Joseph Haas, M.D.

2430 Estancia Blvd Suite 104 • Clearwater, Florida 33761

Ph: 727-723-2442 Fax: 727-796-7350

PATIENT NAME: _____ HOME PHONE: _____

ADDRESS: _____ CELL PHONE: _____

CITY: _____ ST: _____ ZIP CODE: _____

PATIENT DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER:_____

EMPLOYER: _____ PHARMACY PHONE: _____

EMERGENCY CONTACT:_____ HOME/CELL PHONE: _____

REFERRING DOCTOR: _____ PHONE NUMBER: _____

INSURANCE NAME: _____ POLICY NUMBER: _____

PLEASE NOTE:

If you are a self-pay patient, payment is expected in advance of your initial appointment. All other patients with a co-pay or co-insurance your payment is due at the time of service. We will file all Medicare and secondary insurance claims.

THERE IS A $36.00 CHARGE FOR ALL RETURNED CHECKS/CHARGE BACKS. PAYMENTS MADE WITH A DEBIT OR CREDIT CARD WILL INCUR AN ADDITIONAL 5% FEE.

CHARGES MAY OCCUR FOR MISSED/RESCHEDULED/CANCELLED APPOINTMENTS WITHOUT 48 HOURS (2 FULL BUSINESS DAYS) NOTICE. THIS CHARGE WILL BE THE SAME FEE YOU OR YOUR INSURANCE WOULD HAVE PAID FOR THAT APPOINTMENT. YOU MAY INQUIRE ABOUT THOSE FEES AT ANY TIME.

THERE WILL BE A CHARGE TO YOU (OR YOUR INSURANCE COMPANY IF ALLOWED) FOR TELEPHONE SESSIONS IN WHICH PSYCHOTHERAPY OR MEDICATION MANAGEMENT OCCURS.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO JOSPEH HAAS, M.D., FOR MEDICAL SERVICES PROVIDED BY HIM.

I ALSO AGREE TO PAY FOR ANY BALANCE NOT COVERED BY THE INSURANCE, AND IN THE EVENT MY ACCOUNT DEFAULTS, I AUTHORIZE JOSEPH HAAS, M.D. TO CHARGE MY CREDIT CARD PROVIDED BELOW FOR ANY BALANCE DUE

DEBIT/CREDIT CARD # _____ EXP DATE: _____

NAME AS IT APPREARS ON CARD: _____ CVV:____

SIGNATURE OF PATIENT OR GUARDIAN:_____

DATE: _____ DRIVERS LICENSE: _____

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ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY EMERGENCY MEDICAL CARE AND RELEASE OF INFORMATION

ASSIGNMENT OF INSURANCE BENEFITS: For services rendered by JOSEPH HAAS MD PA, I assign the benefits due to me under my insurance company to reimburse JOSEPH HAAS MD PA for these services; I agree that if these benefits are insufficient to cover the entire bill or the illness/injury is not covered by my insurance, I will be responsible for payment of the entire bill or any balance.

FINANCIAL RESPONSIBILITY: I agree to pay JOSEPH HAAS, MD all balances due and not payable by insurance on my account from the beginning date to the ending date of treatment. I further agree to pay all costs of any balance, including attorney's fees, and any collection fees. I further agree to allow my debit/credit card to be debited for any balance due. I also agree to pay Dr. Haas a returned check fee of $36.00 per return and/or $36.00 per credit card chargeback. If we are NOT an in network provider for your insurance we may send in claims on your behalf as a courtesy to you; any monies received from your insurer will be applied to your balance due but will not be considered as "payment in full" or "consideration in full" Furthermore, if any claims are denied by your insurer for any reason you will still owe for the medical services that were provided to you or on your behalf. All past due invoices are subject to a 1.5% per month service charge.

CANCELLATION POLICY: I understand that there will be a fee charged to the responsible party if a scheduled appointment is not cancelled a full 48 (business hours, M-F 9am-4pm) in advance, except in cases of an emergency.
Messages left on the voice mail are not a sufficient form of cancellation. This charge will be the same fee you or your insurance would have paid for the appointment if we are an in network provider with your insurer. I also understand that insurance benefits do not apply to this fee and that the charges incurred are the sole responsibility of the patient or responsible party and agree to this fee if the cancellation policy is not followed.

AUTHORIZATION FOR RELEASE OF INFORMATION: I give permission to JOSEPH HAAS MD PA and their agents to release information as needed, including psychiatric, psychological, or drug and alcohol treatment information to all insurance companies and its representatives for the processing of my claims, if requested.

