DENT NEUROLOGIC INSTITUTE

716.250.2000 | dentinstitute.com
Amherst | 3980 Sheridan Drive • Amherst, NY 14226
Orchard Park | 200 Sterling Drive • Orchard Park, NY 14127
Buffalo | 40 George Karl Boulevard • Buffalo, NY 14221

Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

★ **Documents:** You must complete all the enclosed documents prior to your appointment time. COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITIAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS. If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.

★ **Insurance Card:** You must provide us with your insurance card.

★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan $200 is required at the time of service; any remaining responsibility will be billed to you.

★ **Identification:** You must provide us with photo ID or two other forms of identification.

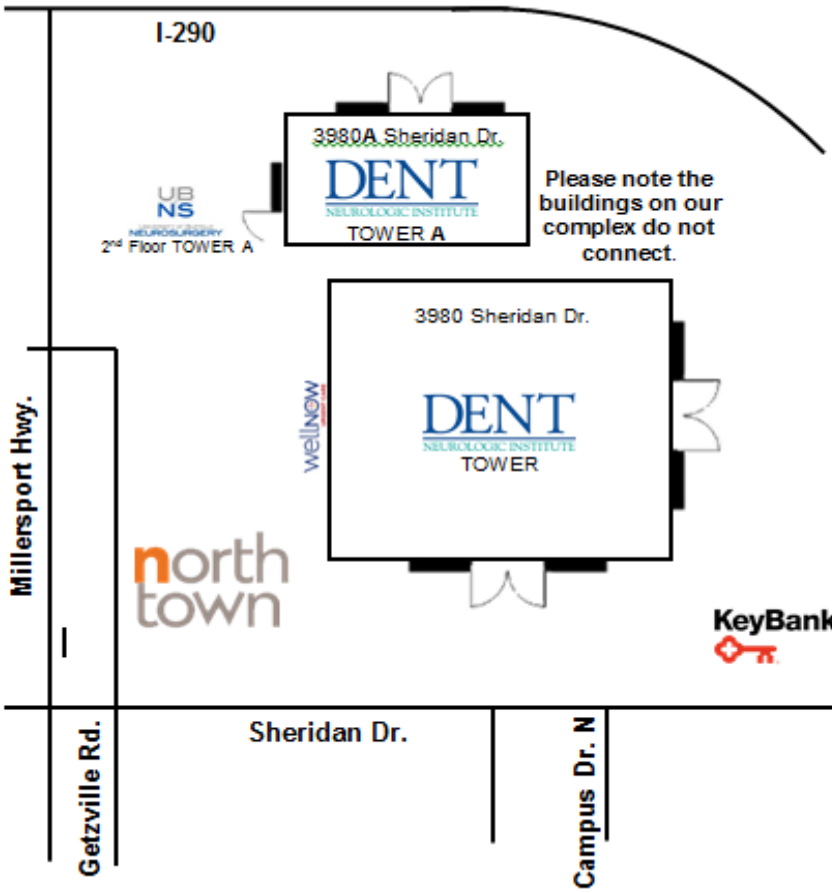
★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are REQUIRED at visit

Be sure to visit our website at www.dentinstitute.com for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

Advance Notice is Required for all Cancellations

If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.



