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# NEW PATIENT QUESTIONNAIRE

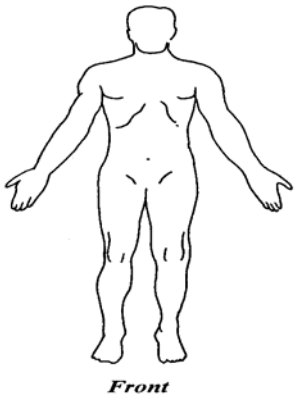
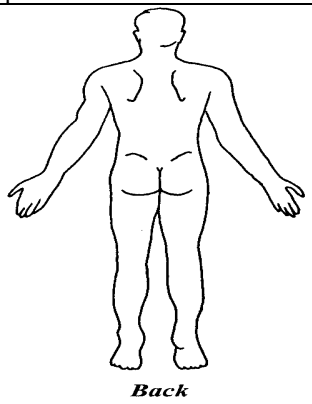
Date: ___/_____/_____

Name (last) _____ (first) _____ DOB _____ Age _____ Sex: Male Female

Height _____ Weight _____ ( ) Right- Handed ( ) Left- Handed Social Security No. _____- _____- _____

How would you describe yourself? African American Asian Caucasian Hispanic Middle Eastern
Native American Pacific Islander Other: _____

**CURRENT SYMPTOMS** Please mark the location(s) of your pain with an "X" and show where it goes with an arrow.
If whole areas are painful, shade in the painful area. Circle the words which best describe you pain.

| | | | | |
|---|---|---|---|---|
| sharp<br>throbbing<br>cutting<br>dull, aching<br>pressure<br>muscle pain<br>cramping |  <br>*Front*<br>right left | shooting<br>electric-like<br>pins and needles<br>weakness<br>numbness |  <br>*Back*<br>left right | burning<br>skin sensitivity to light touch, cold<br>abnormal swelling, hair/nail growth<br>abnormal sweating<br>abnormal skin color changes<br>abnormal skin temperature<br>limited movement |

**Please list your complaints** in order of importance.

**Complaint #1**: _____

Do you have this pain: ( ) constantly (90-100% of the time), ( ) frequently (75%), ( ) intermittently (50%), ( ) occasionally (25%)

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pain Intensity**: | Current | None | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Severe |
| Circle your pain intensity with | 7 day average | None | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Severe |
| "0" representing no pain and | Least pain score the last 7 days | None | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Severe |
| "10" the most severe pain imaginable | Worst pain score the last 7 days | None | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Severe |

What increases or decreases your pain?

| Increase | | Decrease |
|---|---|---|
| | Bending forward | |
| | Bending backwards | |
| | Sitting | |
| | Standing | |
| | Walking | |
| | Exercise | |

| Increase | | Decrease |
|---|---|---|
| | Coughing or Straining | |
| | Bowel movements | |
| | Lying down | |
| | Pushing shopping cart | |
| | Relaxation | |
| | Medications (give names) | |

**Complaint #2**: _____

Do you have this pain? ( ) constantly (90-100% of the time), ( )frequently (75%), ( )intermittently (50%), ( )occasionally (25%)

What makes it worse? _____

What makes it better? _____

Pain Scale: current ___/10, 7 day average ___/10, 7 day least ___/10, 7 day worst ___/10

**Complaint #3**: _____

Do you have this pain: ( ) constantly (90-100% of the time), ( ) frequently (75%), ( ) intermittently (50%), ( ) occasionally (25%)

What makes it worse? _____

What makes it better? _____

Pain Scale: current ___/10, 7 day average ___/10, 7 day least ___/10, 7 day worst ___/10

If you have both back and leg pain: back is ____% of entire pain leg is _____ % of entire pain

If you have both neck and arm pain: neck is ____% of entire pain arm is _____% of entire pain

How many blocks can you walk before having to stop because of pain? _____ blocks

**HISTORY OF PRESENT ILLNESS.** When did you first start having the pain? _____ / _____ / _____ (mm/dd/yyyy)

How did your symptoms start? _____ Suddenly ____ Gradually Over what period of time? _____
_____