EMERGENCY MEDICAL CARE: In the event of an accident in which emergency medical care or treatment is needed, I authorize Dr. Joseph Haas, MD to arrange for the care of treatment necessary for my emergency condition. I further authorize the treatment facility or medical personnel to provide emergency medical care and treatment and agree to be responsible for medical costs because of such emergency treatment.

RIGHTS OF INDIVIDUALS IN TREATMENT: I have read and understand the basic rights of treatment with Dr. Joseph Haas. These rights include:

a) The right to be informed of the various steps and activities involved in receiving treatment.
b) The right to confidentiality under federal and state laws relating to the receipt of services.
c) The right to humane care and protection from harm abuse or neglect.
d) The right to make an informed decision, whether to accept or refuse treatment.
e) The right to contact and consult with counsel and select practitioners of my own choice at my own expense.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS. NO GUARANTEE OR ASSURANCE HAS BEEN MADE TO ME AS TO THE RESULTS THAT MAY BE OBTAINED.

_____ _____

PATIENT/LEGAL GUARDIAN/FINACIALLY RESPONSIBLE PARTY SIGNATURE **DATE**

_____

PRINTED NAME OF PATIENT

Joseph Haas, M.D.
2430 Estancia Blvd Suite 104 • Clearwater, Florida 33761
Ph: 727-723-2442 Fax: 727-796-7350

Electronic Communication Policy and Authorization

Out of concern for your privacy, Joseph Haas M.D. P.A. discourages the use of electronic means of communication (including texting, email, and voicemail messages) as there are limitations to ensuring confidentiality. We do NOT always use an encrypted electronic communication service. Unencrypted electronic communications carries a risk to privacy and confidentiality.

Should you choose to communicate with us electronically, we ask that you limit electronic communications to brief messages and do not include detailed, sensitive information for your protection.

By signing this and/or using electronic communication to communicate with us or by asking us to electronically communicate with you, you agree to release and hold harmless Joseph Haas M.D. P.A. from any liability associated with the privacy or security of any electronic communication.

You also agree to the following:

- Electronic correspondence is only monitored during business hours form **Monday – Friday, 9am to 5pm**, and may not be viewed in a timely manner. **If it is an urgent matter, or you require immediate medical assistance, do NOT use electronic communication to contact us. Call 911 or visit the nearest emergency clinic.**
- Any electronic communication may become part of your medical record.
- Electronic communications may be viewed by persons other than the intended recipient due to safety concerns, staff leave, and/or administrative reasons.
- If you communicate with us electronically, we will use the electronic communication address(es) you have provided us.
- If someone you have designated on your consent form as being eligible to receive information about your care communicates with us electronically, you hereby authorize us to respond to them electronically. The same stipulations that apply to communications between you and Joseph Haas M.D. P.A. will apply to communications between Joseph Haas M.D. P.A. and the designated person(s).
- If you disclose information via electronic communication that may constitute a threat to yourself or others, we will take appropriate action (including but not limited to alerting law enforcement) to ensure the safety and you and/or others and limit our liability. Your safety is our top priority.

AUTHORIZATION:

I hereby acknowledge Joseph Haas M.D. P.A. discourages the use of electronic communication as he does not always use encrypted means of electronic communication. By signing this authorization, I give Joseph Haas M.D. P.A. permission to communicate with me electronically should I choose to and am aware of the limitations and potential risks related to using electronic communication. Therefore, I understand and agree to the terms listed above and understand my use of electronic communication means my confidentiality cannot be guaranteed. I may revoke this authorization at any time.

_____ _____

Signature Date

_____

Printed Name

Joseph Haas, M.D.
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WELCOME TO THE OFFICE OF JOSEPH HAAS, M.D.
BOARD CERTIFIED CHILD ADOLESCENT AND ADULT PSYCHIATRIST
& ADDICTION MEDICINE

We are pleased that you made the decision of choosing our office! Please, do not hesitate to ask our office staff any questions you might have as we would like your time with us to be as comfortable as possible. The following is a few guidelines of our office.