DENT
NEUROLOGIC INSTITUTE

Amherst Location

3980 Sheridan Drive
Amherst, New York 14226

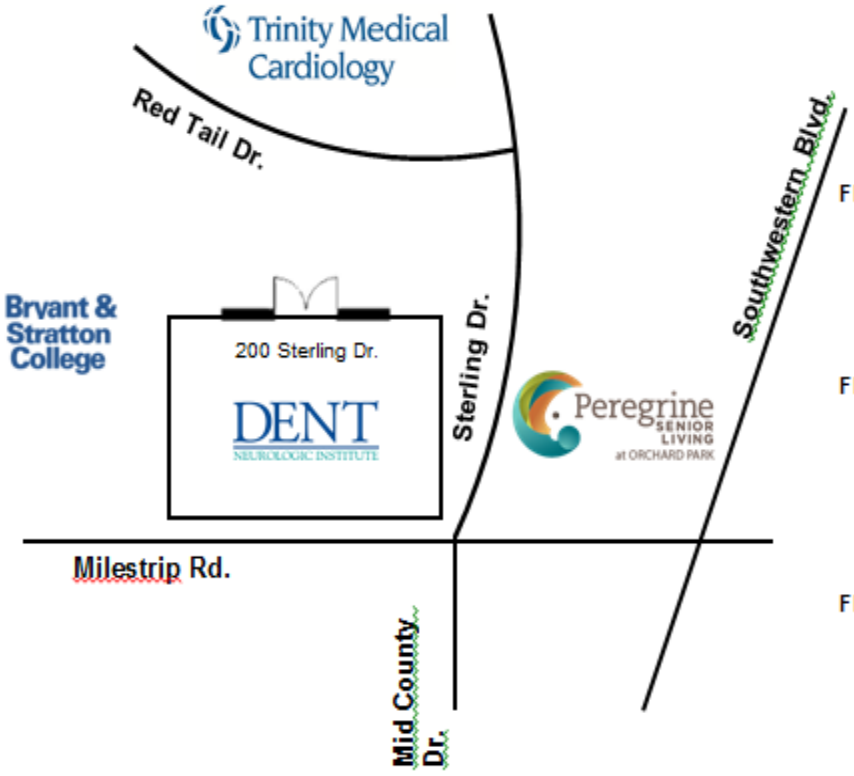
DRIVING DIRECTIONS:

FROM NIAGARA FALLS/NORTH TOWNS

- Robert Moses Parkway South
- I-190 South
- I-290 East
  (Youngman Exp/Exit 16 towards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

FROM SOUTH TOWNS

- I-190 East
- Merge into I-290
  (Youngman Exp/Exit 50)
- Exit Sheridan Drive (Exit 6)
- Left onto Sheridan Drive
- Right at light into Dent Tower



Orchard Park Location

200 Sterling Drive
Orchard Park, NY 14127

DRIVING DIRECTIONS:

FROM SOUTH TOWNS

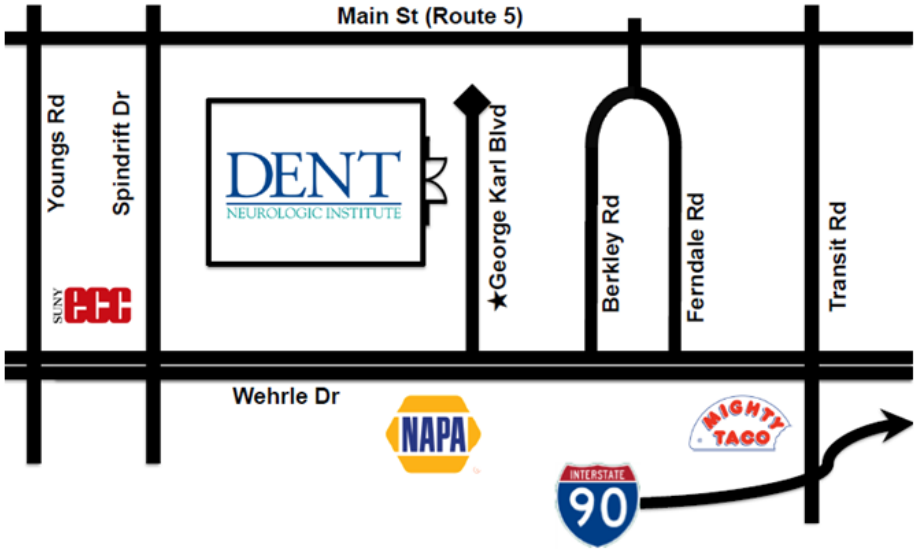
- Route 219 N to Milestrip Road East
  (1st Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM BUFFALO

- Thruway (90) West to Route 219
- Exit Milestrip Road East
  (2nd Exit onto Milestrip Road)
- Left at traffic light onto Sterling Drive
- Left on Red Tail
- Left into parking lot

