Blackhawk TMS Center

We bring light to depression and anxiety.

Welcome to Blackhawk TMS Center; Blackhawk TMS Center is a forward-thinking specialty clinic that uses transcranial magnetic stimulation (TMS) to provide effective, non-pharmaceutical treatment for mental health conditions. With an office in Danville, California, Blackhawk TMS Center is leading the field in treating patients who have depression and other mental health problems, as well as conditions affecting the nervous system.

Medical Director Said Ibrahimi, MD, and Clinical Director William J. Shryer, DCSW, LCSW, lead a team passionate about helping patients recover from some of the most debilitating health conditions using innovative approaches with proven benefits.

Mental health and neuropathic conditions can be challenging to treat, as patient responses to treatments can vary so dramatically. Many patients find little or no relief even after trying multiple forms of medication, but TMS gets to the root of the problem by focusing on the areas of the brain from which these conditions arise. Using state-of-the-art technology to administer these painless, safe therapies, the team at Blackhawk TMS Center can stimulate precisely the right parts of the brain to restore function, improve blood flow, and reduce symptoms.

Blackhawk TMS Center has highly qualified staff who all excel at their roles and have a sincere desire to improve the lives of their many grateful patients.

4145 Blackhawk Plaza Circle, Suite 201, Danville, CA 94506
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MAIN PURPOSE FOR THIS CONSULTATION:

PRESENTING PROBLEM/PRIMARY SYMPTOMS/BEHAVIORS?

PRIOR ATTEMPTS TO CORRECT PROBLEM/PRIOR PSYCHIATRIC HISTORY
Please include contact with other professionals, medications, types of treatment, ect. What did they do or not do?

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TREATMENT COURSE

The FDA recommended treatment for depression is 20-36 sessions usually performed (5 days a week). It is a noninvasive outpatient procedure which is usually 20-25 minutes that is pre-scheduled with no restriction on activities including driving before and after the treatment. The first session usually lasts one hour as we do localization of the area to be treated as well as the first treatment session.

____Initial here

DAY OF THE TREATMENT

- You can perform your normal daily activities prior and subsequent to the treatment with no restriction of eating, drinking or driving.
- If you are on regular medications make sure you keep the same schedule whether they are psychiatric or non- psychiatric medications.
- If you take medications as needed for anxiety or pain make sure you mention it to the technician prior to treatment, and normally there is no restriction associated with that.
- Less than 5% have some discomfort or pain especially with the initial treatment, most of the time it's very mild and gets better very quickly, however if you want to take an over-the-counter pain medication before the treatment you may do so at least 30 minutes before the session if you wish.
- During the treatment you will be awake and alert. The one rule is that you may not fall asleep.
- Please dress comfortably and casually for your treatment.
- If you have longer hair, please wear it down and be sure that there are no metal accessories attached; i.e bobby pins or clips.
- If you have any discomfort our Staff will always be with you, so please mention it to the staff person with you.
- If you wish to have a family member or a friend sit with you during the treatment you're welcome to invite them we have a special chair reserved for them.
- You will be fully awake and alert throughout the treatment and can communicate at all times with the staff and anyone else in the room with you.

***We also ask that when starting TMS treatment, you do not plan on taking any time off in the midst of having treatments which includes going on long vacations as this can interfere with receiving the full benefit from TMS.**

We value and respect your time as we reserve the appointment for you, if you have to cancel or change the appointment please give our staff notice so that we will make the proper readjustments in the schedule. We will do our best to try to accommodate rescheduling you with short notice if necessary. Our staff will make the best effort to try to do so.

CLINICAL TEAM FOR TMS

At BLACKHAWK TMS we take great pride in the integrated approach we have among our staff including clinical and administrative team. Our staff includes a team of providers supervised by our Medical Director Said A. Ibrahimi, MD, and our Clinical Director, William Shryer, DCSW, LCSW, and TMS technician's. We will do everything possible to ensure your privacy, comfort, and most importantly your safety and wellness.

____ Initial here

Thank you for the confidence you have in us. We always welcome your questions and feedback.

