Park Place Health Solutions

PATIENT INFO

Name: _____
(LAST) (MI) (FIRST)

Address: _____
(STREET) (CITY) STATE) (ZIP)

Home Phone: Work Phone: Cell Phone:

Email Address:

DOB: / / Soc. Sec #: - -

Driver's License #: State:

Marital Status: S M W Spouse's Name:

Your Employer: Occupation:

Employer Address: _____
(STREET) (CITY) (STATE) (ZIP)

Referred By: Primary Care Physician:

PHARMACY NAME,LOCATION & PHONE NUMBER:

INSURANCE INFORMATION

Insurance Type: Health Personal Pay PI/Auto Worker's Comp Medicare

Insurance Name:

Member #: Group #:

Insurer's Name (If Different From Patient): Relationship to Patient:

Insurer's DOB: / / Insurer's Soc. Sec #: - -

Insurer's Employer:

Person responsible for account:

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

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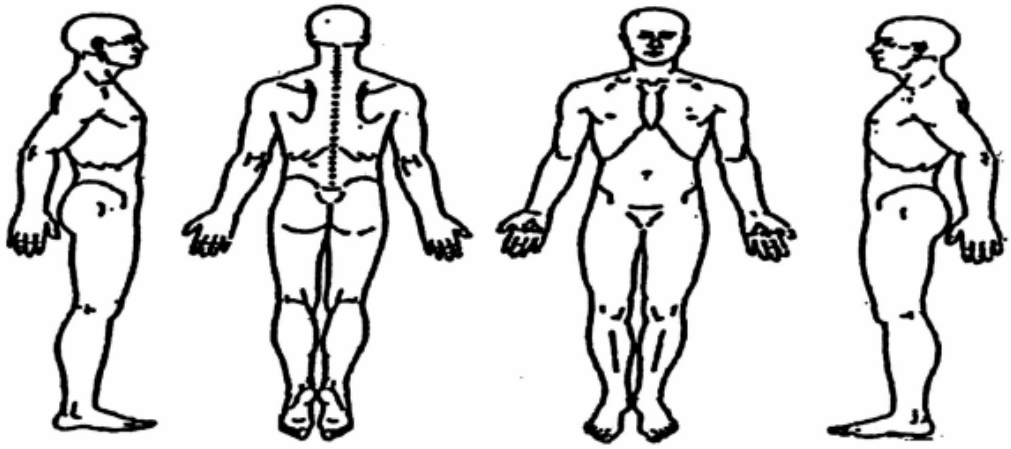
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Today's problem will be filed as: □ Insurance/ Self Pay □ Auto Accident □ Workman's Compensation

2. Chief Complaint/Reason for the visit: _____

3. Indicate on the drawings below where you have pain/symptoms



4. How would you describe the type of pain?

□ Sharp
□ Dull
□ Diffuse
□ Achy
□ Burning
□ Shooting
□ Stiff
□ Numb
□ Tingly
□ Sharp with motion
□ Shooting with motion
□ Stabbing with motion
□ Electric like with motion
□ Other:_____

5. How often do you experience your symptoms?

□ Constantly (76-100% of the time)
□ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time)
□ Intermittently (1-25% of the time)

6. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

□ Not at all□ A little bit □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social activities?

□ Not at all□ A little bit □ Moderately □ Quite a bit □ Extremely

10. Who else have you seen for your problem?

□ Chiropractor
□ ER physician
□ Massage Therapist
□ Neurologist
□ Orthopedist
□ Physical Therapist
□ Primary Care Physician
□ Other: _____
□ No one

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11. **How long have you had this problem?** _____

12. **How do you think your problem began?** _____

13. **What aggravates your problem?**

_____

14. **What alleviates your problem?**

_____

15. **Do you consider this problem to be severe?** □ Yes □ Yes, at times □ No

16. **What concerns you the most about your problem; what does it prevent you from doing?**