FROM PENNSYLVANIA

- Thruway (90) East to Exit 56
- Left onto Milestrip Road
- Left onto Sterling Drive
- Left on Red Tail
- Left into parking lot



Buffalo Location
40 George Karl Boulevard
Buffalo, NY 14221
Suite 120

From Niagara Falls

- I-190 South toward Buffalo
- Exit 16 for I-290 East toward Rochester/ Tonawanda
- Take ramp left for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Buffalo

- Route 33 East toward Airport
- Take ramp right for Thruway I-90 East toward Albany (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

From Southtowns

- Route 219 North toward Buffalo
- Take ramp right for Thruway I-90 East toward Buffalo (*Toll road)
- Exit 49 for Transit Rd.
- Turn left onto Transit Rd.
- Turn left onto Wehrle Dr.
- Turn right onto George Karl Blvd.
- Turn left into parking lot

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DENT NEUROLOGIC INSTITUTE

REGISTRATION FORM

Today's Date:			
PATIENT INFORMATION			
Last Name:		**Middle:**	**First Name:**
❑ Mr. / ❑ Mrs. / ❑ Miss / ❑ Ms.		**Marital Status (Check one):**	❑ Single / ❑ Married / ❑ Divorced ❑ Separated / ❑ Widowed
Former Name:		**Preferred Name:**	
Birth Date:	**Sex:** ❑ M ❑ F	**E-mail Address:**	
Home Phone: ( )		**Cell Phone:** ( )	
Street Address or P.O. Box:			
City:	**State:**	**Zip Code:**	**Social Security Number:**
Primary Physician:		**Referring Physician:**	
Race:	**Ethnicity:**		**Language:**
Pharmacy Name:	**Pharmacy Address:**		**Pharmacy Phone:**
CONTACT PERSON IN CASE OF EMERGENCY			
Name:		**Relationship:**	
Home Phone: ( )		**Cell Phone:** ( )	
SEXUAL ORIENTATION / GENDER IDENTITY			
Sexual Orientation (Check one):	❑ Lesbian, gay or homosexual / ❑ Straight or heterosexual ❑ Bisexual / ❑ Do not know / ❑ Choose not to disclose		
	Something else, please describe:		
Gender Identity (Check one):	❑ Male / ❑ Female / ❑ Female-to-Male (FTM), Transgender Male, Trans Man ❑ Male-to Female (MTF), Transgender Female, Trans Woman ❑ Genderqueer, neither exclusively male nor female ❑ Choose not to disclose		
	Additional gender category or other, please specify:		

DENT NEUROLOGIC INSTITUTE
INSURANCE INFORMATION

You will need to give your insurance card to the receptionist			
Last Name:	**Middle:**	**First Name:**	
Person Responsible for Bill (if not self):	**Address (if different):**	**Home Phone: ( )**	
		Cell Phone: ( )	
Birth Date: / /	**Occupation:**		
Responsible Party's Employer:	**Employer Address:**	**Employer Phone: ( )**	
PRIMARY INSURANCE	**Insurance Plan:**		
Policy No:	**Group No:**		
Subscriber's Name (if not self):	**Subscriber's SSN:**	**Co-pay Amount:**	
	Subscribers DOB: / /		
Patient's Relationship to Subscriber (Check one):	❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**		
SECONDARY INSURANCE	**Insurance Plan:**		
Policy No:	**Group No:**		
Subscriber's Name (if not self):	**Subscriber's SSN:**		
	Subscribers DOB: / /		
Patient's Relationship to Subscriber (Check one):	❑ **Self** ❑ **Spouse** ❑ **Child** ❑ **Other**		

IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,
YOU <u>MUST</u> COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM

PLEASE READ

Important Insurance Plan Information

Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from $75 - $200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

DENT Participates with:

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus/Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

DENT does NOT Participate with:

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

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DENT NEUROLOGIC INSTITUTE

WORKERS COMPENSATION

SUPPLEMENTAL INFORMATION FORM

Today's Date:	Date of Birth:	
Patient Name:	Social Security No:	
Date of Injury:		
Employer Name:	Employer Address:	
Employer Phone Number: ( )	Your Job Title:	Are you out of work due to this injury: ❑ Yes ❑ No

COMPENSATION INSURANCE CARRIER INFORMATION

Insurance Carrier Name:	Insurance Carrier Address:
Carrier Claim Number:	WCB Case Number:
Name of Case Manager:	Phone: ( )
	Fax: ( )
Briefly Describe the Injury you Sustained:	
Briefly Describe how Injury Occurred:	

ATTORNEY INFORMATION

Attorney Name:	Attorney Address:
Phone: ( )	Fax: ( )

Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.