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FINANCES

- Most Insurances accepted
- Private pay fee schedule available
- Please visit our website, www.blackhawktms.com, for additional financing options

FINANCIAL INFORMATION: Person Responsible for payment/copays.

Name: _____Date of Birth: _____ Age: ____

Home Phone: _____ Other Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Marital Status: _____ Social Security #: _____ Sex: ☐ M ☐ F

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Credit Card Authorization Form
(Payments and Co-pays)

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Patient Name: _____

Credit Card Information Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
☐ Other: _____

Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize the Staff of Blackhawk TMS Center to charge my credit card above for amounts invoiced. I understand that my Credit Card information will be saved to file for future services on my account.

_____ _____
Cardholder Signature Date

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NEW PATIENT REGISTRATION

PATIENT INFORMATION

Referred by: _____ Date: _____

Name: _____ Age: _____

Home Phone: _____ Other Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: _____

Social Security #: _____ Sex: ☐ F ☐ M

Employer's Name: _____ Phone: _____

Address: _____

_____

Nearest Relative *NOT* living with patient: _____

Home Phone: _____ Other Phone: _____

Relationship: _____

Address: _____

_____

Primary Care Physician Name: _____ Phone: _____

Address: _____

INSURANCE INFORMATION:

Name: _____ Date of Birth: _____

Primary Insurance: _____ Phone: _____

ID#: _____ Policy, Group or Local #: _____

Address Listed On Insurance Card: _____

City: _____ State: _____ Zip: _____

If applicable, I authorize release of medical information, necessary to process my claims and payment of medical benefits to this provider for services rendered. I understand that I am responsible for all charges incurred at the time of service. My signature authorizes BLACKHAWK TMS Center to charge services rendered as needed to the credit card on file. **I have read and agree to the Conditions of Service, Financial Policy and Consent for Treatment.**

Signature of Insured or Authorized Person: _____

Date: _____

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CONDITIONS OF SERVICE

APPOINTMENTS: _____ *(INITIALS)*

I UNDERSTAND ALL APPOINTMENT TIMES HAVE BEEN RESERVED FOR ME AND/OR MY FAMILY. MY CANCELLATION OF THIS TIME REQUIRES NOTICE IT IS ADVISABLE FOR ME TO **ARRIVE 10 MINUTES PRIOR TO MY APPOINTMENT.**

(AFTER-HOUR CANCELLATIONS MAY BE LEFT ON THE VOICEMAIL SYSTEM.)

I AM AN INITIAL (NEW) PATIENT ____. I AM AN ESTABLISHED PATIENT ____.

Confidentiality: _____ *(INITIALS)*

Certain circumstances are exceptions to the laws of confidentiality, under which a physician/therapist is legally required to report. These include:

- **Intent to harm yourself (suicide)**
- **Intent to harm another person**
- **Child, physical and/or sexual abuse**
- **Abuse of an elder or dependent adult**

FINANCIAL POLICY

Payments: _____ *(INITIALS)*

If you have a co-pay with your insurance, full payment of co-pay for each visit is required at the time of service. We accept cash, checks, MasterCard and Visa.

Family Member(s)/Parent(s)/Guardians of Disabled Adult Patients: _____ *(INITIALS)*

Family member(s)/parent(s)/guardian of disabled patients, who are chronically-ill adults, are required to complete all financial documents and accept full financial responsibility for the treatment of their disabled adult relative.

Disabled adult patients need to sign an Exchange of Information form. This allows the staff to discuss the financial and clinical information with the family member(s)/parent(s)/guardian of the disabled adult. The professional staff will discuss the patient's treatment, as long as an Exchange of Information form is signed by the disabled adult patient. Conservatorship document copies will be accepted in lieu of an **Exchange of Information form.**

I have read and understand these statements and agree to abide by these policies.

Patient's Signature: _____ **Date:**_____

Parent/Guardian's Signature: _____ **Date:** _____
(if applicable)

Relationship to Patient: _____

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CONSENT FOR TREATMENT

I intend that this provider of health services will provide:

_____

Patient's Name

with behavioral health and consultation services including Transcranial Magnetic Stimulation, and other treatment modalities as appropriate.