1. **Pharmacy Refills**

   If you need a prescription filled before your next appointment, please, do the following: 3 days prior to running out of your meds, call your pharmacy and have them fax a refill request to our office @ 727-796-7350. The prescription(s) should be ready for you at your pharmacy the next business day. If you have done the above, and the refill is not available at your pharmacy, call our office directly with your medication name, dose and quantity and it will be taken care of the next business day. Please note there may be a charge for medication refills without an appointment. You may inquire with our office about those charges. Pt's who are on Suboxone/Subutex or any Benzodiazepines, you must call the office directly for your refill (please make sure you have your pharmacy ph # ready along with medication, strength, directions)

2. **Appointment Cancellation Policy**

   Our policy is to cancel your scheduled appointment 2 full business days to avoid all charges. Leaving a voice mail is NOT sufficient; you MUST speak with the office to avoid any fees.

   If you cancel or reschedule without adequate notice or simply miss/forget your appointment, you are responsible for the charge of:

   A) Your co-pay if you have insurance that will cover your missed appointment.
   B) The full fee if you are self-paying or if your insurance will not cover the missed appointment.

***PLEASE NOTE: It is NOT the responsibility of this office to remind you of your appointments, please be sure that you write down your appointment times (at home or work) and schedule appropriately.**

3. **Phone Sessions**

   Phone sessions may be available if it is impossible for you to be here in person. However, not all insurances cover this fee (including Medicare) you can inquire with our office as to these fees.

Thank You.

Patient/Guardian Signature_____

Patient/Guardian Name Printed_____

Date_____

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Health Care Surrogate:

Do you have a Health Care Surrogate? Yes:_____ No:____

If yes:

Name: _____ Relation: _____

Phone: _____

If no: Would you like information regarding a Health Care Surrogate?

Yes: ___ No: ___

What is a Health Care Surrogate?

Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker could make such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____ , have received a copy of this office's **Notice of Privacy Practices.**

_____
Please Print Name

_____
Signature **(Parent or Legal Guardian must also sign if the patient is under the age of 18.)**

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgement
- o An emergency prevented us from obtaining acknowledgement
- o Other (Please Specify)

_____

_____

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Authorization for Release of Confidential Information

(Note " * " Indicates **REQUIRED** for Validity)
EXCHANGE INFORMATION FOR HEALTHCARE

- PT Name: _____ SS# _____ DOB: _____

Authorize Joseph Haas, MD., PA, and the program and/or clinician named below to exchange with one another health information including psychiatric, alcohol and/or drug abuse information. I understand that my records are protected under the Federal and State Regulations governing the confidentiality and privacy of health information under 45 CFR Parts 160 and 164.42 CFR Part 2 and FS 394 and 397 and cannot be disclosed without any written authorization unless provided for by the regulations. I understand that the information in my health record may include information relating to sexually transmitted disease, HIV or AIDS.

- Providers Name: _____
- Purpose of this Disclosure: _____
- Type of Release: _____ Mail _____ Verbal *Please note, we DO NOT accept Faxed Records*

I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken in reliance on it, and in any event that authorization expires automatically in one year unless initialed below. (Initialed release will automatically renew annually)

Initial by Client to renew annually _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to assure treatment.

I hereby release Joseph Haas, M.D., PA from liability which may arise because of information disclosed under this authorization, should it be presumed that such information is later used to my detriment.

_____ _____
*Client Signature *Date

_____ _____
When applicable, Signature of Date
_____ Parent _____ Guardian _____ Personal Representative (Legal Papers Required)

_____ _____
Witness Signature Date

PROBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent of the subsequent disclosure of this information. Florida Law requires that any person, agency or entity receiving information shall maintain such information as confidential and exempt from the provisions of the public records law.

FOR OFFICE USE ONLY: Authorized information release by: _____

Date Released: _____ Information Released: _____

Joseph Haas, M.D.
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Attention all insurance patients of Dr. Joseph Haas, MD. PA

If you miss/cancel/no show/or reschedule an appointment **without a full 48 business hours' notice** for an appointment with Dr. Haas, OR if you have requested to have your session over telephone, you are being notified that your insurance's official policy is to NOT pay for appointments that patients do not physically attend. Dr. Haas will attempt to get your insurance to pay for any appointments you pay if you fail to attend in person; but in case your insurer does not initially pay or later requests the monies returned to them, our new policy will require you to leave a **$250.00** retainer to cover the appointment.

This retainer will be held as a credit balance on your account until your treatment with Dr. Haas is completed and will be returned to you afterwards unless you have a co-pay balance exceeding it to Dr. Haas.

Attention all insurance patients: This is to notify you that your insurance carrier **DOES NOT** pay for the specific urine drug screen we preform that is required for your treatment. Therefore, there will be a fee of **$40.00** for all urine drug screens that are preformed in the office in addition to your normal co-pay.