DENT NEUROLOGIC INSTITUTE

NO-FAULT

SUPPLEMENTAL INFORMATION FORM

Patient Name:	Date of Birth: Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: ❑ Yes ❑ No
Injury Sustained:	
INSURANCE CARRIER INFORMATION	
Insurance Carrier Name:	Insurance Carrier Address:
Name of Adjuster:	Claim Number:
Phone: ( )	Fax: ( )
ACCIDENT DETAILS	
Location of Accident:	
Briefly Describe how the Accident Occurred:	
Were you a: ❑ Driver ❑ Passenger ❑ Pedestrian	
If Driver or Passenger, were you: ❑ Belted ❑ Not-Belted	
Have you Filed a Claim with your Carrier: ❑ Yes ❑ No	Have you Completed and Returned your No-Fault Application: ❑ Yes ❑ No
ATTORNEY INFORMATION	
Attorney Name:	Attorney Address:
Phone: ( ) Fax: ( )	
Signature:	**Date:**

FOR OFFICE USE ONLY

PROVIDER: **DENT NEUROLOGIC GROUP** **PO Box 8000 Dept 057** **Buffalo, NY 14267** **Signature: _____**	**CLAIM# _____** **DATE OF LOSS: _____** **CARRIER: _____**

DENT NEUROLOGIC
NEW PATIENT HISTORY FORM

Today's Date _____

Name: _____ Age: _____ DOB: _____

1. Please describe the problem that you would like addressed, e.g., what it consists of, how and when it started, what worsens and relieves it.

_____

_____

_____

_____

_____

2a. Who is your **primary physician with address** (if known)?

_____

_____

2b. What physicians have you seen for this problem?

_____

_____

3. List all illnesses and/or hospitalizations/surgeries you have had during your life:

_____ _____

_____ _____

_____ _____

_____ _____

4. List the <u>name and dose for each</u> prescription and over-the-counter medication you are <u>currently</u> taking:

Drug: _____ **Dose:** _____

_____ _____

_____ _____

_____ _____

_____ _____

5. Any drug allergy?

<u>Drug</u> <u>Reaction</u>

_____ _____

_____ _____

_____ _____

6. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

Treatment	Date	Results

7. Other problems? Please **circle** the ones that apply to you:

Neurologic
Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke).

Constitutional
Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes
Blurry vision, double vision, decreased vision, cataract, glaucoma.

Ears, Nose, Mouth, Throat
Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning).

Cardiovascular
Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory
Cough, emphysema, asthma.

Gastro-Intestinal
Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis.

Genito-Urinary
Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems.

Skin
Rash or other skin abnormality.

Musculoskeletal
Joint pain/swelling/stiffness, neck/lower back pain, muscle aches

Psychiatric
Depression, anxiety, other psychiatric problems.

Print Name: _____

Continued from # 7

Endocrine
Diabetes, thyroid problems, hormonal problems

Hematologic
Anemia, easily bruises, bleeding disorder.

Allergy
Itching, rash, swollen lips/tongue.

