STAATS
PSYCHIATRIC SERVICES

NEW PATIENT REGISTRATION PACKET

Please complete ALL sections below

Patient Information:

Patient's Legal Name: _____
Preferred Name: _____ Pronoun: He: ____ She: ____ They: _____
Date of Birth: _____
Email: _____ Cell #: _____
Street: _____
City: _____ State: _____ Zip: _____

Communication:

I agree to receive text messages in various formats and contents from Staats Psychiatric Services.
Yes ☐ No ☐

Insurance and Guarantor Information:

Primary Insurance Carrier: _____
Member ID: _____ Group #: _____
Subscriber/Main Insured's Name: _____ Date of Birth: _____
Patient's Relationship to Subscriber: _____
Subscriber's School/Employer: _____

****

Secondary Insurance Carrier: _____
Member ID: _____ Group #: _____
Subscriber/Main Insured's Name: _____ Date of Birth: _____
Patient's Relationship to Subscriber: _____
Subscriber's School/Employer: _____

How did you hear about us? _____

Brief Personal History:

Did you finish High School? _____ Go to College? _____ Finish College? _____
Degree/Occupation/Employer: _____
What is your Sexual Orientation? Heterosexual: _____ Gay/Lesbian: _____ Bisexual: _____
What is your Marital Status? Single: _____ Married: _____ Divorced: _____ Widowed: _____
Committed Relationship: ___ Domestic Partnership: _____ (How Long? _____)

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Please list any known *MEDICATION* allergy: _____

Are you taking any prescription medications? ☐ **Yes** ☐ **No**

If yes, please fill out the section below. Please feel free to attach a list of all your Rx medicines if space provided below is not sufficient.

Current Prescription Medication			
Medicine Name:	Strength/Dose	How often taken	Date Started

Arthritis Yes No	Asthma Yes No	Cancer Yes No	Diabetes Yes No
Glaucoma Yes No	Heart Disease Yes No	Thyroid Disease Yes No	Allergies Yes No
Irritable Bowel Yes No	High Blood Pressure Yes No	High Cholesterol Yes No	Kidney Disease Yes No
Osteoporosis Yes No	Seizures Yes No	Anemia Yes No	Migraines Yes No
GERD Yes No	Other:		

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Are there any psychiatric medications that you have previously taken? If yes, please check below.

Antidepressants

__ Anafranil (Clominpramine)
__ Asendin(Amoxpine)
__ Celexa (Citalopram)
__ Cymbalta (Duloxetine)
__ Deplin (L-Methylfolate)
__ Trazodone(Desyrel)
__ Elavil(Amitryptaline)
__ Effexor (XR) (Venlafaxine)
__ Fetzima (Levomilnacipran)
__ Lexapro(Escitalopram)
__ Ludiomil(Maprotiline)
__ Marplan(Isocarboxazid)
__ Nardil(Pheneline)
__ Norpramin(Desipramine)
__ Parnate(Tranylcypromine
__ Pamelor or Aventyl(Nortryptaline)
__ Paxil(Paroxetine)
__ Prozac(Fluoxetine)
__ Pristiq(Desvenlafaxine)
__ Remeron(Mirtazinpine)
__ Serzone(Nefazodone)
__ Sinequan(Doxepin)
__ Surmontil(Trimipramine)
__ Tofranil(Imipramine)
__ Trintellix (vortioxetine)
__ Vivactil(Protriptylinne)
__ Viibryd
__ Wellbutrin(SR,XL)(Bupropion)
__ Zoloft(Sertraline)
__ Luvox (Fluvoxamine

Anxiolytic/Sedative/Hypnotic

__ Ambien (CR) (Zolpidem)
__ Ativan(Lorazepam)
__ Atarax/Vistaril(Hydroxyzine)
__ Bendadryl
__Belsomra (suvorexant)
__ Buspar(Buspirone)
__ Centrax(Prazepam)
__ Cogentin(Benztropine)
__ Dalmane(Flurazepam)
__ Halcion(Triazolam)
__ Inderal(Propranolol)
__ Klonopin(Clonazepam)
__ Librium(Chlordiazepoxide)
__ Noctec (Chloral Hydrate)
__ Phengram(Promethazine)
__ Restoril(Temazepam)
__ Serax(Oxazepam)
__ Tranxene(Clorazepam)
__ Valium(Diazepam)
__ Xanax(Alprazolam)