Please Note: ALL NEW PATIENTS are **REQUIRED** to do a urine screening on their first visit.

We thank you in advance for your cooperation on this matter.

Patient Name: _____

Patient Signature: _____

Date: _____

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New Patient Questionnaire

1. What is the **Main** problem you want addressed during your initial appointment/evaluation?

_____
_____
_____
_____

2. What do you expect from Dr. Haas?

_____
_____
_____
_____

3. Please **circle** which statement best describes your current situation:
   A. Resources "Time, Money and Effort" are available and are not going to limit any necessary or reasonable treatment.
   B. Resources "limited" and this must be considered when devising a treatment plan.
   C. Resources "minimal" and therefore I am looking for the minimal amount of care needed to address the problem and gain some relief

4. What do you expect the outcome to be?

_____
_____
_____
_____

5. Have you been receiving recent treatment for this problem? YES or NO

   If yes – from whom?

_____
_____

   What type of treatment did you receive?

_____
_____

   How effective has it been?

_____
_____

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MEDICATION LIST

Please list all prescriptions and over the counter medications you are currently taking.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Any Drug Allergies:

1. _____
2. _____
3. _____
4. _____

Notes:

_____
_____
_____
_____
_____
_____

Print Patient Name: _____

Patient/Parent/Guardian Signature: _____

Date: _____

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INVENTORY OF DEPRESSIVE SYMPOMATOLOGY (SELF-REPORT)

Name: _____ Today's Date: _____

Please fill in the one response to each item that best describes you for the past seven days.

SECTION 1

1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable, or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? Ⓨ Ⓝ

   If you answered NO above,
   please proceed to **SECTION 2**

2. At any time in the past, did any of these spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner? Ⓨ Ⓝ

3. Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack? Ⓨ Ⓝ

4. *During the worst attacks you can remember, did you:*
   a. have skipping, racing, or pounding of your heart? Ⓨ Ⓝ
   b. have sweating or clammy hands? Ⓨ Ⓝ
   c. tremble or shake? Ⓨ Ⓝ
   d. have a choking sensation or a lump in your throat? Ⓨ Ⓝ
   e. have chest pain, pressure, or discomfort? Ⓨ Ⓝ
   f. have nausea, stomach problems or sudden diarrhea? Ⓨ Ⓝ
   g. feel dizzy, unsteady, lightheaded, or faint? Ⓨ Ⓝ
   h. Did things around you feel strange, unreal, detached, or unfamiliar, or did you feel outside of or detached from part, or all, of your body? Ⓨ Ⓝ
   i. feel that you were losing control or going crazy? Ⓨ Ⓝ
   j. fear you were dying? Ⓨ Ⓝ
   k. have tingling or numbness in parts of your body? Ⓨ Ⓝ
   l. have hot flushes or chills? Ⓨ Ⓝ

5. In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack? Ⓨ Ⓝ

SECTION 2

1. In the past month, were you fearful or embarrassed being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public, writing while someone watches or being in social situations? Ⓨ Ⓝ

   If you answered NO above,
   please proceed to **SECTION 3**

2. Is this fear excessive or unreasonable? Ⓨ Ⓝ

3. Do you fear these situations so much that you avoid them or suffer through them? Ⓨ Ⓝ

4. Does this fear disrupt your normal work or social functioning or cause you significant distress? Ⓨ Ⓝ

SECTION 3

1. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Ⓨ Ⓝ

   If you answer NO above,
   Please proceed **to SECTION 4**

2. During the past month, have you re-experienced the event in a distressing way (i.e., dreams, intense recollections, flashbacks, or physical reactions)? Ⓨ Ⓝ
3. In the past month, have you
   a. Avoided thinking about the event, or have you avoided things that remind you of the event? Ⓨ Ⓝ
   b. Had trouble recalling some important part of what happened? Ⓨ Ⓝ
   c. Become less involved or interested in hobbies or social activities? Ⓨ Ⓝ
   d. Felt detached or estranged from others? Ⓨ Ⓝ
   e. Noticed that your feelings are numbed? Ⓨ Ⓝ
   f. Felt that your life would be shortened because of this trauma? Ⓨ Ⓝ