Have you ever had cancer? ____ No ____ Yes, describe _____

8. Have you had any of the following tests?

Test	Date	Where
MRI	_____	_____
CT	_____	_____
Carotid Doppler	_____	_____
EMG	_____	_____
EEG	_____	_____
SPECT/PET	_____	_____
Other (myelogram, angiogram, biopsy, spinal tap):		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Do you use tobacco? ___ No ___Yes, pack per day ___, # of years____ Quit date _____

Do you use alcohol? ___ No ___ Yes, amount _____

Who lives with you at home? _____

Describe your work: _____

_____

Disability? _____ No _____ Yes, since _____

10. Have you fallen in the past 12 months? ___ No ___Yes

Do you feel unsteady when standing or walking? ___ No ___ Yes

Print Name: _____

11. Tell us about your family's health:

Mother: _____

Father: _____

Brother #1: _____ Sister #1: _____

Brother #2: _____ Sister #2: _____

Brother #3: _____ Sister #3: _____

Brother #4: _____ Sister #4: _____

12. What do you hope to achieve with your doctor?

_____

_____

_____

_____

13. Emergency contact:

Name: _____ Relationship: _____

Phone: _____ Mobile Phone:_____

_____

Print Name

_____ _____

Signature Date

Tell Us How We're Doing!
Visit Our Website at www.dentinstitute.com and take our online survey

For office use only:

BP _____ Pulse _____ Resp. _____ Wt. _____ Ht. _____

DENT
DIZZINESS, BALANCE & TINNITUS CENTER

Dizziness Questionnaire

Name: _____ DOB: _____ Date: _____

CHIEF CONCERN: Please check all the symptoms that you are currently experiencing:

□ Dizziness □ Lightheadedness □ Vertigo (spinning)
□ Imbalance □ Unsteadiness □ Falling

Describe in your own words how your dizziness or imbalance problem feels: _____

_____

HISTORY OF PRESENT ILLNESS

1. When did your problem start (date): _____ Was there any related event? □ YES □ NO
   a. If YES, check all that apply:
      □ An ear infection □ A cold
      □ Auto accident □ Other: _____
2. Was the onset of your problem: □ Gradual □ Sudden □ Overnight □ Other: _____
3. Is your dizziness/imbalance: □ Constant □ It comes and goes in spells or attacks
   a. If it comes and goes in spells or attacks:
      □ How many attacks have you experienced over the last 3 months ____ or _____ times per month?
      □ Please list a specific number for the following:
         □ They occur every # ___ hours ___ days ___weeks ___ months
         □ And they last # ___ seconds ___ minutes ___ hours ___ days ___ months
      □ Do you have any warning the attacks will occur? □ YES □ NO
         If YES, describe: _____
      □ Are you completely free of dizziness/imbalance between attacks? □ YES □ NO
4. Does your dizziness/imbalance occur with position changes? □ YES □ NO
   a. If YES, check all that apply:
      □ Rolling your body right or left □ Turning your head left or right
      □ Looking up, or head back position □ Bending over, or head down position
      □ Going from lying to sitting position □ Other: _____
5. Do you know of anything that makes your dizziness/imbalance better? □ YES □ NO
   a. If YES, check all that apply:
      □ Not moving your head □ Rest
      □ Medication: _____
      □ Other: _____
6. Do you know of anything that makes your dizziness/imbalance worse? □ YES □ NO
   a. If YES, check all that apply:
      □ Moving your head □ Riding or driving in the car
      □ Large crowds or busy walkways □ When your hungry or haven't eaten
      □ Other: _____

Print Name: _____

7. Is your dizziness/imbalance currently: □ Getting better □ Same □ Getting worse □ Variable
   a. If variable, rate the severity of your symptoms at the best times and the worst times on a scale of 1-10 with 10 being the worst. _____ Best times _____ Worst times
8. Do your symptoms limit your daily activities? □ YES □ NO
9. Do you have trouble walking in the dark or at dusk? □ YES □ NO
10. Do you have trouble walking on uneven surfaces (eg. lawn)? □ YES □ NO
11. When dizzy/imbalanced, must you support yourself to stand or walk? □ YES □ NO
    a. If YES, how do you support yourself? _____
12. Have you ever fallen due to your dizziness/imbalance? □ YES □ NO
    a. If YES, # of falls: _____ # of near falls: _____
    b. Do you tend to fall to the: □ Right □ Left □ Back □ Front □ All
13. Do you have a history of migraine headaches? □ YES □ NO
14. Did you recently get new glasses or has there been a change in your vision? □ YES □ NO
15. Have you ever had IV antibiotics or chemotherapy? □ YES □ NO