I understand that once I mail my completed packet to the office, they will contact me for an appointment once it is received. I understand I will have one TMS consultation. The insurance is informed that you have requested TMS treatments and any pre-authorization forms needed will be sent to the insurance company for submission of the TMS treatments. Private pay patients will be directed to a private pay fee schedule/consent. At the business office's direction, the second appointment is established to determine your Motor Threshold followed by the first TMS treatment. Allow 1 ½ hours for this appointment. Subsequent daily appointments will be scheduled. At the end of every fifth treatment, you will complete several depression rating scales.

I understand that communication between this provider and me is confidential and privileged to the full extent of the state and federal law including the current HIPAA privacy rules. I have read the Notice of Privacy Practices and signed, dated and returned the Consent to Use and Disclose Private Health Information. My further questions can be directed to Privacy Officer in the Business Office.

I further understand that certain circumstances are exceptions to the laws of confidentiality, under which a provider is legally required to report. These include:

- Intent to harm yourself (suicide)
- Intent to harm another person
- Child abuse, physical and/or sexual
- Abuse of an elder or dependent adult

If a physician/therapist reasonably believes one of these exceptions applies, he or she will make every effort to resolve the issue by discussing it with you before reporting it to the proper agency

Signature: _____Date: _____

Relationship to Patient: _____

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SIGN, DATE AND RETURN

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

The BLACKHAWK TMS Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we have provided you, copies of the current notice are available in the Blackhawk TMS office.
I acknowledge that I have received the Notice of Privacy Practices.

_____ ____ / _____/ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print Patient Name Relationship to Patient

_____
Name of Guarantor (relative of adult patient, legal guardian or conservator)

If written acknowledgement is not obtained, please check reason:

- ☐ Notice of Privacy Practices Given - Patient Unable to Sign
- ☐ Notice of Privacy Practices Given - Patient Declined to Sign
- ☐ Other _____

.....

_____ ____ / ____ / ____
Signature of BLACKHAWK TMS CENTER Representative Date

_____ _____
Print Name Department

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CONSENT TO RELEASE MEDICAL INFORMATION

Name of Patient: _____ Provider or Facility: _____

Date of Birth: _____ Address:_____

_____

Fax: _____ Phone: _____

This authorizes the above listed provider or facility to release the following medical information and/or documentation to Blackhawk TMS in accordance with the Lanterman-Petris-Short Act and/or 42 Code of Federal Regulation.

□ Psychiatric Medical Records
□ Alcohol and/or Drug Abuse Records
□ Other:_____

Disclosure shall be limited to the following information:

□ Discharge Summary □ Consult □Physical Examination
□ Social Service Assessment ☒ Telephone Consultation(s) □ Psychiatric Workup
□ Educational Assessment □ Neurodevelopmental/ Neuropsychological Assessment
□ Psychological Testing □ Laboratory Reports □ Occupational Therapy Assessment
□ Last Medication Sheet □ Audiologist Report □ Speech/Language Assessment
□ Other: _____

I understand that my protected health information may be used for treatment, payment, or health care operations. I understand I have the right to review the privacy notice prior to signing this consent and Blackhawk TMS has reserved the right to change their privacy practice, if applicable. I understand that I have the right to request a restriction on the use of protected health information. When Blackhawk TMS agrees to the request, the request is binding on Blackhawk TMS. This consent expires in one year unless I notify Blackhawk TMS otherwise in writing. I understand that I have the right to revoke this consent in writing except to the extent that action has been taken in reliance on this consent. I understand that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and no longer be protected by rule 45 CFR ξ 164.506(c) & 508; 65 Red. Reg.at 82509.

I further release my attending or primary care physician and his/her associates, employees and agents from any liability arising from the release of this information or record to such designated person or agencies.

I have carefully read and I understand the foregoing. I consent to the release of the above-specified information about myself and the treatment or services he/she or myself have received to: Blackhawk TMS, P.O. Box 1613, Danville, Ca 94526-6613.

