PEDIATRIC
HEADACHE
CENTER
OF RICHMOND

Patient Name: _____

DOB: _____

New Patient Questionnaire

Briefly, reason for your visit: _____

Address: _____

City, State & Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

PCP & Phone Number: _____

Pharmacy Name & Address: _____

Who can we thank for referring you? _____

Insurance Information

Primary Insurance: _____ Member ID #: _____

Subscriber's Name: _____ Subscriber's Date Of Birth: _____

Relationship to Patient: _____

Secondary Insurance: _____ Member ID #: _____

Subscriber's Name: _____ Subscriber's Date Of Birth: _____

If Minor

Name of Parent / Legal Guardian: _____

Length of Pregnancy: _____

List problems during delivery: _____

How many days was your baby hospitalized after birth: _____

Were milestone normal? Yes ☐ No ☐ If no, please elaborate: _____

OFFICE USE

Date Received: _____

PEDIATRIC
HEADACHE
CENTER
OF RICHMOND

Patient Name: _____

DOB: _____

Past Medical History:

Birth marks, rashes: _____

Any of the following problems: asthma, stomach trouble, anxiety, depression, headaches, speech or language problems fainting or passing out, seizures (febrile seizures, involuntary movements):

_____

_____

_____

Any tests, treatments or procedures? Head or bodily injuries in the past?: _____

_____

_____

_____

Medications currently taking: _____

_____

_____

_____

_____

_____

_____

Medications taken in the past: _____

_____

_____

_____

_____

_____

_____

PEDIATRIC
HEADACHE
CENTER
OF RICHMOND

Patient Name: _____

DOB: _____

Allergies (include reaction to medication): _____

_____

_____

_____

_____

Family History:
(Ex: frequent miscarriages, developmental problems, autism, mental retardation, learning problems, hyperactivity, migraine, seizures, muscle disorders, movement disorders, strokes at less than 50 years old)

Mother: _____

Father: _____

Siblings: _____

_____

Other: _____

Social History:
Please list everyone who lives in the home (include their relationship to the patient):

_____

_____

_____

_____

_____

_____

School / Employer : _____

Grade / Type of Work: _____

Anything additional the doctor should know? _____

_____

_____

PEDIATRIC HEADACHE CENTER OF RICHMOND

Patient Name: _____ Date of Birth: _____

Authorization for Treatment

- I hereby authorize medical treatment by the physician, the clinical staff, and technical employees assigned to my care.
- I authorize my treating providers to order any ancillary services, such as laboratory or radiology tests, or any other services or treatments deemed necessary for my care and safety.
- I understand I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns before treatment is provided.
- In the event a healthcare worker is exposed to my blood or bodily fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus, or hepatitis C virus, I consent to the testing of my blood and/or bodily fluids for these infections and the reporting of my test results to the healthcare worker who has been exposed, as required by Virginia law.
- I understand Pediatric Headache Center of Richmond, PLLC utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPPA and other patient privacy and health information management regulations. I understand my healthcare providers will have access to my healthcare information as is necessary to provide and coordinate my care.
- I understand Pediatric Headache Center of Richmond, PLLC utilizes electronic prescribing mechanism for electronic transmission of prescriptions and any medications my physician prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I authorize the release of my prescription history to Pediatric Headache Center of Richmond, PLLC from any pharmacy or drug monitoring agency.

_____ **Initial: I have read, understand and agree to the Authorization to Treat terms.**

Payment Arrangements

- I agree to accept financial responsibility for the payment of the costs of health care services provided to me and my dependent(s) by or on behalf of Pediatric Headache Center of Richmond, PLLC.
- By signing this document, I authorize the assignment to Pediatric Headache Center of Richmond, PLLC of all payments of all payments under any insurance benefits otherwise payable to me for services provided under any insurance policy (hospitalization, major medical, or any other insurance or benefit plan).
- By signing this document, I authorize the release of my protected health information (PHI) to my insurance companies or other third party payers, including their representatives, as necessary to determine coverage or as required to accomplish payment by my insurers for covered healthcare services.
- I agree to pay at the time of service, any required co-payments, co-insurance, and deductibles, as well as charges for services provided by Pediatric Headache Center of Richmond, PLLC which are not covered by my insurance.
- I have reviewed the details of the credit card policy for balances beyond 60 days.