DO YOU HAVE ANY OF THE FOLLOWING EAR RELATED SYMPTOMS:

16. Do you have difficulty hearing? □ YES □ NO
    a. If YES, when did it start: _____ □ Both ears □ Right ear □ Left ear
17. Do you wear hearing aids? □ YES □ NO
18. Do you experience noise or ringing in your ears? □ YES □ NO
    a. If YES, which ears: □ Both ears □ Right ear □ Left ear
    b. Describe the noise: □ Ringing □ Buzzing □ Chirping □ Hissing □ Other
    c. Is it: □ Steady □ Pulsatile □ Constant □ Occasional
    d. Does anything stop the noise or make it better:
19. Do you have pain, fullness, or pressure in your ears? □ YES □ NO
    a. If YES, which ears: □ Both ears □ Right ear □ Left ear
    b. Does it coincide with your dizziness/imbalance? □ YES □ NO

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Indicate if constant or episodic):

Yes	No				Comments
□	□	1. Double/blurred vision or blindness	□ Constant	□ Episodic	_____
□	□	2. Numbness of face or extremities	□ Constant	□ Episodic	_____
□	□	3. Weakness in arms or legs	□ Constant	□ Episodic	_____
□	□	4. Clumsiness in arms or legs	□ Constant	□ Episodic	_____
□	□	5. Confusion or loss of consciousness	□ Constant	□ Episodic	_____
□	□	6. Difficulty with speech or swallowing	□ Constant	□ Episodic	_____

PLEASE NOTE ANY PRIOR RELEVANT EVALUATIONS, TESTS, TREATMENTS

20. Have you seen other healthcare providers for this problem? □ YES □ NO
    a. If YES, who: □ Primary MD □ Ear, Nose, Throat MD (ENT) □ Neurologist
       □ Cardiologist □ Emergency Room MD □ Physical Therapist
21. Have you had tests done for this problem elsewhere? □ YES □ NO
    - □ ENG/VNG Where: _____ When: _____ Results: _____
    - □ MRI/CT Where: _____ When: _____ Results: _____
    - □ Hearing tests Where: _____ When: _____ Results: _____
    - Other: _____

Print Name:_____ DOB: _____ Date: _____

Pre-Testing _____ Post-Therapy _____

Dizziness Handicap Inventory

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

P1.	Does looking up increase your problem?	Yes	Sometimes	No
E2.	Because of your problem, do you feel frustrated?	Yes	Sometimes	No
F3.	Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
P4.	Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
F5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
F6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	Yes	Sometimes	No
F7.	Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
P8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
E9.	Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
E10.	Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
P11.	Do quick movements of your head increase your problem?	Yes	Sometimes	No
F12.	Because of your problem, do you avoid heights?	Yes	Sometimes	No
P13.	Does turning over in bed increase your problem?	Yes	Sometimes	No
F14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
E15.	Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
F16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
P17.	Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
E18.	Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
F19.	Is it difficult for you to go for a walk around your house in the dark?	Yes	Sometimes	No
E20.	Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
E21.	Because of your problem, do you feel handicapped?	Yes	Sometimes	No
E22.	Has your problem placed stress on your relationship with members of your family/friends?	Yes	Sometimes	No
E23.	Because of your problem, are you depressed?	Yes	Sometimes	No
F24.	Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
P25.	Does bending over increase your problem?	Yes	Sometimes	No

Following Section to be Completed by Examiner

Scoring: Yes = 4 points Sometimes = 2 points No = 0 points

Functional Subscale = F — Functional Subscale: _____/36

Emotional Subscale = E — Emotional Subscale: _____/28

Physical Subscale = P — Physical Subscale: _____/30

Total Score: _____/100

Reference: Jacobson G., Newman C., The Development of the Dizziness Handicap Inventory. Arch Otolaryngology Head Neck Surgery Vol. 116, April 1990.

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Patient Name:_____ Date:_____

DOB: _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Name:_____ Date:_____

DOB: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