4. In the past month, have you:
   a. Had difficulty sleeping? Ⓨ Ⓝ
   b. Become especially irritable or have outbursts of anger? Ⓨ Ⓝ
   c. Had difficulty concentrating? Ⓨ Ⓝ
   d. Become nervous or were constantly on your guard? Ⓨ Ⓝ
   e. Become easily startled? Ⓨ Ⓝ
5. During the past month, have these problems significantly interfered with your work or social activities or caused you significant distress? Ⓨ Ⓝ

SECTION 4

1. Have you worried excessively or been anxious about 2 or more things (i.e.: finances, children's well-being, misfortune, etc.) over the past 6 months? More than most others would? Are these worries present most days? Ⓨ Ⓝ

If you answered NO above,
Please proceed **to SECTION 5**

2. Do you find it difficult to control the worries or do they interfere with your ability to focus on what you are doing? Ⓨ Ⓝ
3. When you were anxious over the past 6 months, did you, most of the time:
   a. Feel restless, keyed up, or on edge? Ⓨ Ⓝ
   b. Feel tired, weak, or exhausted easily? Ⓨ Ⓝ
   c. Have difficulty concentrating or find your mind going blank? Ⓨ Ⓝ
   d. Feel irritable? Ⓨ Ⓝ
   e. Have difficulty sleeping (falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? Ⓨ Ⓝ

SECTION 5

1. In the past month, have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (i.e., you thought you were dirty/contaminated/had germs; fear of contaminating others; fear of harming someone even though you did not want to, or fearing you would act upon some impulse, or fear/superstitions that you would be responsible for things going wrong, or obsessions with sexual thoughts, images, or impulses, or hoarding/collecting, or religious obsessions.) Ⓨ Ⓝ

If you answered NO above,
Proceed to **Question #4**

2. Did they keep coming back into your mind even when you tried to ignore or get rid of them? Ⓨ Ⓝ
3. Do you think these obsessions are the product of your own mind and that they are not imposed from the outside? Ⓨ Ⓝ
4. In the past month, did you do something repeatedly without being bale to resist doing it (i.e.: washing or cleaning excessively; counting or checking things over and over; or repeating/collecting/arranging things; or other superstitious rituals)? Ⓨ Ⓝ
5. Did you recognize these obsessive thoughts or compulsive behaviors were excessive or unreasonable? Ⓨ Ⓝ
6. Did these obsessive thoughts and/or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour? Ⓨ Ⓝ

SECTION 6

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? Ⓨ Ⓝ
2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? Ⓨ Ⓝ

If you answered NO above,
Please proceed **to SECTION 7**

1. Over the past two weeks, when you feel depressed or uninterested:
   a. Was your appetite decreased or increased nearly every day? Ⓨ Ⓝ
   b. Did your weight decrease or increase without intentionally trying? Ⓨ Ⓝ
   c. Did you have trouble sleeping nearly every night (falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)? Ⓨ Ⓝ
   d. Did you talk or move more slowly than normal or were you fidgety, restless, or have trouble sitting still almost every day? Ⓨ Ⓝ
   e. Did you feel tired or without energy almost every day? Ⓨ Ⓝ
   f. Did you have difficulty concentrating or making decisions almost every day? Ⓨ Ⓝ
   g. Did you feel worthless or guilty almost every day? Ⓨ Ⓝ
   h. Did you repeatedly consider hurting yourself, feel suicidal, or wish you were dead? Ⓨ Ⓝ

SECTION 7

1. Have you EVER. . .
   a. Discussed an emotional problem with your medical doctor? Ⓨ Ⓝ

a. Received care from a psychiatrist? Ⓨ Ⓝ
b. Received care from a psychologist, psychotherapist, social worker, family therapist, or other mental health professional? Ⓨ Ⓝ
c. Been to Alcoholics Anonymous? Ⓨ Ⓝ
d. Talked to a drug counselor? Ⓨ Ⓝ

2. Race/ethnicity
a. Black/African American Ⓨ Ⓝ
b. Asian/Pacific Islander Ⓨ Ⓝ
c. White Ⓨ Ⓝ
d. Native American Ⓨ Ⓝ
e. Hispanic/Latino Ⓨ Ⓝ
f. Prefer not to answer

3. Are you currently working? Ⓨ Ⓝ

SECTION 8

Please fill ONE circle for each of the following three scales

0 – Not at All 1, 2, 3 – Mildly 4, 5, 6 – Moderately 7, 8, 9 – Mostly 10 - Extremely

1. To what extent have emotional symptoms disrupted your work in the last month?

0	1	2	3	4	5	6	7	8	9	10

2. To what extent have emotional symptoms disrupted your social life in the last month?

0	1	2	3	4	5	6	7	8	9	10

3. To what extent have emotional symptoms disrupted your family life/home responsibilities in the last month?

0	1	2	3	4	5	6	7	8	9	10

DO NOT WRITE IN THIS SECTION. TO BE FILLED OUT BY STAFF

Outcome of screening:

Referred for further evaluation

Referred for emergency evaluation

Referred but participant refused

Referral not necessary

Already in treatment

For which anxiety disorders or illness was the participant referred (fill in ALL that apply)?