Are your symptoms related to an i**njury**? NO YES If yes:
Date of Injury ____ / ____ / _____ (mm/dd/yyyy) Time: _____ AM PM

Where did your injury occur? (Address or description of location): _____
_____

The injury was Lifting Falling Twisting Whiplash Repetitive Strain Injury

Describe how your injury occurred: _____
_____
_____
_____

When did you realize that you were injured? _____

**The injury was** Not Work Related Work Related

**If injury was WORK RELATED:** Did you report your injury to your employer/supervisor: _____ When: _____

Please list the injured body parts, as a result of your work injury: _____
_____

Have you ever experienced the same or similar symptoms before this work injury? ___ Yes ___ No If "Yes", please explain:
_____
_____

Claim # _____Claim status: Active Settled

Permanent & Stationary: NO YES If yes, when? ____ / ___ / _____ (mm/dd/yyyy)

Were you awarded Future Medical Benefits: NO YES

**Are your symptoms related to a MOTOR VEHICLE ACCIDENT (MVA)?** NO YES If "No", please go to next page:

**Accident Information:** Date of accident? _____ Time of day _____ am pm

Location of the accident: (street/city/highway/state/etc) _____

_____

Direction you were headed? North South East West Direction of other vehicle? North South East West

Road condition: dry wet snowy icy slippery other _____

Area(s) of vehicle damaged? rear front driver side passenger side

How many vehicles were involved in the accident? _____

Were you the: driver; passenger front seat back seat on driver side in the middle on passenger side

Were you wearing a seat belt? NO YES Were you wearing a shoulder strap? NO YES

Does your vehicle have an airbag? NO YES If yes, did it inflate? NO YES

Was a traffic citation given? NO DON'T KNOW YES Who received the citation? _____

**History of the Accident:** Describe how the accident occurred (please be specific): _____

_____

_____

Did you lose consciousness? NO YES If yes, for how long? _____

At the time of the accident were you looking? straight ahead to the right to the left up down

Was your body turned? NO YES to the left YES to the right

**Was your vehicle:** stopped slowing down gaining speed moving at a steady speed

Estimate how fast your vehicle was traveling: _____mph

What were the year, make and model of the vehicle you were in? Year _____ Make _____ Model _____

**Was the other vehicle?** stopped slowing down gaining speed moving at a steady speed
Estimate how fast the other vehicle was traveling: _____ mph
What were the year, make and model of the other vehicle? Year _____ Make _____ Model _____

Did your vehicle collide with anything? NO YES If yes, what? _____

Were you aware of the impending collision? NO YES Did you prepare yourself for the collision? NO YES
If yes, how? _____

Did any of your body parts hit the interior of the car? NO YES If yes, explain: _____

_____

Did anything in the car hit you? NO YES If yes, explain: _____

_____

How many people were in your vehicle? _____ . Besides you, was anyone else injured? NO YES If yes, who? ____

_____

_____

Any: cuts bruises scratches fractures? If yes, explain: _____

_____

Damage to your vehicle? Mild Moderate Significant Totaled

**HISTORY OF TREATMENT**

If injured, were you treated at the scene? NO YES If yes, how? _____

_____

Did you go to a hospital? NO YES If yes, when? _____

City? _____ Name of hospital? _____

If yes, did you get hospitalized? NO YES If yes, how long? _____

Name of the doctor who treated you? _____

Describe treatment and/or diagnostic testing: _____

_____

What did that doctor say was wrong with you? _____

_____

Please list all the doctors seen for this injury, other than at a hospital. List in the order seen:

**Name of doctor #1**: _____ Type of doctor? _____ City? _____

Describe treatment, tests, or referrals: _____

_____

What did the doctor say was wrong with you? _____

_____

Results of treatment? _____

Date of first treatment? _____ Last treatment? _____ Number of treatments? _____

Length of treatments? _____ Still being treated? NO YES If yes, how often? _____

**Name of doctor #2**: _____ Type of doctor? _____ City? _____

Describe treatment, tests, or referrals: _____

_____

_____

What did the doctor say was wrong with you? _____

_____

Results of treatment? _____

Date of first treatment? _____ Last treatment? _____ Number of treatments? _____

Length of treatments? _____ Still being treated? NO YES If yes, how often? _____

**Name of doctor #3**: _____ Type of doctor? _____ City? _____

Describe treatment, tests, or referrals: _____

_____

_____

What did the doctor say was wrong with you? _____

_____

Results of treatment? _____

Date of first treatment? _____ Last treatment? _____ Number of treatments? _____

Length of treatments? _____ Still being treated? ( )no, ( )yes If yes, how often? _____

Any other treatment, tests, therapy or examinations that have not been described? NO YES

If yes, explain: _____

_____

Were you treated by any of these providers before? NO YES If yes, explain: _____

_____

Do you treat your condition at home? NO YES If yes, explain: _____

_____

Are you using ( ) brace, ( ) cane, ( ) crutches, ( ) wheelchair?

Has there been a recommendation of testing or treatment which you have not received? NO YES

What treatment(s) offer you the most relief? _____

_____

**DISABILITY:** Has this illness affected your work performance? NO YES If yes, how? _____

Before developing this condition, how would you describe your health? Excellent Good Fair Poor
If fair or poor, explain: _____

Activities you avoid because of pain: ( )going to work, ( )performing household chores, ( )doing yard work or shopping, ( )driving ( )socializing , ( )participating in recreation, ( )having sexual relations, ( )exercising, ( )caring for self

Have you missed work or been placed on modified duty due to this condition? NO YES If yes, explain: _____

**PRIOR WORK INJURIES:** List in chronological order.

| | Date | Injured body part(s) | Claim# | Status of the claim | Employer |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

**PRIOR NON-WORK RELATED INJURIES:** List in chronological order.

| | Date | Injured body part(s) | Claim# | Status of the claim | Employer |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

Have you experienced the same or similar symptoms before the onset of this condition? NO YES. If yes, explain: _____

Have you received a **prior** disability award? NO YES If yes, explain: _____

Have you served in the military? NO YES If yes, did you receive a medical discharge? NO YES
If yes, explain: _____

Have you suffered any new injuries to the body parts which were injured in the accident? NO YES
If yes, explain: _____

**PAST MEDICAL HISTORY:** Have you ever had any of the following health problems?

| | | | |
|---|---|---|---|
| ☐Diabetes Type I II | ☐Arthritis | ☐Bleeding | ☐Hepatitis A B C |
| ☐High blood pressure | ☐Fibromyalgia | ☐Cancer | ☐HIV/ AIDS |
| ☐Chest pain, heart attack | ☐Lupus | ☐Kidney disease | ☐Syphilis |
| ☐Asthma, COPD | ☐Stroke (TIA) | ☐Seizure or epilepsy | ☐TB |

Other medical problems:

| | |
|---|---|
| 1 | 5 |
| 2 | 6 |
| 3 | 7 |

List all surgeries (date and type of operation):

| | |
|---|---|
| 1. Laminectomy? | 5. |
| 2. Fusion? | 6. |
| 3. | 7. |

Are you pregnant? N/A NO Not sure YES _____
Are you on a special diet? NO YES If yes, please describe _____
Have you ever had any problems with anesthesia/sedation? NO YES (Please describe) _____

| CURRENT MEDICATIONS | Dose | How many at a time | How many times a day | Benefits/ side effects | First Intake? | Last intake? | Refill needed? |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Please check the medications that you are currently on. Indicate the dosage and number of pills you are taking per day.
Cross out medications that you have tried in the past, indicate the reason for stopping.