Antipsychotics

__ Abilify(Aripiprazole)
__ Clozaril(Clozapine)
__ Fanapt(Iloperiddone)
__ Geodon(Ziprasidone)
__ Haldol(Haloperidol)
__ Loxitane(Loxapine)
__ Latuda(Lurasidone)
__ Mellaril(Thioridazien)
__ Moban(Molindone)
__ Navane(Thiothixene)
__ Orap(Primozine)
__Prolixin(Fluphenazine)
__ Rexulti (brexpiprazole)
__ Risperdal(Risperidone)
__ Saphris (Asenapine)
__ Serentil(Mesoridazine)
__ Seroquel(Quetiapine)
__ Stelazine(Trifluoperazine)
__ Thorazine(Chlorpromazine)
__ Invega(Paliperidone)
__Trilafon(Perphenazine
__ Vraylar (cariprazine)
__ Zyprexa(Olanzapine)

Chemical Dependence

__ Antabuse(Disulfuram)
__ Campral(Acamprosate)
__ Revia(Naltrexone)Vivitrol

Mood Stabilizers

__ Depakote (Valproic Acid)
__ Lithium(Eskalith,Lithobid)
__ Lamictal(Lamotrigine)
__ Neurontin(Gabapentin)
__ Tegretol(Carbamazepine)
__ Topamax(Topiramate)
__ Trileptal(Oxcarbazepine)
__ Lyrica
__ Nuedexta(Dextromethorphan/Quinidine)

Stimulants

__ Adderall(XR)(Dextroampheamines)
__ Catapres(Clonidine)
__ Concerta(Methylphenidate)
__ Cyclert(Pemoline)
__ Dexedrine(Dextroamphetamine)
__ Evekeo (amphetamine sulfate)
__ Metadate ER/CD(Methlyphenidate)
__ Provigil(Modafanil)
__ Ritalin(Methlyphenidate)
__ Strattera(Atomoxetine)
__ Vyvanse(Lisdexamfetamine)

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PSYCHIATRIC SERVICES

Please list below all your Physicians including your Primary Care Physician and their contact information.

Current Physicians

Name of Physician	Specialty	Phone Number

Do you currently see a counselor/psychotherapist?

Therapist

Name of Therapist	Specialty	Phone Number

Is your psychotherapy contingent on a Court Order? ☐ **Yes** ☐ **No**

Have you been in counseling or psychotherapy before? ☐ **Yes** ☐ **No**

Have you seen a psychiatrist before? ☐ **Yes** ☐ **No**

If yes, please provide the name and contact information of your previous psychiatrist.

Name:	**Phone Number:**

Have you had any psychiatric hospitalizations? ☐ **Yes** ☐ **No**

If yes, please indicate where and approximate dates:

Hospitalizations

Hospital Name	Date Admitted	Date Discharged

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Do you use tobacco? ☐ Yes ☐ No

(If yes, please indicate type and frequency) _____ _____

If you have quit tobacco, please indicate date quit? _____

Do you consume alcohol? ☐ Yes ☐ No

(If yes, please describe frequency and quantity of alcohol consumption)

_____(# of glasses) **per** ☐ Day ☐ Week ☐ Year

Illicit Drug Use							
Substance	Current Use				Past Use			
Cannabis (Marijuana)		Yes		No		Yes		No
Cocaine		Yes		No		Yes		No
Ecstasy		Yes		No		Yes		No
LSD		Yes		No		Yes		No
Rx Drug Abuse		Yes		No		Yes		No
Amphetamines		Yes		No		Yes		No
Heroin		Yes		No		Yes		No
Other (please specify)								

Have you ever been in detox or rehab ☐ Yes ☐ No

If yes, please list below the name of Facility and approximate dates.

Detox / Rehab			
Facility Name	Date Admitted	Length of Stay	Attending Physician

Do you have any history of childhood abuse? ☐ Yes ☐ No

Is there any family history of alcohol/substance abuse? ☐ Yes ☐ No

If yes, please provide further information.