Panic disorder

Social phobia

Post-traumatic stress disorder

Generalized anxiety disorder

Obsessive compulsive disorder

Depression

Other: _____

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INVENTORY OF DEPRESSIVE SYMPOMATOLOGY (SELF-REPORT)

Name: _____ Today's Date: _____

Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep:
   - 0 I never take longer than 30 minutes to fall asleep
   - 1 I take at least 30 minutes to fall asleep, less than half of the time
   - 2 I take at least 30 minutes to fall asleep, more than half of the time
   - 3 I take more than 60 minutes to fall asleep, more than half the time

2. Sleep During The Night:
   - 0 I do not wake up at night
   - 1 I have a restless, light sleep with a few brief awakenings each night
   - 2 I wake up at least once a night, but I go back to sleep easily
   - 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time

3. Waking Up Too Early:
   - 0 Most of the time, I awaken no more than 30 minutes before I need to get up
   - 1 More than half the time, I awaken more than 30 minutes before I need to get up
   - 2 I almost always awaken at least one hour or so before I need to, but I eventually go back to sleep
   - 3 I awaken at least one hour before I need to, and can't go back to sleep

4. Sleeping Too Much:
   - 0 I sleep no longer than 7-8 hours/night, without napping during the day
   - 1 I sleep no longer than 10 hours in a 24-hour period, including naps
   - 2 I sleep no longer than 12 hours in a 24-hour period, including naps
   - 3 I sleep longer than 12 hours in a 24-hour period, including naps

5. Feeling Sad:
   - 0 I do not feel sad
   - 1 I feel sad less than half the time
   - 2 I feel sad more than half the time
   - 3 I feel sad nearly all the time

6. Feeling Irritable:
   - 0 I do not feel irritable
   - 1 I feel irritable less than half the time
   - 2 I feel irritable more than half the time
   - 3 I feel extremely irritable nearly all of the time

7. Feeling Anxious Or Tense:
   - 0 I do not feel anxious or tense
   - 1 I feel anxious or tense less than half the time
   - 2 I feel anxious or tense more than half the time
   - 3 I feel anxious or tense nearly all the time

8. Response Of Your Mood To Good Or Desired Events:
   - 0 My mood brightens to a normal level which lasts for several hours when good events occur
   - 1 My mood brightens but I do not feel like my normal self when good events occur
   - 2 My mood brightens only somewhat to a rather limited range of desired events
   - 3 My mood does not brighten at all, even when very good or desired events occur in my life

9. Mood In Relation To The Time Of Day:
   - 0 There is no regular relationship between my mood and the time of day
   - 1 My mood often relates to the time of day because of environmental events (i.e., being alone, working)
   - 2 In general, my mood is more related to the time of day than to environmental events
   - 3 My mood is clearly and predictably better or worse at a particular time each day

9A. Is Your Mood Typically Worse In The: (Circle One)

   a. Morning
   b. Afternoon
   c. Night

9B. Is Your Mood Variation Attributed To The Environment? (Circle One)

Yes or N

10. The Quality Of Your Mood:
    0 The mood (internal feelings) that I experience is very much a normal mood
    1 My mood is sad, but this sadness is pretty much like the sad mood I would feel if someone close to me died or left
    2 My mood is sad, but this sadness has a different quality to it than the sadness I would feel if someone close to me died or left
    3 My mood is sad, but this sadness is different from the type of sadness I would feel if someone died or left

Please complete EITHER 11 OR 12, but not both.