PEDIATRIC HEADACHE CENTER OF RICHMOND

Patient Name: _____Date of Birth: _____

- I understand all unpaid balances will be billed to my address on file with this office and I am responsible for updating my registration information as necessary.
- I understand I am responsible for paying the balance of my bill in full unless other arrangements have been approved in advance.
- I understand there is a $40.00 charge for any check returned by my bank.
- I understand any past due amount owed on my account may be referred to a collection agency, and I will be responsible for all collection charges and associated legal fees, in addition to the full balance on my account.
- By signing this document, I agree photocopies of this document are as legally binding as the original.

_____ **Initial: I have read, understand and agree to the Payment Arrangement terms.**

Office Policies

- **Confidentiality**

  This clinic abides by federal privacy regulations and keeps your protected health information (PHI) confidential. Your PHI may be disclosed to plan your treatment or in determining eligibility for coverage of claims processing. You have a right to review and receive a copy of the complete Notice of Privacy Practices which outlines the full policy.

- **Payment Policy**

  Co-payments, or co-insurance are expected at the time of service. Your insurance will then be billed for the visit. We appreciate the handling of any outstanding balances promptly. Please refer to the details of the credit card policy for balances beyond 60 days. There is a $40.00 charge for any returned check.

- **Phone Calls & Refill Requests**

  Messages are checked frequently, and calls returned as quickly as possible. We do reserve the right to require one business day to return non-urgent calls and three business days for paperwork requests to be processed.

- **Emergencies**

  As a reminder, our clinic is open Monday – Thursday 8:30am to 5:00pm, and will return calls received up until noon on Fridays. Dr. Alford is available during these times for emergent and non-urgent issues. Should an emergency arise after hours, the patient can proceed to the nearest emergency room or urgent care facility. Our goal is to do our best to prepare for these after-hours emergencies at the time of your visit, so there is a plan of action in place to provide comfort until you can contact the office. Life threatening emergencies should be addressed by calling 911.

- **Cancellation, No-Show and Late Arrivals**

  Our goal is to provide quality healthcare to all our patients in a timely manner. We understand life happens however no-shows, late arrivals, and last minute cancellations can be disruptive not only to our clinic, but our other patients. Please be aware of our policy regarding appointments.

PEDIATRIC HEADACHE CENTER OF RICHMOND

Patient Name: _____Date of Birth: _____

Appointment Cancellation: When you book your appointment, you are holding a space on our calendar that is no longer available to our other patients. In order to be respectful of your fellow patients, please call our office as soon as you know you will not be able to make your appointment. We ask you give us a minimum of one full business day notice if cancellation is necessary. Exceptions, of course will be made in the case of an emergency or sudden illness. Late cancellations (less than one business day), in excess of two will result in a cancellation fee of $50 charge to the patient account.

No-Shows: Patients are reminded of their appointments two - four days prior by email and/or phone call. When a patient misses an appointment without cancelling, we will charge the patient account a $50 missed appointment fee.

Late Arrival: Again, we understand there are occasions when sometimes things are just out of your control. If however you arrive more than 10 minutes later then your scheduled appointment we cannot guarantee you will be seen. The decision is at the discretion of the office based on numerous factors. We ask that you understand. You may need to be rescheduled for another date. If you are unable to be seen, and this happens in excess of two occasions, a fee of $50 will be assessed on your account as this will constitute a missed appointment.

_____ **Initial: I have read, understand and agree to the Office Policies terms.**

Patient / Parent or Guardian Signature _____Date_____

Patient / Parent or Guardian Printed Name_____

Privacy and Disclosure

Our Notice of Privacy Practices (NPP) provides information about how we may use and disclose your personal health information. By signing below, you acknowledge you have been informed of our NPP and offered a copy of the document.