_____ _____
Signature of Patient and/or Guardian, if applicable Date Signed

_____
Printed Name of Patient and/or Guardian, if applicable

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MEDICAL HISTORY

Past significant medical and/or behavioral problems: _____
_____
_____
_____
_____

Previous prescriptions or over-the-counter medications, for any purpose:

Medication:	Dosage:	Directions:	Side Effects:	Reason for discontinuation:

Note: If you need more space please write on the back of this page

Current significant medical problems, for **any** purpose: _____
_____
_____
_____
_____

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Current prescriptions or over-the-counter medications, for any purpose:

Medication:	Dosage:	Directions:	Side Effects:	Reason for discontinuation:

Note: If you need more space please write on the back of this page

Do you have a history of Thyroid problems? No _____ Yes _____ If yes, please elaborate:

_____

Other doctors/clinics seen regularly _____

_____

_____

Describe any history of head trauma or being knocked out. _____

_____

_____

Have you ever had any seizures or seizure-like activity? (If so, please describe) _____

_____

_____

Have you ever had any periods of spaciness or confusion? (If so, please describe) _____

_____

_____

Do you have any prior medical hospitalizations? (If so, please give the date or age, cause and outcome)

_____

_____

_____

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CURRENT LIFE STRESSES: Include anything that is currently stressful for you, examples include relationships, job, school, finances, and children: _____

_____

_____

_____

Social activities: Please describe your relationships with peers & siblings while growing up, i.e., clubs, organizations. _____

_____

_____

Sleep behavior: – sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

_____

_____

_____

Educational History:
Last grade completed _____ Last school attended_____

Employment History: – summarize jobs you have had, listing most favorite and least favorite

_____

_____

Alcohol and Drug History: (Please list each recreational drug (including alcohol) separately including the age you started, stopped (if relevant) including how that substance made you feel and what benefit you got from it.) These include alcohol: hard liquor, beer, wine; steroids, prescription tranquilizers or sleeping pills; inhalants: glue, gasoline, cleaning fluids, etc.; marijuana, hash, cocaine, crack, amphetamines, crank, ice, ecstasy, opiates: heroin, codeine, morphine or other pain killers; barbiturates, hallucinating drugs: LSD, mescaline, mushrooms, or PCP.)

_____

_____

_____

Have you ever experienced withdrawal symptoms from alcohol/drugs? ☐ No ☐ Yes, (length of time and duration of withdrawal?) _____

_____

Have you ever felt guilty about your drug/alcohol use? ☐ No ☐ Yes,

_____

_____

Have you ever used drugs/alcohol first thing in the morning? ☐ No ☐ Yes,

_____

_____

If you are currently consuming alcohol, please indicate how often and how much, ***as alcohol can have a negative impact with TMS therapy.*** _____

_____

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If you are currently using any recreational drugs, please indicate how much and how often:

_____
_____
_____

Caffeine: – please give your average use per day including source and estimated quantity

_____
_____

Nicotine: – estimate your average use per day both past and present (nicotine is in tobacco, cigarettes, cigars, chew and pipe) _____

Describe any history of being physically, emotionally, sexually or verbally abused:

_____
_____
_____
_____
_____

FAMILY HISTORY

Family Structure: – who lives in your current household?

Name:	Age:	Relationship to you:

Current Marital or Relationship Satisfaction: _____
_____

Significant Developmental Events: –*these are those positive and negative experiences that have had a significant impact on your life (examples include but are not limited to marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)* _____

_____
_____
_____
_____

Describe your relationships within your family between siblings, parents, your neighbors, local and community activities (i.e. church). _____

_____
_____
_____
_____

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Describe yourself: _____

Describe your strengths: _____

Please use this space to include any other important details about yourself that you would like us to be aware of: _____

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Symptom Checklist

Please check any symptoms you have recently experienced:

- ☐ Headaches
- ☐ Dizziness
- ☐ Unexplained pain
- ☐ Menstrual problems/changes
- ☐ Urinary problems
- ☐ Changes in bowel habits (specify)