_____

17. What is your: Height_____ **Weight** _____

18. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

19. What type of exercise do you do?
□ Strenuous □ Moderate □ Light □ None

20. Have you had labs done recently (within the last 6 months)? □ Yes □ No
If "Yes", when and where? _____

21. Indicate if you have any immediate family members with any of the following (Please indicate the relationship to you):
□ Rheumatoid Arthritis □ Diabetes □ Lupus □ Multiple Sclerosis (MS)
□ Heart Problems □ Cancer (see add. Forms) □ ALS
□ Other:

_____

22. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? □ Yes □ No
If Yes, why? _____

25. Have you had any past injuries or trauma, such as car accidents (ever?), falls, sports injuries, etc.?
□ Yes □ No
If "Yes", please provide details:

_____

_____

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26. For each of the conditions listed below, place a check in the "Past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "Present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid-Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	HIV/AIDS
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	Multiple Sclerosis (MS)
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain	□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheum. Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Dermatitis/Eczema/Rash						
□	□	Other: _____						

27. List all prescription medications you are currently taking:

_____

_____

_____

28. List all of the over-the-counter medications you are currently taking:

_____

_____

_____

29. List all Allergies (medications, food, seasonal, etc.) you may have:

_____

_____

_____

30. List all surgical procedures you have had:

_____

_____

_____

31. Is there anything else you wish to let us know about you visit today? □ Yes □ No

If "Yes", please provide details:

_____

_____

Patient Signature_____ **Date:** _____

Insurance Verification Disclosure/Agreement

As a courtesy, Park Place Health Solutions will verify and file my health insurance. However, verification of my insurance benefits does NOT guarantee payment for services rendered. As such, in the event of my health insurance non-payment or limitations, I am financially responsible for all charges incurred.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Office Manager ___Signature on file_____ Date ____on file_____

Please note, this office is a multidisciplinary doctor group. We have done this for various reasons, with the most important one being that our facility can enjoy a more comprehensive approach to your health by utilizing an integrative health care model. All services received in this office are medically billed under Dr. Jason Kouri MD or Park Place Health Solutions. As such, when you receive your explanation of benefits from your health insurance company, it will indicate the date of services and procedure codes and insurance payments made to Dr. Jason Kouri, MD or Park Place Health Solutions, Inc. In addition, all credit and debit card processing will be done on our behalf and will show as a charge from Park Place Health Solutions, or Latch-D inc.

Patient Signature_____ Date_____

Park Place Health Solutions

Informed Consent

Dear Patient:

Every type of health care is associated with some risk of a potential problem. This includes chiropractic care. We want you to be informed about potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

Chiropractic adjustments are the moving of bones with the physician's hands or with the use of a machine. Frequently, adjustments create a "popping" or "clicking" sound/sensation in the areas being treated.

In this office, we use trained assistants who may assist the physician with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. On the occasion when your physician is unavailable, your care may be handled by another physician or trained assistant.

Stroke: Stroke is the most serious problem associated with chiropractic adjustments. Stroke means that a portion of the brain does not receive oxygen from the blood stream. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death. The chiropractic adjustment that is related to the vertebral artery stroke is called Extension-Rotation-Thrust Atlas Adjustment. We DO NOT use this type of adjustments on our patients. Other type of neck adjustments may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA Vol. 37, No. 2, June 1993) estimate that the incidence of this type of stroke is 1 per every 3,000,000 upper neck adjustments. This means that an average chiropractic would have to be in practice for hundreds of years before they would statistically be associated with a single patient stroke.