	Family Member(s)
History of Alcoholism	
History of Illicit Drug use	

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Is there family history of psychiatric illness? Yes ☐ No ☐

Family History Psychiatric Illness	Family Member(s)	
Depression		
Anxiety disorder		
Bipolar disorder/ Schizophrenia		
Suicide attempts/Completed in family		

Do you have a previous diagnosis with a Psychiatric Practice: Yes ☐ No ☐

If yes, please explain: _____

Chief complaint bringing you in for treatment: _____

Treatment Goals: _____

Crisis Information

Are you currently experiencing any suicidal thoughts, feelings, or actions? Yes ☐ No ☐
If yes, please explain: _____

Are you currently experiencing any homicidal/violent thoughts or feelings? Yes ☐ No ☐
If yes, please explain: _____

TMS (Transcranial Magnetic Stimulation) SCREENING: A non-Pharmacological Treatment for Depression

Are you interested in TMS? Yes ☐ No ☐

If yes, do you have any metallic implants in or around head or neck (excluding Dental/Cochlear Implants)? Yes ☐ No ☐

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NOTICE AND CONSENT

As the patient or their legal representative, I hereby consent to necessary examination, procedures, and/or treatments prescribed by my physician, his/her assistants, or designee as is necessary in his/her judgment.

I authorize my nurse practitioner and Staats Psychiatric Services to use and disclose my personal health information to receive payment for the care I receive. I have received a copy of the Notice Privacy Practices with further details on how my health information may be used.

I agree to be responsible for all charges during my treatment. I have been notified that some services may not be covered under my insurance plan and I am financially responsible for any non-covered services. If the office files a claim to my insurance carrier, I authorize payment of medical benefits to be made to my provider. In the event my insurance carrier does not pay my claim within a reasonable amount of time (60 days) I may be billed for services provided. I have read and acknowledge the receipt of office financial policy.

I understand that if I do not call at least 24 business hours in advance of a scheduled appointment to cancel, arrive 15 or more minutes late for the appointment or if I simply miss (no-show) a scheduled appointment I will be charged a missed appointment fee.

My signature below indicates I have read the Notice and Consent and agree to all terms.

Patient Name: _____ DOB: _____

Legal Guardian/Representative Name (Printed) : _____

Relationship: _____

Signed: _____ Date: _____

(Patient or Legal Guardian/Representative)

Agreement for Long Term Controlled Substance Prescriptions

The use of controlled substances can be habit forming and may cause addiction issues. This medication is only part of the treatment of attention deficit hyperactivity disorder (ADHD), Anxiety Disorder, Insomnia, Binge Eating Disorder (BED), or others. The goals of this medication therapy are to improve my ability to work and function, and to reduce symptoms of my psychiatric condition without causing dangerous side effects.

I have discussed the following with my Provider and understand:

I should not combine this medication with alcohol or street drugs.

- If I drink alcohol or use street drugs, I may not be able to think clearly and could become sleepy or sedated and risk personal injury.
- If I drive or operate a motor vehicle, this medication could impair my reaction time and/or judgement and lead to an accident and personal injury. If I feel sedated or tired, I will not drive or operate a motor vehicle.
- This medication can be habit forming, and if I, or anyone in my family has a history or drug or alcohol problems, there is an increased risk of addiction for myself.
- If I want to stop this medication, I may do so at any time under the supervision of my psychiatric provider to avoid withdrawal effects and feeling sick.

I agree to the Following:

- I am responsible for my medication(s). I will not share, sell, or trade my medication.
- I will not take medication from others that have not been prescribed to me.
- I will not increase my medication without speaking with my psychiatric provider during a scheduled appointment.
- My medication will not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all my appointments with my psychiatric provider.
- I will not attempt to obtain these medication(s) from another provider.
- I will not use illicit drugs, drink excessively or consume energy beverages or excessive amounts of caffeine.
- I may be subject to random urine drug screens and/or pill counts. If any misuse of my prescription is suspected.
- I will comply with the recommended treatment plan made by my provider, including referrals for medical screening.
- I will treat the staff at Staats Psychiatric Services with respectful behavior.
- I will not abuse the emergency paging system for refill requests of my controlled substance.

Refills: Refills will be made only during regular office hours: Monday through Friday 9am – 6pm. No refills will be made after hours, holidays, or weekends. I must contact the practice 5 business days prior to running out of my medication to request a refill. Processing refills can take 3-5 business days. I will not show up at the practice without an appointment requesting a refill.