| NARCOTICS | ANTI-INFLAMMATORIES (NSAIDS) | ANTIDEPRESSANTS |
|---|---|---|
| ☐ Codeine | ☐ Aleve (Naproxen) | ☐ Celexa |
| ☐ Demerol (Meperidine) | ☐ Celebrex | ☐ Cymbalta |
| ☐ Dilaudid (Hydromorphone) | ☐ Feldene (Piroxicam) | ☐ Elavil (Amitriptyline) |
| ☐ Fentanyl (Duragesic patch) | ☐ Ibuprofen (Motrin, Advil) | ☐ Effexor (Venlafaxine) |
| ☐ Levorphanol | ☐ Indomethacin (Indocin) | ☐ Desyrel (Trazodone) |
| ☐ Lortab | ☐ Lodine (Etodolac) | ☐ Lexapro |
| ☐ Methadone | ☐ Naprosyn (Naproxen) | ☐ Norpramin (Desipramine) |
| ☐ Morphine /MS Contin | ☐ Relafen (Nabumetone) | ☐ Pamelor (Nortriptyline) |
| ☐ Norco | ☐ Toradol (Ketorolac) | ☐ Paxil (Paroxetine) |
| ☐ Nucynta | **SLEEPING PILLS** | ☐ Prozac (Fluoxetine) |
| ☐ Opana | ☐ Ambien (Zolpidem) | ☐ Serzone (Nefazodone) |
| ☐ Oxycontin /Oxycodone | ☐ Lunesta | ☐ Sinequan (Doxepin) |
| ☐ Percocet | **BLOOD THINNERS** | ☐ Wellbutrin (Bupropion) |
| ☐ Suboxone | ☐ Aspirin | ☐ Zoloft (Sertraline) |
| ☐ Tylenol with codeine | ☐ Coumadin | **OTHERS** |
| ☐ Vicodin (Hydrocodone) | ☐ Plavix | ☐ Lidoderm |
| | **ANTI-ANXIETY** | ☐ Depakote (Valproic Acid) |
| | ☐ Ativan (Lorezapam) | ☐ Dilantin (Phenytoin) |
| **MUSCLE RELAXANTS** | ☐ Buspar (Buspirone) | ☐ Lamictal (Lamotrigine) |
| ☐ Baclofen (Lioresal) | ☐ Halcion (Triazolam) | ☐ Lyrica |
| ☐ Flexeril (Cyclobenzaprine) | ☐ Klonopin (Clonazepam) | ☐ Neurontin (Gabapentin) |
| ☐ Robaxin (Methocarbamol) | ☐ Serax (Oxazepam) | ☐ Tegretol (Carbamezapine) |
| ☐ Soma (Carisoprodol) | ☐ Valium (Diazepam) | ☐ Topomax (Topiramate) |
| ☐ Zanaflex (Tizanidine) | ☐ Xanax (Alprazolam) | ☐ Ultram (Tramadol) Ultracet |

**ALLERGIES** to medications (including antibiotics, local anesthetics, or materials):

| | | | |
|---|---|---|---|
| latex | | | |
| x-ray contrast dye, iodine | | | |

Review of Systems (Circle all that apply).

| | |
|---|---|
| **General** | Fever Chills Unplanned weight loss Night sweats |
| **Eyes** | Glaucoma Double/blurred vision Blind spots |
| **Nose:** | Sinusitis Bleeding Congestion Runny nose Hearing loss |
| **Throat:** | Sore throat Difficulty swallowing Hoarseness Dentures Full/Partial Snoring |
| **Heart**: | Chest pain Previous heart attack Murmur Dizzy spells Congestive heart failure last six months |
| **Lungs:** | Wheezing Shortness of breath Cough Tuberculosis |
| **GI:** | Abdominal pain Heartburn Nausea Vomiting Diarrhea Constipation Incontinence Dark stools Rectal bleeding |
| **GU:** | Sexual dysfunction Urinary retention |
| **Musculoskeletal:** | Knee pain Shoulder pain Restricted movement |
| **Skin** | Rash Easy bruising/bleeding Lesions Abnormal hair loss Nail ridging, pitting |
| **Neurological:** | Seizures Dizziness Weakness Drowsiness Trouble walking Problems controlling bowel/ bladder |
| **Psychiatric:** | Difficulty falling or remaining asleep Excessive fatigue Feeling depressed Memory loss |
| **Endocrine:** | Heat / cold intolerance Diabetes Thyroid disorder |
| **Hematology:** | Easy bruising Low platelet count Enlarged lymph nodes |