Disk Herniations: Disk herniations that create pressure on a spinal nerve or the spinal cord are frequently successfully treated by chiropractors and chiropractic adjustment, traction, etc. This includes both in the neck and back. Yet, occasionally, chiropractic treatment (adjustments, traction, etc.) will aggravate the problem and rarely, surgery may cause a disk problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, a chiropractic adjustment (or treatment) may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or mid-back. They extend from your back to your front chest area. Rarely, a chiropractic adjustment will crack a rib bone and this is referred to as a fracture. This occurs only on patients who have weakened bones from conditions such as osteoporosis. Osteoporosis can be detected on your x-rays. We adjust all patients very carefully, and especially with those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

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Physical Therapy Burns: Some machines we use generate heat. We also use both heat and ice, and occasionally recommend them for home use. Everyone's skin has different sensitivity to these modalities and rarely, heat or ice can burn or irritate the skin. The result is a temporary increase in skin pain, and there may be some blistering of the skin. These problems occur so rarely that there are no available statistics to quantify their probability.

Soreness: It is common for chiropractic adjustments, traction, massage therapy, exercise, etc., to result in a temporary increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic change. It is not dangerous, but if it occurs, be sure to inform your physician.

Other Problems: There may be other problems or complications that might arise from chiropractic treatment other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment.

Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will always provide you with the best care and if results are not acceptable, we will refer you to another health care provider who we feel may assist your condition.

If you have any questions on the above information, please ask your physician. Once you have a full understanding, please sign and date below.

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Secondary Number: _____

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Witnessed By _____ Date _____

Park Place Health Solutions

Assignment of Benefits

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered, grants and conveys for deferred payment to Park Place Health Solutions, a lien and assignment against the proceeds of the patient's insurance settlement with all the following rights, power, and authority:

RELEASE OF INFORMATION: You are authorized to release information concerning my condition and treatment to my insurance company, attorney or insurance adjustor for purposes of processing my claim for benefits and payment for services rendered to me.

IRREVOCABLE ASSIGNMENT OF RIGHTS: You are assigned the exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above within 5 days following your receipt of such bill for services to the extent of such bills are payable under the terms of the policy. This demand specifically conforms to Sec. 542.057 of the Texas Insurance Code, and Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Park Place Health Solutions

THIRD PARTY LIABILITY: If my injuries are the result of negligence from a third party, then I instruct the liability carrier to issue a separate draft to pay in full all services rendered, payable directly to Park Place Health Solutions**.**

STATUTE OF LIMITATIONS: I waive my rights to claim any statute of limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician/facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

REJECTION IN WRITING: I hereby authorize the physician/clinic named above to establish a PIP or UM/UIM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider/clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. I allege that electronic signatures are not adequate proof of rejection, and are invalid to establish rejection, and instruct my carrier to provide only copies of my original signature regarding rejection as evidence of rejection of PIP or UM/UIM.

TERMINATION OF CARE: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he/she has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor; I will notify this physician/facility immediately. I understand the failure to do so may jeopardize my case.

By my signature be it known that I have read and fully understand the above contract.

Patient Name (Printed) _____Date _____

Patient Signature _____

Parent/Guardian Signature _____
Office Manager____Signature on FIle_____Date _____

Park Place Health Solutions

HIPAA Disclosure

Name:_____ DOB:_____/_____/_____

We are unable to discuss your treatment with individuals unless you give us written permission.

{ } I authorize the release of information including the diagnosis, records, images, examination rendered to me, claims and information, and appointment times or types.

{ } I **DO NOT** authorize the release of information including the diagnosis, records, images, examination rendered to me, claims and information, and appointment times or types.

I hereby authorize the following individuals to all HIPPA regulated information:

Name:_____

Relation:_____Phone:_____

Name:_____

Relation:_____Phone:_____

Name:_____

Relation:_____Phone:_____

Expiration Date of Authorization

This authorization is effective unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to this office and contact the Privacy Officer.

Patient Name (Printed) _____ Date _____

Patient Signature _____

Parent/Guardian Signature _____

Park Place Health Solutions

X-RAY CONSENT FORM

Patient Name _____ Date _____

During your examination, the doctor may feel that x-rays will be needed in order to diagnose your condition. In addition, they may be required in order to administer treatment. By signing below, I consent to having the diagnostic x-rays performed, which the doctor determines is clinically necessary.

