Bridger Psychiatric Services

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:_____

Preferred Pharmacy:

_____
Street City State Zip

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.

Medication:
There is a 48-hour turnaround time for all prescription refills. Refill requests made with less than 48 hours 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 doses of medications without first consulting with my physician.
- I will inform my physician of all medications I am taking including those prescribed by other physicians as well as any over-the-counter/herbal remedies.
- I will inform my physician of any side effects or adverse reactions I may be having.
- Abruptly discontinuing my medications without the physician's knowledge may result in mild to severe withdrawal symptoms.
- Combining alcohol with certain medications can promote depression and can cause sleep disturbances as well as other adverse reactions.

Initial that you reviewed this section _____

Emergency Contact Information:
During normal business hours: Monday - Thursday 8:00am-6:00 pm and Friday 8:00 am-12:00pm, direct all emergency phone calls to the office at 406-586-5511. If it is after business hours, please call the Help Center at 406-586-3333 and have Dr. Olson paged. Our office will always have a physician on call through the Help Center. If you are in crisis you may also go directly to the emergency room or call 911.

Initial that you have reviewed this section _____

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 have read through 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.

_____ Date_____
Patient/Guardian Signature

_____ Date_____
Reviewed with Patient

_____ Date_____
Physician Signature

Bridger Psychiatric Services

Thank you for choosing Bridger Psychiatric Services. 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 your physician or a staff members.

Confidentiality/Privacy Practices:
Bridger Psychiatric Services complies with HIPPA regulations regarding the disclosure of health care information. We are required by law 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 the notice so long as it remains in effect. We reserve the right to change the terms of this notice as necessary. You may receive a copy of any revised notices at our office or by mail

All of your records are kept under strict confidentiality and none of your records may be released to a third party without a written release of information. There are two exceptions to the rule of confidentiality: 1) If you are deemed a serious threat to yourself or 2) If you are deemed a serious threat to others. If either of these conditions is present, your information will be released to the appropriate parties in order to protect yourself or others. Patient records are kept for seven years, after which time they are destroyed.
Initial that you have reviewed this section _____

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 child abuse or neglect.
- 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.

Initial that you have reviewed this section _____

Access to Your Personal Health Information:
You have the right to your personal health information. All requests for access must be made 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 be amended or corrected. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests must be in writing and must state the reasons for the request.
Initial that you have reviewed this section: _____

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 in order 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, it your responsibility to submit any claims to the proper insurance company.

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 Medicaid, Allegiance, Blue Cross Blue Shield, and Montana Health Co-op. We do not file any claims for Medicare or any secondary insurance where Medicare is primary. We do not accept Workman's Compensation. If we are not in network with your insurance, be prepared to pay for your office visits in full at time of service. Direct any insurance or billing questions to the office manager.

If your insurance company rejects a claim for any reason, you are responsible for payment in full. Failure to maintain a current balance may result in being discharged. If you have extenuating circumstances, please discuss payment options with the office manager.

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

We accept cash, checks, money orders or Visa and Mastercard. If we receive returned check we will no longer accept your checks and a fee will be assessed to your account.
Initial that you have reviewed this section _____

Appointments:
Late cancellations or missed appointments may result in being discharged from the practice. Cancellations must be made within 24 hours prior to the appointment time. Missed appointments and late cancellations will result in charges assessed for the cost of the appointment.

Bridger Psychiatric Services

Patient_____ Birth Date_____

I hereby authorize the use or disclosure of personal health information about me as described below.

1. BPS may release/obtain my personal health information to/from the following person(s) or group:

_____
Person/Facility/Agency

_____
Address City State Zip

2. I authorize release of the following information:

__Discharge Summary	__History & Physical	__Billing Info	__Aftercare Plan
__Psychiatric Exam	__Social History	__Labs	__HIV/AIDS Results
__Psychological Exam	__Progress Notes	__Dr. Orders	__Other(specify) _____

3. The purpose of the authorized use or disclosure:
   ____ At the request of the patient
   ____ Other
   (Describe)_____

4. If you are the representative of a patient, describe the scope of your authority to act on the patient's behalf:_____

5. I understand that I may revoke this authorization at any time except to the extent that action has been taking by Bridger Psychiatric Services in reliance on this authorization.

   Expiration Date: ____ / ____ / ____ (MM/DD/YY)

6. I understand that I am not required to sign this authorization form and that Bridger Psychiatric Services will not condition the provision of treatment or payment to me on the signing of this authorization.

_____ _____
Patient Signature (Or Representative) Date

_____ _____
Witness Date

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? Many times people have a pretty hood hunch not only about what is causing the problem, but also about what 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 STRENTHS DO YOU POSSESS THAT HAVE HELPED YOU IN THE PAST AND WILL CONTINUE TO FACILITATE YOUR IMPRVEMENT 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

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):

PRESENT HEIGHT: _____ PRESENT WEIGHT: _____

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

_____

_____

Mother's alcohol/drug history_____

Have any of you 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 you father ever sought psychiatric treatment? (Please circle) YES NO
If yes, for what purpose?

_____

_____

Father's alcohol/drug history_____

Have any of you 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 ABOUVE 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
- ☐ 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
- ☐ Difficulty sleeping
- ☐ Neck swelling
- ☐ Pain behind ear
- ☐ Pain from jaw movement
- ☐ Pain in temple
- ☐ Scalp itching
- ☐ Trouble swallowing

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
- ☐ Other_____
  _____

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Nipple leaking milk
- ☐ Nipple bleeding
- ☐ Nipple discharge
- ☐ Breastbone tenderness

GASTROINTESTINAL AND HEPATIC

- ☐ Abdominal (stomach/belly pain)
- ☐ Anal (or rectal) pain

- ☐ Painful bowel movements
- ☐ Discharge/leakage near anus

- ☐ 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_____

_____

- ☐ 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
- ☐ Black bowel movements

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Leg pain
- ☐ Muscle cramps
- ☐ Muscle pain
- ☐ Repeated bone fractures

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

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?