11. Decreased Appetite:
    0 There is no change in my usual appetite
    1 I eat somewhat less often or lesser amounts of food than usual
    2 I eat much less than usual and only with personal effort
    3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat

12. Increased Appetite:
    0 There is no change from my usual appetite
    1 I feel a need to eat more frequently than usual
    2 I regularly eat more often and/or more amounts of food than usual
    3 I feel driven to overeat both at mealtime and between meals

Please complete either 13 OR 14, not both

13. Decreased Weight: (Within The Last Two Weeks)

    0 I have not had a change in my weight
    1 I feel as if I have had a slight weight loss
    2 I have lost 2 or more pounds
    3 I have lost 5 or more pounds

14. Increased Weights: (Within The Last Two Weeks)
    0 I have not had a change in my weight
    1 I feel as if I have had a slight weight gain
    2 I have gained 2 or more pounds
    3 I have gained 5 or more pounds

15. Concentration/Decision Making:
    0 There is no change in my usual capacity to concentrate or make decisions
    1 I occasionally feel indecisive or find that my attention wanders
    2 Most of the time, I struggle to focus my attention or make decisions
    3 I cannot concentrate well enough to read or make even minor decisions

16 View Of Myself:
    0 I see myself as equally worthwhile and deserving as other people
    1 I am more self-blaming than usual
    2 I largely believe I cause problems for others
    3 I think almost constantly about major and minor defects in my life

17 View Of My Future:
    0 I have an optimistic view of my future
    1 I am occasionally pessimistic about my future, but for the most part, I believe things will get better
    2 I'm pretty certain my immediate future (1-2 months) does not hold much promise of good things for me
    3 I see no hope of anything good happening to me anytime in the future

18 Thoughts Of Death Or Suicide:
    0 I do not think of death or suicide
    1 I feel that life is empty and/or wonder if it is worth living
    2 I have thought of suicide or death several times for several months
    3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actively tried to take my life

19 General Interest:
    0 There is no change from usual in how interested I am in other people or activities
    1 I notice that I am less interested in people or activities
    2 I find I have interest in only one or two of my formerly pursued activities
    3 I have virtually no interest in formerly pursued activities

20 Energy Level:
    0 There is no change in my usual level of energy
    1 I get tired more easily than usual
    2 I must make a big effort to start or finish my usual daily activities (i.e., shopping, housework, cooking, or going to work)
    3 I really cannot carry out most of my usual daily activities because I just don't have the energy

21 Capacity For Pleasure Or Enjoyment (Excluding Sex):
    0 I enjoy pleasurable activities just as much as usual
    1 I do not feel my usual sense of enjoyment from pleasurable activities
    2 I rarely get a feeling of pleasure from any activity
    3 I am unable to get any pleasure or enjoyment from anything

22 Interest In Sex (please rate **interest**, not **activity**):
- 0 I am just as interested in sex as usual
- 1 My interest in sex is somewhat less than usual or I do not get the same pleasure from sex as I used to
- 2 I have little desire for or rarely derive pleasure from sex
- 3 I have absolutely no interest or have no pleasure from sex

23. Feeling Slowed Down:
- 0 I think, speak, and move at my usual rate of speed
- 1 I find that my thinking is slowed down, or my voice sounds dull or flat
- 2 It takes me several seconds to respond to most questions and iu'm sure my thinking is slowed
- 3 I am often unable to respond to questions without extreme effort

24 Feeling Restless:
- 0 I do not feel restless
- 1 I am often fidgety, wring my hands, or need to shift how I am sitting
- 2 I have impulses to move about and am quite restless
- 3 At times, I am unable to stay seated and need to pace around

25 Aches And Pains:
- 0 I do not have any feeling of heaviness in my arms or legs and do not have any aches or pains
- 1 Sometimes I get headaches or pains in my stomach, back, or joints, but these pains are only sometimes present, and they do not stop me from doing what I need to do
- 2 I have these sorts of pains most of the time
- 3 These pains are so bad, they force me to stop what I am doing

26 Other Bodily Symptoms:
- 0 I do not have any of these symptoms: heart pounding fast, blurred vision, sweating, hot and cold flashes, chest pain, heart turning over in my chest, ringing in my ears, or shaking
- 1 I have some of these symptoms, but they are mild and are present only sometimes
- 2 I have several of these symptoms and they bother me quite a bit
- 3 I have several of these symptoms and when they occur, I must stop doing whatever I am doing

27 Panic/Phobic Symptoms:
- 0 I have no spells of panic or specific fears/phobia (ie animals or heights)
- 1 I have mild panic episodes or fears that usually change my behavior or stop me from functioning
- 2 I have significant panic episodes or fears that for me to change my behavior but **do not** stop me from functioning
- 3 I have panic episodes at least once a week or severe fears that stop me from carrying on my daily activities