Patient / Parent or Guardian Signature _____ Date_____

Patient / Parent or Guardian Printed Name_____

☐ Patient / Parent or Guardian refuses to sign Privacy and Disclose portion of form.
Reason:

PEDIATRIC HEADACHE CENTER OF RICHMOND

Patient Name: _____Date of Birth: _____

Permission to Disclose Private Health Information (PHI)

I give permission to the person(s) listed in the table documented to receive Private Health Information or other authorized information listed in the comments section. I understand this form is legally binding and I may revoke my authorization at any time by submitting a request to change, add, or terminate such permission in writing to the office of Pediatric Headache Center of Richmond, PLLC.

DATE OF PERMISSION	NAME OF INDIVIDUAL	RELATIONSHIP	COMMENTS: I.E. MAY ACCOMPANY, PICK UP MEDS, INFORMATION, ETC.	TELEPHONE NUMBER	PATIENT/ GUARDIAN INITALS	DATE PERMISSION REVOKED

In order to obtain information by telephone, the party calling the practice must be able to share the patient password with the staff.

Patient Password: _____

Patient / Parent or Guardian Signature _____Date_____

Patient / Parent or Guardian Printed Name_____

PEDIATRIC HEADACHE CENTER OF RICHMOND

Patient Name:_____

Date of Birth:_____

Tele-visit Terms and Conditions

The Pediatric Headache Center of Richmond Tele-visit Program affords patients the opportunity to complete Tele-visit appointments from the comfort of their own home or any appropriate internet access point. The program is open to select patients who meet the requirements to complete the tele-visit appointments.

Those requirements include: 1. Having the technology to support the Tele-visit. 2. Having been seen by a Pediatric Headache Center of Richmond provider within the last 12 months.

At this time, insurance coverage may not be available for this service. Each patient or patient's guarantor must complete the following acknowledgments:

If my insurance does not cover this service, I acknowledge that I waive my right to file a claim with my insurance carrier and will not request that my insurance be charged for this service at a later date.

If my insurance does not cover this service, I acknowledge that I have agreed to "self-pay" for these specific Tele-visit services provided to me through Pediatric Headache Center of Richmond, and I will be responsible for payment in full at the time of service via a credit card during the enrollment process.

I acknowledge that I have agreed to comply with the requirements of this program and understand that the selection to participate, and continued participation, is subject to the program requirements and periodic review by the treating provider, staff, and administration. The Pediatric Headache Center of Richmond provider reserves, at its sole discretion, the right to refer me back to an in-person visit if conditions change or because of non-compliance.

I acknowledge that I have been informed that the minimum charge for the tele-visit is $75.00. I also acknowledge that I have been informed that cancellation of this appointment with less than 24 hours' notice will result in a no-show fee of $50.00 to my credit card on file.

I acknowledge that I have read and understand the overview of the Tele-visit provided by Pediatric Headache Center of Richmond, and that I will provide the appropriate technology to complete the visit, and that this requirement is my responsibility, and that I can provide the equipment, connectivity, and software requirements.

I acknowledge that I should be in a secure environment (not a restaurant, lobby, etc.) for the visit, and that it is my responsibility to ensure the privacy of my information on my computer/device.

I acknowledge that the provider conducting the Tele-visit is authorized to determine in advance or during the Tele-visit, in his or her sole discretion, whether I am or remain eligible for this Tele-visit.

Intial:_____

PEDIATRIC HEADACHE CENTER OF RICHMOND

DISCLAIMER Informed Consent and Terms of Use

Please indicate your consent to and understanding of the terms and conditions of use of the Pediatric Headache Center of Richmond Tele-visit system before starting your interview with the provider.