Prescriptions from Other Providers: I will not attempt to obtain prescriptions for this medication or similar medications from other providers. If another controlled substance prescription is prescribed to me (for appropriate alternate medical conditions), I will alert my psychiatric provider to this new prescription as well as alert the other prescribing provider to the medication prescribed to me by my psychiatric provider.

Termination Agreement: If I break this agreement or if my psychiatric provider decides that this medication is no longer helping me, the medication may be stopped by my psychiatric provider in a safe way.

Printed Patient / Legal Guardian Name: _____

Patient/legal Guardian Signed Name: _____ Date: _____

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TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.

2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.

3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

a. I may revoke my right at any time by contacting Staats Psychiatric Services at (512) 593-7070.

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.

a. I understand that my insurance carrier will have access to my medical records for quality review/audit.

b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.

c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. All copayments/coinsurance will be collected the morning of the scheduled Telehealth Appointment.

8. I understand that this document will become a part of my medical record.

By signing this form, I attest that I have personally read this form (or had it explained to me) and fully understand and agree to its contents.

Patient Name: _____ DOB: _____
Legal Guardian/Representative Name (Printed) : _____
Relationship: _____
Signed: _____ Date: _____
(Patient or Legal Guardian/Representative)

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PATIENT FINANCIAL POLICY SHEET

Thank you for choosing our practice to handle your behavioral health needs.

We are dedicated to providing you with the best possible care and service. Understanding your financial responsibilities is an essential element to your care and treatment. If you have any questions regarding these policies, please feel free to contact our office staff.

Unless we can bill your insurance, **full payment is due at the time of service**.

For your convenience we accept the following payment types:

■ Cash ■Visa ■MasterCard ■Discover ■American Express

OFFICE VISIT STANDARD RATES:

- Initial Medication Management Evaluation: Range of $350.00 to $450.00
- Medication Management routine follow up $175.00 to $300.00
- Phone consultations that exceed 5 minutes: $100.00 per 15 min.
  (Phone consultations are **NOT** covered by insurance)
- Initial Therapy Evaluation: $175.00
- Therapy Follow-up: $150. 00

rates may vary based on insurance

MEDICATION REFILLS:

- Prescription refills for controlled substance (outside of office visit): $25.00
- **NOT** covered by insurance
- Prescription refills require a notice of 3 business days.

APPOINTMENTS:

- Courtesy reminder calls are made two days prior to your scheduled appointment. Please be sure to keep our office updated with current contact numbers and e-mail address.
- Cancellations made less than 24 business hours prior to your scheduled appointment will result in a missed appointment fee of: $99.00
- Missed appointment fees are **NOT** covered by insurance. The office reserves the right to charge Patients for all missed appointments.
- Patients who arrive more than 15 minutes past their scheduled appointment time will not be seen and will need to be rescheduled. Late arrivals may also result in a missed appointment fee: $99.00
- Patients who are consistently unable to keep their scheduled appointments will receive written notification of discontinuation of care.

MISCELLANEOUS FEES:

- **Medical Records:** Pages 1-20: $25.00, $0.50 per additional page, plus postage.
- **Letters:** Minimum of $25.00 charges may vary depending on nature and complexity.
- **FMLA/Disability:** Requires an appointment. Paperwork charges may vary.

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STATEMENTS:

Our office will supply monthly statements to the Patient Portal. Statements are only issued to a patient that has an outstanding balance greater than $5.00.

INSURANCE POLICY:

Our office will only submit claims and accept insurance reimbursements from insurance carriers for which we are contracted with. Patients are responsible for any coinsurance amounts, co-payments, and deductibles as outlined by the individual's insurance carrier. Our office policy is to collect coinsurance, co-payments, and deductibles when you arrive for your appointment.

If you have insurance coverage with a carrier who we are not contracted with, we may offer to prepare a claim for you on an unassigned basis. This means that it is your responsibility to send your insurance carrier the filled-out claim. As a result, any reimbursements would be sent directly to you. Consequently, the charges for your care and treatment are due at the time of the service.

If your health plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

It is the Patient's responsibility to inform our office of any changes in insurance coverage at least 48 business hours prior to the scheduled appointment, this is to ensure correct benefit information and any required authorizations. Failure to do so will result in full office visit charges due by the patient at the time of the scheduled appointment.

By signing below, you acknowledge that you have read and understand the policies as outlined and that you understand the following Disclaimer: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations, and exclusions of the member's contract at the time of service."

