Craig Thornhill, LPC, LAC
PO Box 770147
Steamboat Springs, CO 80477
810 Lincoln Ave.
970-879-7637 office / 970-871-6811 fax
cthornhillcounseling@gmail.com

CLIENT REGISTRATION FOR SERVICES

Thank you for seeking counseling services from this office. We sincerely appreciate your choice to seek services here. Please let us know if you have any questions regarding you or your family's counseling here.

Please answer the questions below for you or your child. Please leave blank any questions that you do not wish to provide answers to.

Please print your (client's) name below:

_____ **Date of Birth**_____

Please provide your physical address:

_____
_____
_____

Please provide your mailing address (if different than physical):

_____
_____
_____

Please provide a primary phone # _____**cell / landline / other**

Is it ok to leave a messages at this number? Yes / No

Secondary Phone # _____**cell / landline / other**

Is it ok to leave messages at this number? Yes / No

Are you (client) an Armed Forces Veteran? Yes / No

What branch if so?_____

How did you hear about this office/who referred you?

_____
_____
_____

Client identified gender preference: Male / Female / Other _____

What is the primary language spoken in the home? _____

What is your (client's) primary Race and Ethnicity?_____

What is the highest education level you (client) have obtained? _____

Do you (client) have any specific vocational or other technical training/certificates/skills? Yes / No

Explain below if so please:

_____
_____
_____

Please explain your current employment status?

_____
_____
_____

Please explain your current living arrangements?

_____
_____
_____

Number of children under 18 living in the home? _____

Do you have any identified disabilities, physical or other _____Yes _____No, if so what?

_____
_____
_____

If applicable, please list your insurance or EAP information below (Please note this does not guarantee acceptance and billing of your insurance). A copy of insurance card must be provided.

_____
_____
_____

Please Identify an Emergency contact. By doing so you allow this office to contact this person in the event of an emergency or safety concern only (please see Privacy Practices Policy for further rights and details regarding the limits of confidentiality and privileged communications):

Name/Contact Information:

_____
_____
_____
_____

Are you currently receiving any disability benefits _____Yes _____No, if so for what reason?

_____
_____
_____

What is your (client's) primary reason for seeking services?

_____
_____
_____
_____
_____
_____
_____

Are there any legal (Probation, Parole, Diversion, etc) or child welfare entities involved at this time? ____Yes ____ No

If so, for what reason?

_____
_____
_____
_____

Parent or legal guardian information if client is a minor:

Parent/Guardian/Representative contact information if different than above:

_____
_____
_____

If the client is a minor, are there any current custody orders/arrangements?

_____
_____
_____
_____

If the client is a minor, are they in school? ____Yes ____ No

If so, what grade? _____

Initial Below Please.

_____I attest the above information is correct.

I am seeking services for: (please circle one or more) ____Myself ____My Child ____My Family

_____

CLIENT'S SIGNATURE **DATE**

_____

CLIENT'S PRINTED NAME

_____

SIGNATURE OF PARENT/GUARDIAN/PERSONAL REPRESENTATIVE **DATE**

_____

GUARDIAN OR LEGAL REPRESENTATIVE'S PRINTED NAME

IF YOU ARE SIGNING AS LEGAL GUARDIAN OR REPRESENTATIVE, PLEASE EXPLAIN THE AUTHORITY YOU HAVE FOR THIS INDIVIDUAL. SUPPORTING DOCUMENTATION MAY BE REQUESTED TO VERIFY YOUR AUTHORITY (ie power of attorney, adoption orders, custody orders, etc).

_____

_____

_____

_____

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPPA)

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal law that is designed to protect the privacy of patient information, provide for electronic and physical security of health and patient medical information, and simplify billing and other electronic transactions by standardizing codes and procedures. A piece of this law known as the HIPPA Privacy Rule creates federal standards for the use and disclosure of Protected Health Information (PHI) by health organizations. One of the requirements of the Privacy Rule is that we give you a **NOTICE OF PRIVACY PRACTICES**, which describes your rights and protections regarding your health care records.

There are instances in which we may be permitted or required to use and disclose health and treatment information about you. You should be aware that you have certain rights regarding the use and disclosure of health and treatment information.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH AND TREATMENT INFORMATION ABOUT YOU

We use and disclose health and treatment information about you for the following reasons:

For Treatment: We may use or disclose PHI with those involved in your care for the purpose of providing, coordinating, or managing your health care and related services. This may include consultation with clinical supervisors or other treatment team members. Other disclosures would only occur with your authorization.

For Payment: We may use and disclose health and treatment information (PHI) about you so that we may bill for the services you receive and collect from appropriate payers or their designated representatives. Only the minimum amount of PHI would be provided in collection services for lack of payment needed for the purposes of collection.

For Health Care Operations: We may use and disclose health and treatment information about you for the purposes of supporting our business included but not limited to case management, quality assessment, employee review activities or licensing related activities.

Your Authorization: We must by law provide disclosures of your PHI upon your request. This may be done through written authorization to disclose your PHI to any other entity for any purpose. Authorizations may also be revoked at any time. Without your written authorization, we cannot use or disclose your PHI for any reason other than described in this notice.

Individuals Involved in Your Care: We may release health or treatment information about you to a family member actively involved in your care with your written authorization, or as allowed by Colorado law (CRS 27-65-121 and 27-65-122).

Verbal Permission: We may provide PHI to a requested entity with your verbal permission until such time as a written authorization can be obtained.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Research: Under certain limited circumstances, we may use and disclose health or treatment information about you for research purposes, if you consent to such research.

Appointment Reminders: We may use and disclose information to contact and remind you that you have an appointment.

Health-Related Information or Resources: We may use and disclose information to contact you in order to tell you about other treatment-related options that may be of interest to you, such as support groups or online self-help resources.

Substance Abuse Health Information: The confidentiality of records related to the diagnosis, treatment, referral for treatment, or prevention of alcohol or drug abuse is protected by federal law (42 USC 290dd-3, 42 USC 290ee-3, and 42 CFR part 2).

HIV Information: All medical information regarding HIV is kept strictly confidential and is released only in accordance with the requirements of state law (C.R.S. 25-4-1405[2013]).

Rights of Minors: All provisions of the Privacy Notice apply to parents, legal guardians, or other persons authorized to act on a minor's behalf, with certain exceptions.

Federal and state laws allow or require we disclose health or treatment information about you, without your written authorization, in certain special circumstances, including:

Public Health Risks (Health and Safety for You and/or Others): We may disclose health information about you for public health activities, when necessary, to prevent a serious threat to your or others' health and safety.

Health Oversight Activities: We may disclose health information about you to a health oversight agency for activities authorized by law, such as audits, investigations, inspections or licensure.

Lawsuits, Legal Actions, and Disputes: If you are involved in a lawsuit or legal action, we may be permitted or required to disclose health information about you in response to a court or administrative order or from a subpoena.

Law Enforcement: We may disclose health information about you if asked to do so by a law enforcement official for various reasons.

Coroners, Medical Examiners, and Funeral Directors: We may disclose information to a coroner or medical examiner.

National Security and Intelligence Activities: We may disclose health information about you in national security activities authorized by law.

As Required By Law: We will disclose health information about you when required to do so by federal, state or local law.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care, upon written request. Your request to inspect and copy your information may be denied in certain limited circumstances.

Right to Amend: If you feel that any health information we have about you is incorrect or incomplete, you may ask us to amend the information. You must provide a reason supporting your request. We may deny your request for various reasons.

Right to an Accounting of Disclosures: You have the right to request an accounting or list of disclosures of health information made about you.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you, however, we are not required to comply with your request.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at a certain telephone number or address. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice: You have the right to receive a written copy of this Notice.

Other Uses: Other uses and disclosures of health information not covered by this Notice or the laws that apply to mental health and substance abuse providers will only be made after you have given your prior written authorization. If you provide us with such a written authorization, you may revoke it, in writing, at any time, and we will no longer use or disclose information for the reasons covered in your prior authorization. However, when you revoke an authorization, we are unable to take back disclosures made in accordance with the authorization while it was in effect.

Assistance and Complaints
If you wish to have more information about our privacy practices or have any questions or concerns, please contact us at the contact information provided in the end of this document.

If you have concerns we may have violated any of your rights regarding PHI, or your disagree with a decision we have made about access to your health information or in response to a request you made to amend or restrict the use of your PHI or requests to have us communicate by alternative means or locations, you may complain to us at the identified contact information below, or to The Secretary of Health and Human Services at 200 Independence Ave, Washington DC, 20201, or by calling 202-619-0257. We will not retaliate in any way against you for making a complaint.

Effective date of this privacy notice is January 29, 2019.

Contact Information:
Craig Thornhill, LPC, LAC
PO Box 770147
Steamboat Springs, CO 80477
810 Lincoln Ave.
970-879-7637 office / 970-871-7637 fax
cthornhillcounseling@gmail.com

I HAVE READ THE NOTICE OF PRIVACY PRACTICES FOR CRAIG THORNHILL, LPC, LAC. I UNDERSTAND MY RIGHTS AS A CLIENT OR AS THE CLIENT'S RESPONSIBLE PARTY

_____

CLIENT'S SIGNATURE **DATE**

_____

CLIENT'S PRINTED NAME

_____

SIGNATURE OF PARENT/GUARDIAN/PERSONAL REPRESENTATIVE **DATE**

_____

GUARDIAN OR LEGAL REPRESENTATIVE'S PRINTED NAME

IF YOU ARE SIGNING AS A LEGAL GAURDIAN OR REPRESENTATIVE, PLEASE EXPLAIN THE AUTHORITY YOU HAVE FOR THIS INDIVIDUAL. SUPPORTING DOUCMENTATION MAY BE REQUESTED TO VERIFY YOUR AUTHORITY (ie power of attorney, custody orders, adoption orders, etc).

_____
_____
_____
_____

Craig Thornhill, LPC, LAC
PO Box 770147
Steamboat Springs, CO 80477
810 Lincoln Ave, Suite 200
970-879-7637 x9 office / 970-871-6811 fax
cthornhillcounseling@gmail.com

DISCLOSURE STATEMENT

DEGREES, CREDENTIALS, LICENSES

I am a Licensed Professional Counselor (#4480) and a Licensed Addiction Counselor (#949), authorized to practice psychotherapy in Colorado by the Department Of Regulatory Agencies. I hold a Bachelor's degree in Psychology from Louisiana State University (1997) and a Master's degree in Counseling Psychology from The University of Colorado Denver, emphasis in family therapy (2004).

I have been practicing psychotherapy since 2004, as well as providing mental health clinical supervision since 2013. I have been practicing addiction counseling since 2012, and addiction clinical counseling supervision since 2016. I have been a nationally certified Mental Health First Aid instructor since 2013.

The practice of licensed or registered persons in the field of psychotherapy is regulated by the Mental Health Licensing Section of the Division of Registrations. Questions or complaints may be addressed to:

The Board of Licensed Professional Counselors Examiners
The Board of Licensed Addiction Counselors Examiners
1560 Broadway, Suite 1350
Denver, Colorado 80202
(303) 894-7800
www.dora.state.co.us/reg_investigations/file_complaint.htm

REGULATION OF PSYCHOTHERAPISTS AND ADDICTION COUNSELORS PURSUENT TO C.R.S. 12-43-214

1. A Registered Psychotherapist is a psychotherapist listed in the State's database and is authorized by law to practice psychotherapy in Colorado, but is not licensed by the state and is not required to satisfy any standardized educational or testing requirements to obtain a registration from the state.

2. A Certified Addiction Counselor I (CAC I) must be a high school graduate or equivalent, complete required training hours and 1,000 hours of supervised experience. A Certified Addiction Counselor II (CAC II) must be a high school graduate or equivalent, complete the CAC I requirements, and obtain additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam. A Certified Addiction Counselor III (CAC III) must have a bachelor's degree in behavioral health, complete CAC II requirements, and complete additional required training hours, 2,000 additional hours of supervised experience, and pass a national exam. A Licensed Addiction Counselor must have a clinical master's degree, meet the CAC III requirements, and pass a national exam.
3. A Licensed Social Worker must hold a master's degree from a graduate school of social work and pass an examination in social work. A Licensed Clinical Social Worker must hold a master's or doctorate degree from a graduate school of social work, practiced as a social worker for at least two years, and pass an examination in social work.

4. A Psychologist Candidate, a Marriage and Family Therapist Candidate, and a Licensed Professional Counselor Candidate must hold the necessary licensing degree and be in the process of completing the required supervision for licensure.

5. A Licensed Marriage and Family Therapist must hold a master's or doctoral degree in marriage and family counseling, have at least two years post-master's or one year post-doctoral practice, and pass an exam in marriage and family therapy.

6. A Licensed professional Counselor must hold a master's or doctoral degree in professional counseling, have at least two years post-master's or one year postdoctoral practice, and pass an exam in in professional counseling.

7. A Licensed Psychologist must hold a doctorate degree in psychology, have one year of post-doctoral supervision, and pass an examination in psychology.

CLIENT RIGHTS AND OTHER IMPORTANT INFORMATION

1. You are entitled to receive information from me about the methods of therapy, the techniques used, the anticipated duration of therapy, and the fee structure.

2. You can seek a second opinion from another therapist or terminate therapy at any time in a professional relationship.

3. Sexual intimacy is never appropriate and should be reported to the board that licenses, registers, or certifies the licensee, registrant or certificate holder.

4. Generally speaking, the information provided by and to the client during therapy sessions is legally confidential and cannot be released without the client's consent. There are exceptions to this confidentiality, as well as other exceptions in Colorado pursuant to C.R.S. 12-43-218, and the NOTICE OF PRIVACY PRACTICES provided:

    a. Mental health and addiction counselors and professional are required to report child and/or elder abuse to law enforcement or child welfare authorities pursuant to C.R.S. 18-65-108.
    b. Persons who are deemed "imminent" risk to themselves due to mental illness or grave disability must be evaluated and may be reported to Law Enforcement or other appropriate professional/medical staff to ensure safety pursuant to C.R.S. 27-65-105.
    c. Mental Health and Addiction Counseling professionals are also mandatory reporters of imminent threats to harm others. Knowledge of a threat to harm another person, building or entity must be reported to Law Enforcement and the identified target of said threat.
    d. Records may have to be released in response to a court order from a judge.

5. If I have concerns related to a client's safety I may involve Law Enforcement to conduct a welfare check to ensure no imminent risk exists to self or others, and to ensure a client does not need evaluation for grave disability pursuant to C.R.S. 27-65-105.

6. I do not engage in direct electronic communication with clients enrolled in treatment due to concerns related to HIPPA and privacy. I cannot guarantee who may be communicating from the other end of a text or email communication, I therefore do not text or email my clients as a general practice. By signing this document you acknowledge that you accept the security risk of using electronic means. I also do not utilize any online social media platforms with clients (largely to protect their confidentiality).

7. My cell phone # 970-846-3441 is available for emergent needs. Texting is an easy way to schedule appointments, though I cannot guarantee 100% confidentiality through texting. There are times when I may not be in cell phone range due to the area we live in, limiting my availability. By signing this disclosure, you understand that I cannot guarantee 24 hr availability for crisis or emergent services for this reason. Should a mental health or substance related crisis emerge, and I am not available/do not respond to a crisis call within 5-10 minutes, please present to the nearest Emergency Department or contact Colorado Crisis Services at 844-493-8255, or 911.

8. Clients have the right to have copies of this document.

9. Under C.R.S 14-10-123.8 parents have the right to access mental health treatment information concerning their minor children, unless the court has restricted access to such information.

10. Persons 15 years of age or older may seek psychotherapy without consent from their parent or guardian. Persons of any age may seek substance specific therapy without parental or guardian consent.

11. By signing this you understand that clients must give me 24 hour notice if they are unable to attend a scheduled appointment. Late cancelation fees may apply if this is not done ($75.00).

12. I can provide a treatment summary to any client or parent who requests this. I do not however as a general practice release specific session notes. Releases of information must be signed by a client or legal guardian to provide a treatment summary to another entity or agency (ie Primary Care Physician, Probation Officer, Advocate, etc).

13. I do not provide any legal child custody or divorce/separation recommendations. Other appropriately credentialed professionals may be enlisted or assigned by the court to provide this type of recommendation if this is needed. I may at times testify as an expert regarding other areas of treatment if requested and/or subpoenaed. This would only be within my scope of practice including mental health and addiction counseling. Testimony hourly fees and other related travel expenses would apply. Releases of information must be in place for HIPPA for mental health and 42CFR for substance related information or testimony to be given in court.

14. Regarding fees for services, my rates are as follows:

    a. I charge by the hour for my services on a sliding fee scale based on a client's ability to pay. My sliding fee range is $75.00-$135.00 per therapy session/hour. **All clients should please allow 30 minutes of extra time for your first session for registration paperwork and review of privacy policies/confidentiality.**
    b. I am qualified to conduct substance specific evaluations and submit subsequent court reports upon request. This process involves diagnostic evaluation, bio psycho social assessment, screening and time devoted to writing reports with treatment or other appropriate level of care recommendations. Releases of information must be in place for HIPPA for mental health and 42CFR for substance related information or testimony to be given in court or to other entities such as attorneys. These evaluations also require longer session times (2 hours) compared to an individual therapy session. These evaluations require extra time from a client for completion of screening and assessment instruments as well as the clinician for completion of the report. Subsequently, the cost is $300.00 for completion of the full evaluation and report. If you are scheduling an evaluation of this kind, by signing this, you also agree not to hold Craig Thornhill, LPC, LAC or Thornhill Counseling, LLC liable for any subsequent court order related to your case after this evaluation is completed.
    c. I offer a onetime free 15-30 minute initial consultation appointment to clarify if my services will benefit potential clients.

d. I am able to bill the following insurances (Anthem, Cigna and United). All individual coverage plans are different. Please provide your insurance card to copy so I can verify benefits for claims. Some plans require up-front payments until a deductible is reached, while others may require a copay due at the time of service. If a client's insurance denies any claims for services, by signing this, the client acknowledges they will be subsequently responsible for payment.
e. If a client is here with an identified funding source for treatment such as REPS, Probation or the Department of Human Services, an active release of information must be signed and sustained for billing purposes with the referring/funding agency or party.
f. I am able to accept credit cards for payment of services at this time (Visa, Mastercard, Discover, and American Express, as well as some Health Savings Account cards).
g. Checks can be made out to Thornhill Counseling.
h. If the above fees are not financially manageable for clients, please speak directly to Craig Thornhill about a possible fee adjustment for services. Any sliding fee adjustments would be based on a client's ability to pay on a case by case basis.
i. Please note fees are subject to change at yearly intervals (February 1st)
j. Fees for services, copays etc are due at the date of service. If this is not possible a balance may be accrued. However, please note there is an unpaid balance limit of $300.00 that must be settled prior to scheduling more appointments (barring potential safety risk assessment to self or others).
k. By signing this you agree to allow Craig Thornhill, LPC, LAC to use your personal health information for billing/insurance/claim submission and recoupment purposes.

15. COVID19 related disclosure:
    a. Craig Thornhill, LPC, LAC / Thornhill Counseling will work to abide by and follow all public health orders and risk mitigations efforts in his office space (810 Lincoln Ave, Suite 200, Steamboat Springs, CO 80487) for contactless payments and documentation exchanges.
    b. By signing this the client or client representative acknowledges that there are inherent risks associated with COVID-19 and any in-person/in-office contacts. Subsequently, you agree to voluntarily assume any risk of exposure or infection associated with COVID-19, and agree to not hold responsible Craig Thornhill, LPC, LAC/Thornhill Counseling for any infection that may have resulted from in-person contacts at the office space identified above. You also agree not to hold Craig Thornhill, LPC, LAC/Thornhill Counseling responsible for any infection, death or harm due to infection from COVID-19 associated with contact from other persons or providers' clients who may also be in the same building suite space.
    c. All clients who attend any in-person sessions agree to a pre appointment screening consisting of COVID-19 risk and symptoms questions. By signing this you agree to not attend any in person meetings if you are displaying any fever, soar throat, or other COVID-19 Centers for Disease Control identified symptoms. Craig Thornhill, LPC, LAC agrees not to charge any clients or submit insurance claims for sessions that were canceled due to this reason.

RECORDS MANAGEMENT

Mental health professionals are required to maintain records of the people they serve, 18 years of age and older, for a period of ten (10) years from the date of termination of services. Under Colorado law (C.R.S. 12-43-224), if you feel we have violated the law regarding maintenance of records for an individual 18 years of age and older, you must file your complaint or other notice with the Division of Professions and Occupations within seven (7) years after you discover or reasonably should have discovered the violation. All records will be maintained as required under Colorado law. Please be advised that records for an individual 18 years of age and older may not be maintained after the ten-year period. Other relevant information related to how records are managed are included in the NOTICE OF PRIVACY PRACTICES provided.

I HAVE READ THE PRECEDING INFORMATION, IT HAS ALSO BEEN PROVIDED VERBALLY, AND BY SIGNING BELOW I ACKNOWLEDGE I UNDERSTAND MY RIGHTS AS A CLIENT OR AS THE CLIENT'S RESPONSIBLE PARTY ENTERING SERVICES WITH CRAIG THORNHILL, LPC, LAC.

_____

CLIENT'S SIGNATURE **DATE**

_____

CLIENT'S PRINTED NAME

_____

SIGNATURE OF PARENT/GUARDIAN/OR PERSONAL REPRESENTATIVE DATE

_____

GUARDIAN OR LEGAL REPRESENTATIVE'S PRINTED NAME

IF YOU ARE SIGNING AS LEGAL GAURDIAN OR REPRESENTATIVE, PLEASE EXPLAIN THE AUTHORITY YOU HAVE FOR THIS INDIVIDUAL. SUPPORTING DOCUMENTATION MAY BE REQUESTED TO VERIFY YOUR AUTHORITY (ie power of attorney, adoption orders, custody orders, etc).

_____

_____

_____

_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

This is a Government document in the public domain.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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 figety 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		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

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 other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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A2663B 10-04-2005