Patients Signature _____ **Date** _____

CONSENT TO X-RAY A MINOR CHILD

I_____ authorize the performance of diagnostic x-ray examination of my child or ward which the above doctor or his associate may consider necessary or advisable in the course of examination and treatment.

Parent/Guardian Signature _____ **Date** _____

THIS PORTION FOR WOMEN ONLY:

I understand that if I am pregnant and have x-rays taken which expose my lower torso to radiation, it is possible to injure the fetus. I am aware that the ten (10) days following the onset of a menstrual period are generally considered to be safe for x-ray exams. With those factors in mind, I am advising my doctor that:

I am pregnant. ○ Yes ○ No

I could be pregnant. ○ Yes ○ No

I am late with my menstrual period. ○ Yes ○ No

I am taking contraceptives. ○ Yes ○ No

I have had a tubal litigation. ○ Yes ○ No

I have had a hysterectomy. ○ Yes ○ No

I have irregular menstrual periods. ○ Yes ○ No My last menstrual period began on

_____

With full understanding of the above, and believing that I am currently not as risk, I wish to have an x-ray examination performed today if requested by the doctor.

Signature _____ **Date:** _____

Park Place Health Solutions

Financial Policy

Welcome to our office and thank you for trusting us with your care. This is a medically integrated office consisting of:
-Primary care including sick visits, physicals and general health.
-Chiropractic care and physical therapy.
** All of our Providers are also certified and multi-trained in HRT (Hormone Replacement Therapy) for both men & women. This includes testosterone therapy as well as estrogen & progesterone (as appropriate for females). Our PA/NP also specializes in diagnostic labs and medically supervised weight loss.

Medical office visits and Labs/Diagnostic testing

For follow up visits and labs, it is imperative that you follow your Providers appointment recommendations and be sure to get labs/attend follow up visits as your Provider instructs. Failure to do so can interrupt your treatment schedule as well as any medication refills needed. Please remember, during busiest times, it can take 3-4 weeks to get back on the Provider's schedule.

For Physical therapy/Chiropractic visits

Your schedule is based upon your exam and x-ray findings, as well as Dr. Park's 26 years experience. All muscles, ligaments, tendons and cartilage must be strengthened and realigned to hold the vertebrae in position. Therefore, you can't expect meaningful changes in just a few visits. Each adjustment builds on the one before. Missing or postponing visits will interfere with the "retraining" of your spine. Therefore, it is important to understand that your cooperation is crucial in facilitating the healing process. Communication about your progress is very important. If at any time, you and/or we feel you are not progressing in your care as expected, we will discuss further testing, changing your therapy and other necessary referrals.
Please feel free to discuss any concerns about your care or questions you may have. ***Your understanding of your condition and your health is our main concern.***

PATIENTS W/O INSURANCE

We request that your visits be paid at the time that services are rendered. We accept checks, MasterCard or Visa. WE DO NOT accept Discover or American Express.

GROUP OR INDIVIDUAL INSURANCE

Your insurance policy is an agreement between you and your insurance company, not between your insurance company and our office. The amount they pay varies from one policy to another. We will call to verify benefits on your insurance; however, the benefits quoted to us by your insurance company are not a guarantee of payment. As a courtesy to you, our office will complete any necessary insurance forms at no additional charge and file them to your insurance company to help you collect. It is to be understood and agreed that any services rendered are
charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or copays.

SECONDARY INSURANCE

Please inform us of any secondary insurance you may have. We will assist you if you need help filing.

FLEX PLANS/ MEDICAL SAVINGS ACCOUNT

Please inform us if you have a medical savings account, sometimes known as a 'flex plan'. We will be happy to provide you with a statement of your charges for reimbursement.

Park Place Health Solutions

INSURANCE FORMS/ PAYMENT

MOST BILLING IS UNDER DR. JASON KOURI, M.D., (MEDICAL DIRECTOR). However, some services may be billed under Dr. James T. Park.