_____

- ☐ Diarrhea
- ☐ Chronic constipation
- ☐ Other physical symptoms (specify)

_____

- ☐ Heart pounding/racing
- ☐ Feelings of panic
- ☐ Difficulty relaxing
- ☐ Change in appetite
- ☐ Vomiting
- ☐ Nausea
- ☐ Weight gain
- ☐ Weight loss
- ☐ Fatigue/low energy
- ☐ Early morning awakening
- ☐ Loss of/decreased enjoyment, in pleasure events
- ☐ Changes in energy level
- ☐ Decreased effectiveness at home, work, school
- ☐ Heeding to be with others excessively
- ☐ Needing to be alone excessively
- ☐ Excessive, constant guilt
- ☐ Crying spells
- ☐ Thoughts/attempts to hurt self
- ☐ Thoughts of death
- ☐ Thoughts of suicide
- ☐ Thoughts of hurting others
- ☐ Difficulty concentrating
- ☐ Difficulty making decisions
- ☐ Feelings of inadequacy
- ☐ Low self-esteem
- ☐ Feeling slowed down
- ☐ Feeling restless at times
- ☐ Feeling hopeless
- ☐ Feeling helpless
- ☐ Mood changes (specify)

_____

- ☐ Changes in memory (specify)

_____

- ☐ Tremors
- ☐ Changes in walk
- ☐ Changes in speech
- ☐ Changes in writing
- ☐ Changes in driving
- ☐ Increased suspicions/concerns
- ☐ Nightmares
- ☐ Hallucinations
- ☐ Excessive/unusual fears
- ☐ Hearing voices
- ☐ Repetitive/bothersome thoughts (specify)

_____

- ☐ Recurrent/bothersome behaviors
- ☐ Feelings of unreality
- ☐ Unusual behaviors (specify)

_____

- ☐ Impulsive Behavior (Problems related to gambling, drinking, eating, spending money, others)
- ☐ Irritability/excessive anger
- ☐ Sexual problems (Describe)

_____

- ☐ Difficulty in relationship
- ☐ Difficulty with mate
- ☐ Difficulty with children
- ☐ Difficulty with co-workers
- ☐ Recommendation of family, friends, associates, to seek help

COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

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BURN'S ANXIETY INVENTORY

Name_____Date_____Total_____

Instructions: Circle the answer that best describes how much that symptom or problem has bothered you during the past seven (7) days.

Category I: Anxious Feelings	Not at all	Somewhat	Moderately	A lot
1.Anxiety, nervousness, worry or fear	0	1	2	3
2.Feeling that things around you are strange, unreal or foggy	0	1	2	3
3.Feeling detached from all or part of your body	0	1	2	3
4. Sudden, unexpected panic spells	0	1	2	3
5. Apprehension or a sense of impending doom	0	1	2	3
6. Feeling tense, stressed, "uptight" or on edge	0	1	2	3
Category II: Anxious Thoughts				
7. Difficulty Concentrating	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to next	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you're on the verge of losing control	0	1	2	3
11. Fears of cracking up or going crazy	0	1	2	3
12. Fears of fainting or passing out	0	1	2	3
13. Fears of physical illness or heart attacks or dying	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated or abandoned	0	1	2	3
16. Fears of criticism or disapproval	0	1	2	3
17. Fears that something terrible is about to happen	0	1	2	3
Category III: Physical Symptoms				
18. Skipping or racing or pounding of the heart	0	1	2	3
19. Pain, pressure or tightness in the chest	0	1	2	3
20. Tingling or numbness in the toes or fingers	0	1	2	3
21. Butterflies or discomfort in the stomach	0	1	2	3
22. Constipation or diarrhea	0	1	2	3
23. Restlessness or jumpiness	0	1	2	3
24. Tight, tense muscles	0	1	2	3
25. Sweating not brought on by heat	0	1	2	3
26. A lump in the throat	0	1	2	3
27. Trembling or shaking	0	1	2	3
28. Rubbery or "jelly" legs	0	1	2	3
29. Feeling dizzy, light-headed or off balance	0	1	2	3
30. Choking or smothering sensations or difficulty breathing	0	1	2	3
31. Headaches or pains in the neck or back	0	1	2	3
32. Hot flashes or cold chills	0	1	2	3
33. Feeling tired, weak or easily exhausted	0	1	2	3
Add Column:				