**FAMILY HISTORY** List all health problems in your family. (mom/dad/brother/sister) ( ) none

☐Alcohol addiction ☐Drug addiction ☐Back pain ☐ Fibromyalgia ☐Migraine headaches ☐Psychiatric illnesses ☐Suicide

Present Physician(s) Name & City _____

_____

Past Physician(s) Name & City _____

_____

**JOB DESCRIPTION**

Who is your employer? _____ What is your job title? _____

What is the nature of your work? _____

When did you start working for this employer? _____

Employed ( ) Full-time ( ) Part-time ____ hrs/day, ____ days/week

( ) Temporarily disabled ( ) Permanently disabled ( ) Retired

How many rest periods do you have per day? _____ How long are the rest periods? _____

How many hours per work day do you? Sit __ stoop ___ walk ___ stand ___ kneel ___ squat ___ climb ___ bend ___ twist _

Please list your job duties/activities at work

| | |
|---|---|
| | |
| | |
| | |
| | |
| | |

**WORK HISTORY** Please list all previous employers before this accident. (Dates/ Employer/ Job Title/ Duties)

1. _____
2. _____
3. _____

**SOCIAL HISTORY**

Are you? single married widowed separated divorced

Are you currently living? alone with spouse partner (name?) _____ with parents with friends other

How many children do you have (names? ages?) _____

_____

Years married/ in long-term relationship _____ Times Married _____ Times Divorced _____

**Education.** How many years of schooling have you had? _____

Please list any degrees which you have: BA BS MBA JD MD RN PhD Other _____

☐partial college training ☐partial high school (10th grade through partial 12th)

☐high school graduate ☐partial junior high school (7th grade through 9th)

☐GED or trade-technical school graduate ☐elementary school (6th grade or less)

Do you exercise? NO YES If yes _____ average min/day, _____times/week

Describe your exercises and frequency _____

_____

If no, why not? _____

_____

Do you have hobbies? NO YES Please describe your hobbies and frequency: _____

_____

**SUBSTANCE USE HISTORY**

| | Yes, currently | Yes, in the past | Never | Date/Time of most recent use | Method of use | How Often? | How Much? |
|---|---|---|---|---|---|---|---|
| Alcohol | | | | | | | |
| Anti-anxiety | | | | | | | |
| Cocaine | | | | | | | |
| Crystal Meth | | | | | | | |
| Heroin | | | | | | | |
| Inhalants | | | | | | | |
| LSD | | | | | | | |
| Marijuana | | | | | | | |
| Methadone | | | | | | | |
| Pain Killers | | | | | | | |
| PCP | | | | | | | |
| Stimulants (pills) | | | | | | | |
| Other | | | | | | | |

Do you use **tobacco**? NO YES _____ packs of cigarettes per day for _____ years.
Quit smoking _____ years ago. Used to smoke _____ packs of cigarettes per day for _____ years.

Have you ever abused **alcohol**? NO YES Attended AA? NO YES If yes, when? _____

Have you ever abused **drugs**? NO YES Attended NA? NO YES If yes, when? _____
Did you ever stop using any of the above because of dependence? NO YES If yes, please list _____
What was your longest period of abstinence? _____

Have you ever been **arrested or convicted**? NO YES **Drug-related:** NO YES **DUI**: NO YES
**Domestic violence** NO YES Other _____

Have you ever been abused? Physically Verbally Emotionally Sexually

Have you ever had psychiatric, psychological, or social work evaluations or treatments? NO YES

If yes, explain _____

Signature: _____ Printed Name: _____ Date: _____

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Date:

___/_____/_____

## THE OSWESTRY DISABILITY INDEX

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. We realize that you may consider more than one statement in a section applicable to you but please mark the one box that most closely describes your present day situation.

**1: Pain Intensity**
- □ 0. My pain is mild to moderate. I do not need painkillers.
- □ 1. The pain is bad but I manage without taking painkillers.
- □ 2. Painkillers give complete relief from pain.
- □ 3. Painkillers give moderate relief from pain.
- □ 4. Painkillers give very little relief from pain.
- □ 5. Painkillers have no effect on the pain.