28 Constipation/Diarrhea:
- 0 There is no change in my usual bowel habits
- 1 I have intermittent constipation or diarrhea which is mild
- 2 I have diarrhea or constipation most of the time, but it **does not** interfere with my day-to-day functioning
- 3 I have constipation or diarrhea for which I take medicine, or which interferes with my day-to-day functioning

29 Interpersonal Sensitivity:
- 0 I have not felt easily rejected, slighted, criticized, or hurt by others at all
- 1 I have occasionally felt rejected, slighted, criticized, or hurt by others
- 2 I have often felt rejected, slighted, criticized, or hurt by others, but these feelings have only had a **slight** effect on my relationships or work
- 3 I have often felt rejected, slighted, criticized, or hurt by others, and these feelings **have** impaired my relationships and work

30 Leaden Paralysis/Physical Energy:
- 0 I have not experienced the physical sensation of feeling weighed down and/or without physical energy
- 1 I have occasionally experienced periods of feeling physically weighed down and/or without physical energy, but without a negative effect on work, school, or activity level
- 2 I feel physically weighed down (without physical energy) more than half the time
- 3 I feel physically weighed down (without physical energy) most of the time, several hours per day, several days per week

Which THREE (3) items/questions were the easiest to understand? _____

For Office Use:

Range: 0 – 84 Score: ____

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GENERAL ANXIETY DISORDER SYMPTOM SEVERITY SCALE (SELF-REPORT)

Name: _____ Today's Date: _____

Please circle the one response to each item that best describes you.

1. Excessive Anxiety and Worry:

Frequency:
How often have you ever been anxious or worried in the past week?

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
How anxious or worried were you? How much distress or discomfort did this anxiety or worrying cause you this past week? How much did they interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

2. Difficulty In Controlling The Worry:

Frequency:
How often have you had difficulty controlling your worry in the past week?

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
Were you able to put the worries out of your mind and think about something else? How hard did you have to try? How much distress or discomfort was associated? How much did this interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

3. Restless Or Feeling Keyed Up Or On Edge

Frequency:
How often have you felt restless or keyed up or on edge in the past week?

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
How restless or keyed up or on edge were you? How much distress or discomfort did this cause you? How much did it interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

4. Being Easily Fatigued:

Frequency:
How often have you been easily fatigued the past week? (What kind of things have made you feel tired?)

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
How severe has it been? How much distress of discomfort did this cause you? How much did it interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

5. Difficulty Concentrating, Or Mind Going Blank:

Frequency:
How often have you had difficulty concentrating or had your mind go blank in the past week?

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
How severe has this been? How much distress or discomfort did this cause you? How much did it interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

6. Irritability:

Frequency:
How often have you felt irritable in the past week?

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
How severe has this been? How much distress or discomfort did this cause you? How much did it interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

7. Muscle Tension:

Frequency:
How often have you experienced muscle tension in the past week?

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
How severe has this been? How much distress or discomfort did this cause you? How much did it interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

8. Sleep Disturbance (Difficulty Falling Or Staying Asleep, Or Restless, Unsatisfied Sleep):

Frequency:
How often have you experienced sleep disturbance (difficulty falling or staying asleep, or had a restless, unsatisfied sleep) in the past week?

0 None of the time
1 Very little of the time (<10%)
2 Some of the time (~20% – 30%)
3 Much of the time (~50% - 60%)
4 Most of the time (>80%)

Intensity:
How severe has this been? How much distress or discomfort did this cause you? How much did it interfere with your life?

0 None
1 Mild. Minimal distress or disruption of activities
2 Moderate. Distress clearly present but still manageable, some disruption of activities
3 Severe. Considerable distress, marked disruption of activities
4 Extreme. Incapacitating distress, unable to continue activities.

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WAT (WORRY-ANXIETY-TENSION SCALE) SELF-REPORT

Name: _____ Today's Date: _____

Please circle the one response to each item that best describes you.

WORRY

In the **past week**, how much have you suffered from worry?

Not at All		Mildly			Moderately			Markedly		Extremely
0	1	2	3	4	5	6	7	8	9	10

ANXIETY

In the **past week**, how much have you suffered from anxiety?

Not at All		Mildly			Moderately			Markedly		Extremely
0	1	2	3	4	5	6	7	8	9	10

TENSION

In the **past week**, how much have you suffered from tension?

Not at All		Mildly			Moderately			Markedly		Extremely
0	1	2	3	4	5	6	7	8	9	10