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THE BURNS DEPRESSION INVENTORY

NAME: _____ DATE: _____

INSTRUCTIONS: The following is a list of symptoms that people sometimes have. Put a check ( ) in the space to the right that bests describes how much that symptom or problem has bothered you during this past week.	0 - NOT AT ALL	1- SOMEWHAT	2- MODERATELY	3- A LOT
SYMPTOM LIST				
Sadness: Do you feel sad or down in the dumps?	0	1	2	3
Discouragement: Does your future look hopeless?	0	1	2	3
Low Self-Esteem: Do you feel worthless?	0	1	2	3
Inferiority: Do you feel inadequate or inferior to others?	0	1	2	3
Guilt: Do you get self-critical and blame yourself?	0	1	2	3
Indecisiveness: Is it hard to make decisions?	0	1	2	3
Irritability: Do you frequently feel angry or resentful?	0	1	2	3
Loss of interest in life: Have you lost interest in your career, hobbies, family and friends?	0	1	2	3
Loss of motivation: Do you have to push yourself to do things?	0	1	2	3
Poor Self-Image: Do you feel old and unattractive	0	1	2	3
Appetite Changes: Have you lost your appetite? Do you overeat or binge compulsively?	0	1	2	3
Sleep Changes: Is it hard to get at good night's sleep? Are you excessively tired and sleeping too much?	0	1	2	3
Loss of Libido: Have you lost your interest in sex?	0	1	2	3
Concerns about Health: Do you worry excessively about your health?	0	1	2	3
Suicidal Impulses? Do you have thoughts that life is not worth living or think you'd be better off dead?	0	1	2	3
Add up your total and record it here:	0			
Total:				

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	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.	0	1	2	3
Add columns:		+	+	
			Total:	

10. If you checked off any problems, how difficult at all 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

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Wakefield Self Report Questionnaire

Name:_____ Date:_____ Score_____

Read these statements carefully, one at a time, and underline or circle the response that best indicates how you feel. It is very important to indicate how you are now, not how you were, or how you would hope to be.

_____ A. I feel miserable and sad.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ B. I find it easy to do the things I used to do.
- 0 Yes, definitely
- 1 Yes, sometimes
- 2 No, not much
- 3 No, not at all

_____ C. I get very frightened or panicky feeling for apparently no reason at all.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ D. I have weeping spells, or feel like it
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ E. I still enjoy the things I used to.
- 0 Yes, definitely
- 1 Yes, sometimes
- 2 No, not much
- 3 No, not at all

_____ F. I am restless and can't keep still.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ G. I get off to sleep easily without sleeping tablets.
- 0 Yes, definitely
- 1 Yes, sometimes
- 2 No, not much
- 3 No, not at all

_____ H. I feel anxious when I go out of the house on my own.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ I. I have lost interest in things.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ J. I get tired for no reason.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ K. I am more irritable than usual.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

_____ L. I wake early and then sleep badly for the rest of the night.
- 0 No, not at all
- 1 No, not much
- 2 Yes, sometimes
- 3 Yes, definitely

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Beck's Depression Inventory II

Name: _____ Date: _____ Score: _____

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 and 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 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.
   (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 weaknesses or mistakes.
   (2) I blame myself all the time for my faults.
   (3) I blame myself for everything bad that happens.

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9. (0) I don't have any thoughts of killings 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.

10. (0) I don't cry any more 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 by things than I ever was.
    (1) I am slightly more irritated now than usual.
    (2) I am quite annoyed or irritated a good deal of the time.
    (3) I feel irritated all of the time.

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 more than I used to.
    (3) I can't make decisions at all anymore.

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

20. (0) I am no more worried about my health than usual.
    (1) I am worried about physical problems like aches, pains, 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 of 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 have almost no interest in sex.
    (3) I have lost interest in sex completely.

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HAMILTON DEPRESSION RATING SCALE (HAM-D)

Name: _____ Date:_____ Score_____

1. DEPRESSED MOOD
   (Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
   0 = Absent
   1 = Sadness, etc.
   2 = Occasional weeping
   3 = Frequent weeping
   4 = Extreme symptoms

2. FEELINGS OF GUILT
   0 = Absent
   1 = Self-reproach, feels he/she has let people down
   2 = Ideas of guilt
   3 = Present illness is a punishment; delusions of guilt
   4 = Hallucinations of guilt

3. SUICIDE
   0 = Absent
   1 = Feels life is not worth living
   2 = Wishes he/she were dead
   3 = Suicidal ideas or gestures
   4 = Attempts at suicide

4. INSOMNIA – Initial
   (Difficulty in falling asleep)
   0 = Absent
   1 = Occasional
   2 = Frequent

5. INSOMNIA - Middle
   (Complains of being restless and disturbed during the night. Waking during the night.)
   0 = Absent
   1 = Occasional
   2 = Frequent

6. INSOMNIA - Delayed
   (Waking in early hours of the morning and unable to fall asleep again)
   0 = Absent
   1 = Occasional
   2 = Frequent

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7. WORK AND INTERESTS
   0 = No difficulty
   1 = Feelings of incapacity, listlessness, indecision and vacillation
   2 = Loss of interest in hobbies, decreased social activities
   3 = Productivity decreased
   4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

8. AGITATION
   (Restlessness associated with anxiety.)
   0 = Absent
   1 = Occasional
   2 = Frequent

9. ANXIETY - PSYCHIC
   0 = No difficulty
   1 = Tension and irritability
   2 = Worrying about minor matters
   3 = Apprehensive attitude
   4 = Fears

10. ANXIETY - SOMATIC
    Gastrointestinal, indigestion Cardiovascular, palpitation, Headaches, Respiratory, Genito-urinary, etc.
    0 = Absent
    1 = Mild
    2 = Moderate
    3 = Severe
    4 = Incapacitating

11. SOMATIC SYMPTOMS - GASTROINTESTINAL
    (Loss of appetite , heavy feeling in abdomen; constipation)
    0 = Absent
    1 = Mild
    2 = Severe

12. SOMATIC SYMPTOMS - GENERAL
    (Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
    0 = Absent
    1 = Mild
    2 = Severe

13. GENITAL SYMPTOMS
    (Loss of libido, menstrual disturbances)
    0 = Absent
    1 = Mild
    2 = Severe

14. HYPOCHONDRIASIS
    0 = Not present
    1 = Self-absorption (bodily)
    2 = Preoccupation with health
    3 = Querulous attitude
    4 = Hypochondriacal delusions

15. WEIGHT LOSS
    0 = No weight loss
    1 = Slight
    2 = Obvious or severe

16. INSIGHT
    (Insight must be interpreted in terms of patient's understanding and background.)
    0 = No loss
    1 = Partial or doubtfull loss
    2 = Loss of insight

17. DIURNAL VARIATION
    (Symptoms worse in morning or evening. Note which it is.)
    0 = No variation
    1 = Mild variation; AM ( ) PM ( )
    2 = Severe variation; AM ( ) PM ( )

18. DEPERSONALIZATION AND DEREALIZATION
    (feelings of unreality, nihilistic ideas)
    0 = Absent
    1 = Mild
    2 = Moderate
    3 = Severe
    4 = Incapacitating

19. PARANOID SYMPTOMS
    (Not with a depressive quality)
    0 = None
    1 = Suspicious
    2 = Ideas of reference
    3 = Delusions of reference and persecution
    4 = Hallucinations, persecutory

20. OBSESSIONAL SYMPTOMS
    (Obsessive thoughts and compulsions against which the patient struggles)
    0 = Absent
    1 = Mild
    2 = Severe