**2 Personal Care**
- □ 0. I can look after myself normally without causing pain.
- □ 1. I can look after myself normally but it causes extra pain.
- □ 2. It is painful to look after myself and I am slow and careful.
- □ 3. I need some help but manage most of my personal care.
- □ 4. I need help every day in most aspects of self-care.
- □ 5. I do not get dressed; I wash with difficulty and stay in bed.

**3 Lifting**
- □ 0. I can lift heavy weights without causing extra pain.
- □ 1. I can lift heavy weights but it causes extra pain.
- □ 2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (i.e. on a table)
- □ 3. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- □ 4. I can lift very light weights.
- □ 5. I cannot lift or carry anything at all.

**4 Walking**
- □ 0. I can walk as far as I wish.
- □ 1. Pain prevents me from walking more than 1 mile.
- □ 2. Pain prevents me from walking more than ½ mile.
- □ 3. Pain prevents me from walking more than ¼ mile.
- □ 4. I can walk only if I use a cane or crutches.
- □ 5. I am in bed or in a chair for most of every day.

**5. Sitting**
- □ 0. I can sit in any chair for as long as I like.
- □ 1. I can sit in my favorite chair only, but for as long as I like.
- □ 2. Pain prevents me from sitting for more than 1 hour.
- □ 3. Pain prevents me from sitting for more than ½ hour.
- □ 4. Pain prevents me from sitting for more than 10 minutes.
- □ 5. Pain prevents me from sitting at all.

**6. Standing**
- □ 0. I can stand as long as I want without extra pain.
- □ 1. I can stand as long as I want but it gives me extra pain.
- □ 2. Pain prevents me from standing for more than 1 hour.
- □ 3. Pain prevents me from standing for more than ½ hour.
- □ 4. Pain prevents me from standing for more than 10 min.
- □ 5. Pain prevents me from standing at all.

**7. Sleeping**
- □ 0. Pain does not prevent me from sleeping well.
- □ 1. I sleep well but only when taking medicine.
- □ 2. Even when I take medication, I sleep less than 6 hours.
- □ 3. Even when I take medication, I sleep less than 4 hours.
- □ 4. Even when I take medication, I sleep less than 2 hours.
- □ 5. Pain prevents me from sleeping at all.

**8. Social Life**
- □ 0. My social life is normal and causes me no extra pain.
- □ 1. My social life is normal but increased the degree of pain.
- □ 2. Pain affects my social life by limiting only my more energetic interests such as dancing, sports, etc.
- □ 3. Pain has restricted my social life and I do not go out as often.
- □ 4. Pain has restricted my social life to my home.
- □ 5. I have no social life because of pain.

**9. Sexual Activity**
- □ 0. My sexual activity is normal and causes no extra pain.
- □ 1. My sexual activity is normal but causes some extra pain.
- □ 2. My sexual activity is nearly normal but is very painful.
- □ 3. My sexual activity is severely restricted by pain.
- □ 4. My sexual activity is nearly absent because of pain.
- □ 5. Pain prevents any sexual activity at all.

**10. Traveling**
- □ 0. I can travel anywhere without extra pain.
- □ 1. I can travel anywhere but it gives me extra pain.
- □ 2. Pain is bad but I manage journeys over 2 hours.
- □ 3. Pain restricts me to journeys of less than 1 hour.
- □ 4. Pain restricts me to necessary journeys under ½ hour.
- □ 5. Pain prevents traveling except to the doctor/hospital

Patient Signature: _____ Date: _____ / ____ /_____

Name: _____ Score: _____ / _____

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# BECK DEPRESSION INVENTORY

Date:

____/_____/_____

On this questionnaire are groups of statements. Please read each group of statements carefully then pick out the statement in each group that best describes the way you have been feeling the past week including today. Circle the number next to the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

| | | | | | |
|---|---|---|---|---|---|
| **1** | 0 | I do not feel sad | **12** | 0 | I have not lost interest in other people. |
| | 1 | I feel sad | | 1 | 1 I am less interested in other people than I used to be. |
| | 2 | I am sad all the time and I can't snap out of it. | | 2 | I have lost most of my interest in other people. |
| | 3 | I am so sad or unhappy that I can't stand it. | | 3 | I have lost all of my interest in other people. |
| **2** | 0 | I am not particularly discouraged about the future | **13** | 0 | I make decisions about as well as I ever could. |
| | 1 | I feel discouraged about the future. | | 1 | I put off making decisions more than I used to. |
| | 2 | I feel I have nothing to look forward to | | 2 | I have greater difficulty in making decisions than before. |
| | 3 | I feel that the future is hopeless and that things cannot improve. | | 3 | I can't make decisions at all anymore. |
| **3** | 0 | I do not feel like a failure. | **14** | 0 | I don't feel I look any worse than I used to. |
| | 1 | I feel I have failed more than the average person. | | 1 | I am worried that I am looking old or unattractive. |
| | 2 | As I look back on my life, all I can see is a lot of failures. | | 2 | I feel that there are permanent changes in my appearance that make me look unattractive. |
| | 3 | I feel I am a complete failure as a person. | | 3 | I believe that I look ugly. |
| **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. | **15** | 0 | I can work about as well as before. |
| | 2 | I don't get real satisfaction out of anything anymore. | | 1 | It takes an extra effort to get started at doing something. |
| | 3 | I am dissatisfied or bored with everything. | | 2 | I have to push myself very hard to do anything. |
| | | | | 3 | I can't do any work at all. |
| **5** | 0 | I don't feel particularly guilty | | | |
| | 1 | I feel guilty a good part of the time | **16** | 0 | I can sleep as well as usual. |
| | 2 | I feel quite guilty most of the time | | 1 | I don't sleep as well as I used to. |
| | 3 | I feel guilty all of the time. | | 2 | I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. |
| **6** | 0 | I don't' feel I am being punished | | 3 | I wake up several hours earlier than I used to and cannot get back to sleep. |
| | 1 | I feel I may be punished | | | |
| | 2 | I expect to be punished | | | |
| | 3 | I feel I am being punished | **17** | 0 | I don't get more tired than usual. |
| | | | | 1 | I get tired more easily than I used to. |
| **7** | 0 | I don't feel disappointed in myself | | 2 | I get tired for doing almost anything. |
| | 1 | I am disappointed in myself | | 3 | I am too tired to do anything. |
| | 2 | I am disgusted with myself. | | | |
| | 3 | I hate myself | **18** | 0 | My appetite is no worse than usual. |
| | | | | 1 | My appetite is not as good as it used to be. |
| **8** | 0 | I don't feel I am any worse than anybody else. | | 2 | My appetite is much worse now. |
| | 1 | I am critical of myself for my weaknesses or mistakes | | 3 | I have no appetite at all anymore. |
| | 2 | I blame myself all the time for my faults. | | | |
| | 3 | I blame myself for everything bad that happens | **19** | 0 | I haven't lost much weight, if any, lately. |
| | | | | 1 | I have lost more than 5 pounds. I am purposely trying to lose weight by eating less. |
| **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 have lost more than 10 pounds. |
| | | | | 3 | I have lost more than 15 pounds. |
| | 2 | I would like to kill myself | | | |
| | 3 | I would kill myself if I had the chance | **20** | 0 | I am no more worried about my health than usual. |
| | | | | 1 | I am worried about physical problems such as aches and pains, upset stomach or constipation. |
| **10** | 0 | I don't cry any more than usual. | | | |
| | 1 | I cry more now than I used to | | 2 | I am very worried about physical problems and it's hard to think of much else. |
| | 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. | | 3 | I am so worried about my physical problems that I cannot think about anything else. |
| **11** | 0 | I am no more irritated now than I ever am. | **21** | 0 | I have not noticed any recent change in my interest in sex. |
| | 1 | I get annoyed or irritated more easily than I used to. | | 1 | 1 I am less interested in sex than I used to be. |
| | 2 | I feel irritated all the time now. | | 2 | I am much less interested in sex now. |
| | 3 | I don't get irritated at all by the things that used to irritate me. | | 3 | I have lost interest in sex completely. |

Name: _____