Patient Name: _____ DOB: _____

Legal Guardian/Representative Name (Printed) _____

Relationship: _____

Signed: _____ Date: _____

(Patient or Legal Guardian/Representative)

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ASSIGNMENT OF BENEFITS FORM

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and behavioral health benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, Medicaid, private insurance, and any other health/medical plan, to issue payment check(s) directly to Staats Psychiatric Services for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Staats Psychiatric Services to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated during examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Staats Psychiatric Services on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Patient Name: _____ DOB: _____
Legal Guardian/Representative Name (Printed) _____
Relationship: _____
Signed: _____ Date: _____
(Patient or Legal Guardian/Representative)Patient Signature Date

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ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Patient Name: _____ DOB: _____

Legal Guardian/Representative Name (Printed) _____

Relationship: _____

Signed: _____ Date: _____

(Patient or Legal Guardian/Representative)

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COURT ACTION/LEGAL FEES FOR NUSE PRACTIIONERS AT STAATS PSYCHIATRIC SERVICES

The following fees are in effect:

1. Preparation time (including submission of records): $300/hour
2. Phone calls: $300/hour
3. Depositions: $330/hour
4. Time required in giving testimony: $330/hour
5. Mileage: $0.40/mile
6. Time away from office due to depositions or testimony: $300/hour
7. All attorney fees and costs incurred by the therapist as a result of the legal action.
8. Filing a document with the court: $100
9. The minimum charge for a court appearance: $1500

A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500).

ALL fees are doubled if counselor had scheduled plans to go out of town. Initial _____
Date _____

COURT ACTION/LEGAL FEES FOR THERAPISTS AT STAATS PSYCHIATRIC SERVICES

The following fees are in effect:

1. Preparation time (including submission of records): $220/hour
2. Phone calls: $220/hour
3. Depositions: $250/hour
4. Time required in giving testimony: $250/hour
5. Mileage: $0.40/mile
6. Time away from office due to depositions or testimony: $220/hour
7. All attorney fees and costs incurred by the therapist as a result of the legal action.
8. Filing a document with the court: $100
9. The minimum charge for a court appearance: $1500

A retainer of $1500 is due in advance. If a subpoena or notice to meet attorney(s) is received without a minimum of 48-hour notice, there will be an additional $250 "express" charge. Also, if the case is reset with less than 72 business hours notice, then the client will be charged $500 (in addition to the retainer of $1500).

ALL fees are doubled if counselor had scheduled plans to go out of town. Initial _____
Date _____

Zero Tolerance for Aggressive Behavior

Ensuring a Healing Environment to Care for Our Patients, Their Loved Ones and Each Other

There is zero tolerance for all forms of aggression. Incidents may result in immediate discharge from Staats Psychiatric Services.

Examples of Aggressive Behavior

- Verbal harassment, threats or abusive language
- Gestures
- Racist or derogatory comments directed at others
- Sexual language directed at others
- Failure to respond to staff instructions.
- Physical assault

Thank you for helping us maintain a safe environment.

Int Req_____

Date _____

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BDI Form

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the **PAST WEEK, INCLUDING TODAY**. Check the number beside the statement you picked. If several statements in the group seem to apply equally well, check each one. Be sure to read all the statements in each group before making your choice.

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 or 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 that 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 weakness 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.

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10 * ( ) 0. I don't cry anymore than usual.
( ) 1. I cry more now than I used to.
( ) 2. I cry all the time now.
( ) 3. I used to be able to cry, but now I can't cry even though I want to.

11 * ( ) 0. I am no more irritated now than I ever am.
( ) 1. I get annoyed or irritated more easily than I used to.
( ) 2. I feel irritated all the time now.
( ) 3. I don't get irritated at all by the things that used to irritate me.

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 than before.
( ) 3. I can't make decisions at all anymore.

14 * ( ) 0. I don't feel I look any worse than I used to.
( ) 1. I am worried that I am looking old or unattractive.
( ) 2. I feel that 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 5 pounds.
( ) 2. I have lost more than 10 pounds.
( ) 3. I have lost more than 15 pounds.

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I am purposely trying to lose weight. [Yes \ No]

20 * ( ) 0. I am no more worried about my health than usual.
( ) 1. I am worried about physical problems such as aches and pains; or 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 about 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 am much less interested in sex now.
( ) 3. I have lost interest in sex completely.