I ACKNOWLEDGE THAT PEDIATRIC HEADACHE CENTER OF RICHMOND TELE-VISITS ARE FOR ROUTINE, NON- URGENT MEDICAL CONDITIONS, AND ARE NOT DESIGNED, INTENDED, OR APPROPRIATE TO ADDRESS SERIOUS, EMERGENT, OR LIFE-THREATENING MEDICAL CONDITIONS. I WILL NOT ATTEMPT TO USE MY TELE-VISIT TO ADDRESS THESE CONDITIONS. IF I AM HAVING A MEDICAL EMERGENCY, I WILL DISCONTINUE MY TELE-VISIT AND CALL 911 OR GO TO THE NEAREST EMERGENCY DEPARTMENT. IF I AM EXPERIENCING SIGNIFICANT PAIN, BREATHING TROUBLE, DEHYDRATION, OR ANY OTHER DISTRESS THAT REQUIRES IMMEDIATE OR URGENT ATTENTION, I WILL DISCONTINUE MY TELE-VISIT AND CALL 911 OR GO TO THE NEAREST EMERGENCY DEPARTMENT. I acknowledge that the Pediatric Headache Center of Richmond Tele-visit service cannot and is not intended to replace the relationships I have with the health care professionals who treat me.

I understand and acknowledge that my Tele-visit will establish a therapeutic clinician patient relationship and that my visit information will result in the creation of a medical record of the Tele-visit, if one does not already exist.

I acknowledge that I will be asked questions regarding the condition for which I am seeking medical care, and that I am obligated to answer questions truthfully. I agree that I will answer these questions completely and accurately and that, if I cannot understand a question or do not know the answer to a question, I will stop my Tele-visit and schedule an in-person visit.

I agree that if I am instructed to discontinue my Tele-visit and contact an available health care provider for any reason, I will do so. I also agree to carefully follow any instructions I receive through my Tele-visit and seek clarification of any instructions that I do not understand.

I attest that I am a resident of AND located in the Commonwealth of Virginia at the time I start this Tele-visit interview.

I attest that I am at least 18 years of age, or, if this Pediatric Headache Center of Richmond Tele-visit interview is for a minor child, the child is at least 2 years of age, and I am the child's parent or legal guardian and am legally authorized to seek care on his or her behalf.

I acknowledge that Tele-visit is only available to established patients of Pediatric Headache Center of Richmond. For purposes of the Tele-visit, an "eligible patient" is an individual who is eligible under applicable state laws to be treated using electronic or advanced telecommunications technology.

I acknowledge that I have reviewed and agreed to the General Pediatric Headache Center of Richmond Tele-visit Terms of Service, and I understand the Pediatric Headache Center of Richmond Tele-visit Privacy Policy.

Initial:_____

PEDIATRIC HEADACHE CENTER OF RICHMOND

Consent for treatment:

I hereby consent to the use of the information I supply as part of the Tele-visit interview by physicians, non-physician advanced practice clinicians (e.g. nurse practitioners, physician's assistants and other advanced clinicians licensed to provide health care services in the Commonwealth of Virginia), and/or other specialists to assess my condition and recommend an appropriate course of care. I understand that I will have a chance to discuss and / or refuse the care recommended by my Tele-visit provider. I acknowledge that Tele-visit providers cannot guarantee any specific results or ensure that all of concerns will be resolved during my Tele-visit. I understand that my Tele-visit provider is not able to provide care for all conditions, and I may need to schedule an in-person appointment with a provider. I further understand that I should schedule an in-person appointment with a physician in the event my symptoms do not resolve within 72-hours following this Tele-visit. I further acknowledge and reaffirm that the general consent for treatment I have signed within the last twelve months is on file with Pediatric Headache Center of Richmond.

I acknowledge that I am an established patient of Pediatric Headache Center of Richmond and an "eligible patient" for a Tele-visit. The requirements for an "eligible patient" include having the technology to support the Tele-visit, displaying or having medical conditions (as determined by the physician/specialist) that would allow for appropriate care via an Tele-visit appointment, having established care with the physician/specialist performing the Tele-visit, and maintaining one in-person visit with this medical professional every twelve months.

If I have questions about or concerns with any part of this consent, I will call the number below to discuss them. The authorizations on this form will remain valid until I revoke (withdraw) them in writing or until the law states they have expired. However, any actions already taken in reliance upon these authorizations will remain valid (I cannot undo actions that were taken while my consent was valid).

I may get help with this process at any time by contacting (804) 658-5385.

As the person who signs this document, you agree to the following terms and conditions. If you are signing this document as the authorized proxy for the patient, where "me" or "my" is used, those terms should refer to "the patient" or "the patient's," unless otherwise noted.