If you receive any correspondence from your insurance carrier pertaining to the care you have received at this office or a request for more information regarding your care, please bring it in as soon as possible. It is very important that we keep your file as up to date as possible.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS

Please present your auto insurance card or health insurance card and tell us if you have retained an attorney. There are four options available for PI patients:

1. Pay cash for your care and we will submit reports whenever necessary.
2. We will bill (accept assignment) from the PIP/Med Pay portion of your auto insurance.
3. We will accept a Letter of protection Doctor's Lien from an attorney and await payment at the time of settlement as long as you remain an active patient.
4. We will bill your standard health insurance plan and you will be responsible for all copays and deductibles as they are incurred.

Although you are ultimately responsible for your bill, we will wait for settlement on your claim for up to six months after your care is completed. Once the claim is settled or if you suspend or terminate the case, any fees for services are due immediately.

MISSED APPOINTMENTS

Please know that we reserve appointment times especially for you. Therefore, we ask that you give 48 hours' notice for appointments changes. However, we REQUIRE you to give us at least 24 hour notice when canceling or rescheduling your appointment. **Appointments canceled/rescheduled less than 24 hours will be charged THE FULL FEE FOR THAT APPOINTMENT TYPE**.

I have read and understand the payment policy of Park Place Health Solutions. I understand that my insurance is an agreement between myself and my insurance company, NOT between Park Place Health Solutions and my insurance company. I understand this practice has the authorization to charge the credit card on file for any outstanding balance.

_____ _____

Patient's signature (or guardian if patient is a minor) **Date**

Park Place Health Solutions

MRS Checklist - BEFORE HRT

Place an "X" for EACH symptom you are currently experiencing. *Please mark only ONE box.*

For symptoms that do not apply, please mark NONE.

	None	Mild	Moderate	Severe	Extremely Severe
1. **Hot flashes, sweating** (episodes of sweating)	☐	☐	☐	☐	☐
2. **Heart discomfort** (unusual awareness of heart beat, heart skipping, heart racing, tightness)	☐	☐	☐	☐	☐
3. **Sleep problems** (difficulty in falling asleep, difficulty in sleeping through the night, waking up early)	☐	☐	☐	☐	☐
4. **Depressive mood** (feeling down, sad, on the verge of tears, lack of drive, mood swings)	☐	☐	☐	☐	☐
5. **Irritability** (feeling nervous, inner tension, feeling aggressive)	☐	☐	☐	☐	☐
6. **Anxiety** (inner restlessness, feeling panicky)	☐	☐	☐	☐	☐
7. **Physical and mental exhaustion** (general decrease in performance, impaired memory, decrease in concentration, forgetfulness)	☐	☐	☐	☐	☐
8. **Sexual problems** (change in sexual desire, in sexual activity and satisfaction)	☐	☐	☐	☐	☐
9. **Bladder problems** (difficulty in urinating, increased need to urinate, bladder incontinence)	☐	☐	☐	☐	☐
10. **Dryness of vagina** (sensation of dryness or burning in the vagina, difficulty with sexual intercourse)	☐	☐	☐	☐	☐
11. **Joint and muscular discomfort** (pain in the joints, rheumatoid complaints)	☐	☐	☐	☐	☐

Please share any additional comments about your symptoms you would like to address.

_____

_____

Do you have cold hands and feet? ☐ Yes ☐ No **Do you have daily bowel movements?** ☐ Yes ☐ No

Do you have gas, bloating or abdominal pain after eating? ☐ Yes ☐ No

Please select your WEEKLY Activity Level based on this criteria ☐ *Physical activity that accelerates heart rate / Breathlessness*

☐ 0-1 day per week (Low) ☐ 2-3 days per week (Average) ☐ More than 3 days per week (High)

Please list any prior hormone therapy?_____

Park Place Health Solutions

Patient Health Questionnaire (PHQ-9)

Patient 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 in some way	™ 0	™ 1	™ 2	™ 3

10. 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 others? Circle one of the following:

Not difficult at all Somewhat difficult Very difficult Extremely difficult