 1 2 3 4 Have problems remembering appointments or obligations?

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0 1 2 3 4 Fidget or squirm with your hands or feet when you have to sit down for a long time?
0 1 2 3 4 Leave your seat in meetings or other situations in which you are expected to remain seated?

0 1 2 3 4 Feel restless or fidgety?
0 1 2 3 4 Have difficulty unwinding and relaxing when you have time to yourself?
0 1 2 3 4 Feel overly active and compelled to do things, like you were driven by a motor?
0 1 2 3 4 Find yourself talking too much when you are in social situations?
0 1 2 3 4 Find yourself finishing the sentences of other people you are talking to, before they can finish them themselves?
0 1 2 3 4 Have difficulty waiting your turn in situations when taking turns is required?
0 1 2 3 4 Interrupt others when they are busy?