Furthermore, with respect to any electronic communications sent regarding the patient, I understand that Pediatric Headache Center of Richmond is only able to respond to such communications based on the information provided in the electronic communication. If insufficient information is provided, Pediatric Headache Center of Richmond will be unable to provide accurate and reliable service(s).

_____ _____ Patient or Parent/Guardian Signature

Date

Pediatric Headache Center Of Richmond

NAME_____

PedMIDAS

PLEASE USE NUMBERS ONLY TO ANSWER THE FOLLOWING

Headache Disability Assessment:

The following questions try to assess how much the headaches are affecting day-to-day activity. Your answers should be based on the last three months. There are no "right" answers, so please put down your best estimate.

1. How many full days of school/work were missed in the last 3 months due to headaches? _____

2. How many partial days of school/work were missed in the last 3 months due to headaches (do not include full days counted in question1)? _____

3. How many days in the last 3 months did you function at less than half your ability in school / work because of a headache (do not include days counted in questions1 and 2)? _____

4. How many days were you not able to do things at home (i.e. chores, homework, etc.) due to a headache? _____

5. How many days did you not participate in other activities due to headaches (i.e. play, go out, sports, etc.)? _____

6. How many days did you participate in these activities, but functioned at less than half your ability (do not include days counted in question 5)? _____

Total PedMIDAS Score _____

PLEASE ANSWER THESE ADDITIONAL QUESTIONS:

a) Headache Frequency _____

b) Headache Severity _____

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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

HIT-6 Questionnaire (Evaluation of headache disability)

This questionnaire was designed to help you describe and communicate the way you feel and what you cannot do because of headaches.

INSTRUCTIONS : To complete, please circle one answer for each question.

1. When you have headaches, how often is the pain severe?

Never Rarely Sometimes Very often Always

---

2. How often do headaches limit your ability to do usual daily activities including household work, work, school, or social activities?

Never Rarely Sometimes Very often Always

---

3. When you have a headache, how often do you wish you could lie down?

Never Rarely Sometimes Very often Always

---

4. In the past 4 weeks, how often have you felt too tired to do work or daily activities because of your headaches?

Never Rarely Sometimes Very often Always

---

5. In the past 4 weeks, how often have you felt fed up or irritated because of your headaches?

Never Rarely Sometimes Very often Always

---

6. In the past 4 weeks, how often did headaches limit your ability to concentrate on work or daily activities?

Never Rarely Sometimes Very often Always

Column 1	Column 2	Column 3	Column 4	Column 5
6 points each	9 points each	10 points each	11 points each	13 points each
_____	_____	_____	_____	_____

To score, add points for answers in each column. **Total Score**: _____

Class I: 36-49, **Class II**: 50-55, **Class III**: 56-59, **Class IV**: 60 and more.
It suggested to talk to your physician for class II and more.

Patient Name:_____ Date:_____

Hamilton Rating Scale for Anxiety

Instructions: This checklist is to assist the physician or psychiatrist in evaluating each patient as to the degree of anxiety and pathological condition. Please fill in the appropriate rating:

NONE = 0 MILD = 1 MODERATE = 2 SEVERE = 3 SEVERE, GROSSLY DISABLING = 4

Item			Rating
1.	Anxious	Worries, anticipation of the worst, fearful anticipation, irritability	_____
2.	Tension	Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax	_____
3.	Fears	Of dark, of strangers, of being left alone, of animals, of traffic, of crowds	_____
4.	Insomnia	Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night-terrors	_____
5.	Intellectual (cognitive)	Difficulty in concentration, poor memory	_____
6.	Depressed Mood	Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing	_____
7.	Somatic (muscular)	Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone	_____
8.	Somatic (sensory)	Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation	_____
9.	Cardiovascular Symptoms	Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat	_____
10.	Respiratory Symptoms	Pressure or constriction in chest, choking feelings, sighing, dyspnea	_____
11.	Gastrointestinal Symptoms	Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation	_____
12.	Genitourinary Symptoms	Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence	_____
13.	Autonomic Symptoms	Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair	_____
14.	Behavior at Interview	Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos	_____
		TOTAL	_____

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

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 in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

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 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.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression