Bone & Joint Specialists

PATIENT NAME: _____ Cellular#_____
First Middle Last
Address: _____Apt./Sp.#: _____
City: _____ State: _____ Zip: _____
Home Phone #: ( ) _____ - _____ Work Phone #: ( ) _____ - _____
Social Security #: _____ - _____ - _____Date of Birth: _____ Age: _____ Male Female
Race and Ethnicity: _____ Email: _____
Employer: _____ How Long? _____
Occupation? _____ Marital Status: S M D W

Who referred you to our office?_____Address: _____

Primary Care Doctor: _____Address: _____

***********Complete this section only if someone other than the patient is financially responsible***********

***Responsible Party: _____Relationship to Patient_____**
***Home Address: _____**
***Telephone #: ( ) _____Birthdate: _____**
***Employer: _____*Insured ID# or Social Security:_____**

EMERGENCY CONTACT: (NAME OF FRIEND OR RELATIVE NOT LIVING WITH YOU).

Contact Name: _____ Relationship to Patient: _____
Home Phone: ( ) _____ - _____ Cellular #: ( ) _____ - _____

WHAT BODY PART ARE WE SEEING YOU FOR?: _____
DATE OF INJURY/ONSET: _____

INSURANCE INFORMATION:

Primary Insurance: _____ Policy ID#: _____Group#_____
Address: _____ City/State/Zip _____
Date of Birth: _____/_____/_____ Insured Name: _____

Secondary Insurance: _____Policy ID#:_____Group#_____
Address:_____City/State/Zip_____
Date of Birth:_____/_____/_____ Insured Name: _____

Worker's Comp Name & Address: _____
Worker's Comp claim#: _______ Date of Injury: _____
Work Comp Adjusters Name:_____Tel#: _____Fax#:_____
Nurse Case Mgr Name: _____Tel#:_____Fax#:_____

I hereby assign all medical benefits to which I am entitled to Bone & Joint Specialists. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorized said assignee to release any information needed to determine these benefits or the benefits for related services.

_____ _____
Responsible Party Signature **Date**

BILLING INFORMATION

**************ONLY COMPLETE THIS SECTION IF MOTOR VEHICLE ACCIDENT ***************

What is the name of the insurance company? _____

Insurance company address: _____

Claims adjusters name: _____ Phone#: ( ) _____

DO YOU HAVE AN ATTORNEY FOR YOUR INJURY? YES NO

Attorney's Name: _____ Phone#: ( ) _____ - _____

Attorney's Address: _____

IF THERE IS A LIEN SIGNED WITH YOUR ATTORNEY, THERE WILL BE A $250 DEPOSIT REQUIRED

**************ONLY COMPLETE THIS SECTION IF INJURED ON THE JOB*******************

Did the injury occur at work? YES NO

If yes, please explain the injury details: _____

_____

Date the injury occurred: _____

Did you report the injury to a supervisor? YES NO Supervisor's Name: _____

Have you had any previous Worker's Compensation injuries in the past? YES NO

If yes, please explain: _____

PATIENTS NAME: _____ DATE: _____

HISTORY FORM

Name: _____ Date: _____
First Middle Last

Height _____Weight _____

Area of the body you are being seen for? _____

Describe injury/accident in detail: _____

Medication	Dose	How long taking	Side effects

******PLEASE LIST NAME OF PHARMACY SO THAT IT CAN BE ELECTRONICALLY SENT TO THE PHARMACY******

Pharmacy Name: _____Pharmacy Number: _____
Pharmacy Cross Streets: _____

Allergies to Medication: ☐ Yes ☐ No
If yes, please list which medication: _____

Allergies: _____

Are you currently or have had problems with your?

	Circle		Describe all yes responses
Eyes	**Yes**	**No**	_____
Ears, Nose, throat	**Yes**	**No**	_____
Lungs, breathing	**Yes**	**No**	_____
Digestion	**Yes**	**No**	_____
Bladder	**Yes**	**No**	_____
Diabetes	**Yes**	**No**	_____
Heart Disease	**Yes**	**No**	_____
High Blood pressure	**Yes**	**No**	_____
Bleeding problems	**Yes**	**No**	_____
Balance problems	**Yes**	**No**	_____
Numbness/tingling	**Yes**	**No**	_____
Blackouts/fainting	**Yes**	**No**	_____
Psychological problems	**Yes**	**No**	_____
Cancer	**Yes**	**No**	_____
Arthritis	**Yes**	**No**	_____
Polio	**Yes**	**No**	_____
Epilepsy	**Yes**	**No**	_____
HIV	**Yes**	**No**	_____
Hepatitis, Tuberculosis	**Yes**	**No**	_____
Other (please describe)	**Yes**	**No**	_____

PAST MEDICAL HISTORY

Surgeries/Hospitalization	Year	Complaint

Have you ever had general anesthesia? ☐ **Yes** ☐ **No**
Any problems with anesthesia? ☐ **Yes** ☐ **No**

If yes, describe _____

SOCIAL HISTORY

Marital status: ☐**Single** ☐**Married** ☐**Divorced** ☐**Separated** ☐**Widowed**

Children: ☐**Yes** ☐**No** **How many children?** _____

Do you live alone? ☐**Yes** ☐**No**

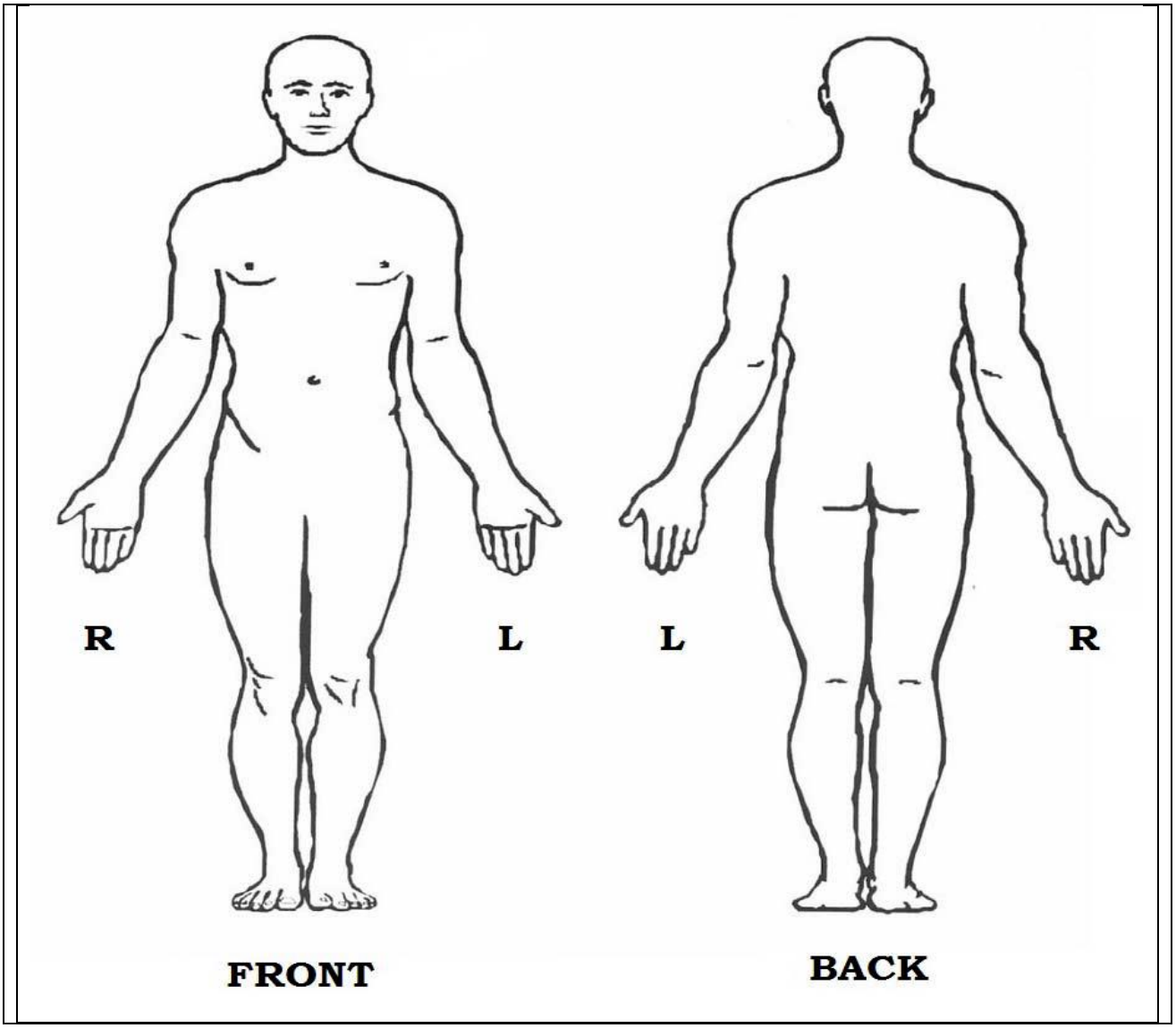
Exercise? ☐**daily** ☐**weekly** ☐**monthly** ☐**rarely** ☐**never**
What type of exercise? _____

Are you on a special diet? ☐**Yes** ☐**No**
History of substance abuse? ☐**Yes** ☐**No What substance?** _____
Do you smoke? ☐**Yes** ☐**No Packs per day?** _____ **for** _____**year (s)**
When did you quit smoking? _____**Packs per day?** _____**for** _____**year(s)**

Drink alcohol? ☐**Yes** ☐**No**
☐**daily** ☐**1-2 per week** ☐**1-2 per month** ☐**1-2 per year**

FAMILY HISTORY

Member	Alive	Age	Health status/cause of death
Father	**Yes** **No**		
Mother	**Yes** **No**		
Sister/Brother	**Yes** **No**		
Sister/Brother	**Yes** **No**		
Sister/Brother	**Yes** **No**		



Please mark the area of injury or discomfort on the chart using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	oooooooooo	^^^^^^	XXXXX	/////////
----------	oooooooooo	^^^^^^	XXXXX	/////////

Please use this space below to describe your condition further if needed:

_____

_____

_____

Date: _____ Name: _____

BONE & JOINT SPECIALISTS
Review of Systems

Patient Name: _____ **Date:** _____

Systemic

Recent weight loss	○ Yes	○No
Recent weight gain	○ Yes	○No
Feeling tired	○ Yes	○No
Fever (as symptom)	○ Yes	○No
Chills (as symptom)	○ Yes	○No

Pulmonary Symptoms

Cough	○ Yes	○No
Difficulty breathing	○ Yes	○No

Cardiac Symptoms

Chest pain or discomfort	○ Yes	○No
Palpitations	○ Yes	○No
Limb swelling	○ Yes	○No

ENT Symptoms

Blurry vision	○ Yes	○No
Worsening vision	○ Yes	○No
Loss of hearing	○ Yes	○No
Ringing in the ears	○ Yes	○No

GI

Upset stomach	○ Yes	○No
Constipation	○ Yes	○No
Red blood in bowel Movement	○ Yes	○No
Diarrhea	○ Yes	○No

Hematological Symptoms

Easy bruising tendency	○ Yes	○No
Easy bleeding	○ Yes	○No

Neurological Symptoms

Walk wobbly or unsteady	○ Yes	○No
Numbness	○ Yes	○No
Tingling	○ Yes	○No
Involuntary movements which come And go	○ Yes	○No

Intequmentary

A rash	○ Yes	○No
Localized loss of skin surface	○ Yes	○No

Endocrine Symptoms

Excessive thirst/fluid intake	○ Yes	○No
Urinary frequency increased	○ Yes	○No
Pain during urination	○ Yes	○No
Loss of hair from head or body	○ Yes	○No

Psychological

Emotional lability	○ Yes	○No
Anxiety	○ Yes	○No
Depression	○ Yes	○No

Musculoskeletal

Muscle weakness	○ Yes	○No
Joint stiffness, localized	○ Yes	○No
Lower back pain	○ Yes	○No
Spinning dizziness (vertigo)	○ Yes	○No

BONE & JOINT SPECIALISTS

DISCLOSURE:

Bone and Joint Specialists is a for-profit corporation solely owned by the physicians providing medical services to the community**.**

Our office does not discriminate against any person on the basis of race, gender, religion, color, national origin, disability, or age.

FINANCIAL POLICY:

PAYMENT FOR MEDICAL SERVICES RENDERED IS DUE AT THE TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

Our office does verify eligibility and benefits with your health insurance company. If we are unable to accomplish this, you will be asked to pay for services rendered until we can confirm your eligibility status. We will do all we can to assist you with your health insurance claims however, insurance is a contract between the insurance company and the insured. Final responsibility for payment of your account rests with you. Our office will bill a secondary insurance only once as a courtesy to the patient. If the insurance does not pay, then the balance becomes the responsibility of the insured.

If you are scheduled for surgery, we require any deductible's as well as coinsurance amounts paid prior to your date of surgery. In addition to the surgeon's fee, there is a need for an assistant at the time of your surgery. The assistant's fee is in addition to the surgeon's fee.

Any prior authorizations obtained by this office on behalf of you, the patient, are not a guarantee of payment, but are based on medical necessity. Claims are subject to your policy provisions and final payment is determined only when your insurance company has received the claim. If you have any questions regarding our medical fees or questions regarding your insurance benefits, please speak with a billing specialist.

A returned check charge of $35.00 will be charged to the account for each returned check.

DELINQUENT AND COLLECTION ACCOUNTS:

- An account becomes delinquent when the minimal monthly payment has not been received within 30 days of the statement date.
- An account that has become delinquent for 60 days, may become a collections account and may be charged a collections handling fee, court cost's and attorney's fee's.
- Exemptions from the above are allowed charges under Medicare and Title XIX (Nevada Medicaid) contracts.
- There may be exceptions to all or any part of the account.
- Balances not paid by your insurance plan within 30 days, will automatically become the responsibility of the responsible party.

CANCELLATION, NO SHOW AND RESCHEDULING POLICY: If you fail to provide us with a 24 hour notice of cancellation or rescheduling, or fail to keep your scheduled appointment, there will be a $50 no-show fee.

I understand that Bone & Joint Specialists may not be a provider on my health plan, and I will be fully responsible for any outstanding charges that my insurance plan does not cover. A photocopy of this assignment is considered as valid as the original.

In the event that my account becomes a delinquent account or a collection account, I agree to pay Bone & Joint Specialists all incurred Finance Charges, Delinquent Account Handling Fee's, Collection Account Handling Fee's and incurred Collection cost's as set forth above in section 3 of the financial policy.

If it is necessary to forward your account to our Collection Agency, a Collection Fee markup of 35 to 50% will be added to the amount owing. Interest will accrue daily at the rate of 1.5% per month or 18% per year.

The mark-up reflects Bone & Joint Specialists receiving only it's billed charges. The additional money will go to the collection agency.

Signature of Responsible Party: _____ Date: _____

Bone and Joint Specialists

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

WHO WILL FOLLOW THIS NOTICE:

- Bone and Joint Specialists

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to health information about you; and
- follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **Research**
- **To Provide Information About Organ and Tissue Donation**
- **To Allow Oversight of the Quality of the Healthcare We Provide**
- **To Allow Workers' Compensation Claims**
- **As Required by Subpoena in Lawsuits and Disputes**
- **Various Uses as Required by Law or to Avert a Serious Threat to Health or**

Safety
The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy**
- **Right to Amend**
- **Right to an Accounting of Disclosures**
- **Right to Request Restrictions**
- **Right to Request Confidential Communications**
- **Right to a Paper Copy of This Notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from ANNA HOLLAND, OFFICE MANAGER at (702) 474-7200.

CHANGES TO THIS NOTICE
We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact ANNA HOLLAND, OFFICE MANAGER. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION.
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement of Receipt of this Notice
We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date. This acknowledgement will be filed with your records.

Acknowledgement of Receipt of Notice of Privacy Practices for Bone & Joint Specialists

I hereby acknowledge that I have received the Notice of Privacy Practices from Bone & Joint Specialists.

I give permission for my protected health information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Print Name: _____

BONE & JOINT SPECIALISTS

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

I Authorize: _____

_____

To release my health care information to: Bone & Joint Specialists
Name of designated individual, organization, or Provider

2680 Crimson Canyon Drive, Las Vegas, NV 89128
Address

(702 228-7355 (OFFICE) (702) 228-4499 (FAX)

Information to be Released:		**Dates of Treatment:**	
X	All Medical Records	X	All Dates
	All Medical Billing Records		**Specific Dates**:
	X-Ray and imaging reports		

Other: _____

Purpose of disclosure: _____

1. I understand that my express consent is required to release any health care information relating to testing/diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.
2. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses. Any and all reports of any type or character.
3. I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at the facility/Provider or write a letter to the facility/Provider.
4. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws.
5. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.
6. I understand I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, or enrollment).

_____ _____
Printed Name Date

_____ _____
Signature of Patient or Legal Representative Date

Authorization will expire 12 months from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

Bone & Joint Specialists

Controlled Substance Questionnaire

	YES	NO	N/A
N/A means not applicable.			
Have you ever used a controlled substance in a way other than prescribed?	_____	_____	_____
Have you ever diverted a controlled substance to another person?	_____	_____	_____
Have you ever taken a controlled substance that did not have the desired effect?	_____	_____	_____
Are you currently using any drugs, including alcohol or marijuana?	_____	_____	_____
Are you using any drugs that may negatively interact with a controlled substance?	_____	_____	_____
Are you using any drugs that were not prescribed by a practitioner that is treating you?	_____	_____	_____
Have you ever attempted to obtain an early refill of a controlled substance?	_____	_____	_____
Have you ever made a claim that a controlled substance was lost or stolen?	_____	_____	_____
Have you ever been questioned about your pharmacy report or PMP report?	_____	_____	_____
Have you ever had blood or urine tests that indicate inappropriate usage of meds?	_____	_____	_____
Have you ever been accused of inappropriate behavior or intoxication?	_____	_____	_____
Have you ever increased the dose or frequency of meds without telling your provider?	_____	_____	_____
Have you ever had difficulty with stopping the use of a controlled substance?	_____	_____	_____
Have you ever demanded to be prescribed a controlled substance?	_____	_____	_____
Have you ever refused to cooperate with any medical testing or examinations?	_____	_____	_____
Have you ever had a history of substance abuse of any kind?	_____	_____	_____
Has there been any change in your health that might affect your medications?	_____	_____	_____
Have you misused or become addicted to a drug, or failed to comply with instructions?	_____	_____	_____
Are there any other factors that your practitioner should consider before prescribing?	_____	_____	_____

_____ _____ _____

Patient's Signature **Patient's Printed Name** **Date**

Bone & Joint Specialists
INFORMED CONSENT FOR
CONTROLLED SUBSTANCE TREATMENT FOR PAIN

Nevada law requires a patient's informed consent before a controlled substance can be initially prescribed to treat the patient's pain. I understand that attempting to reduce my pain is my responsibility, and that the treatment of pain with controlled substances carries with it some additional responsibilities which my practitioner has made me aware. The purpose of this agreement is to help both me and my practitioner comply with the law.
(Please initial each numbered paragraph and sign below to indicate your understanding of all parts of this document.)

POTENTIAL RISKS AND BENEFITS OF USING A CONTROLLED SUBSTANCE FOR THE TREATMENT OF PAIN INCLUDING RISKS OF DEPENDENCY, ADDICTION AND OVERDOSE

_____ I understand there are potential risks and benefits associated with the use of controlled substances for the treatment of pain, and I understand these risks and benefits regarding the medication that I am being prescribed. I may experience certain reactions or side effects that could be dangerous, including drowsiness or sedation, constipation, nausea, itching, allergic reactions, problems with thinking clearly, slowing of my reactions, or slowing or cessation of my breathing. When taking these medications, I understand it may not be safe for me to drive a car, operate machinery, or take care of other people. If I feel at all sedated, confused or otherwise impaired by the medication, I will not do anything that might put other people at risk of being injured.

_____ Controlled substances also include a risk of tolerance, where my body may become accustomed to the original dosage of medication and this may require increased dosages to obtain the same effect. This is a situation that must be discussed with my practitioner, if it arises. I understand that I may become physically dependent these controlled substances, creating a situation where I may experience withdrawal symptoms if I abruptly stop the medication. Withdrawal symptoms present as flu-like symptoms, nausea, vomiting, diarrhea, sweating, body aches, muscle cramps, runny nose, anxiety, and sleep disruption.

_____ I understand that there is a risk of addiction to controlled substances. If I cannot control my usage of the medication, I may need addiction treatment.

_____ I understand controlled substances carry a risk of fatal overdose. If too much of the medication is taken, or if the medication is combined with other medications that may alter my level of consciousness (including alcohol and marijuana), this risk is increased.

_____ My practitioner has discussed with me a form of the controlled substance, if available, that is designed to deter abuse, along with the risks and benefits of using that form of the controlled substance.

_____ My practitioner has discussed possible alternative treatments for my pain that do not include a controlled substance, along with the risks and benefits of the alternate medications or treatments.

_____ It is our mutual decision that a controlled substance may provide some benefit for the treatment of my pain.

PROPER USE OF THE CONTROLLED SUBSTANCE

_____ My practitioner has discussed how to properly use the controlled substance that is being prescribed, and I agree to take the medication as directed and to not deviate from the parameters of the prescription as written by my practitioner.

TREATMENT PLAN AND REFILLS

_____ I have discussed my treatment plan with my practitioner and I have a good understanding of the overall treatment plan and goals of treatment. A main goal of treatment is to use the minimum amount of controlled substance to increase function rather than to remove all pain.

_____ I understand my practitioner's protocol for addressing any requests for refills.

_____ If my treatment for pain with the controlled substance goes beyond thirty (30) days, I understand I will be required to sign and comply with a prescription medication agreement. If treatment exceeds ninety (90) days, I realize that I will be required by Nevada law to complete further assessment regarding my risk of abuse, misuse, or diversion of the controlled substance.

SAFE STORAGE AND DISPOSAL OF A CONTROLLED SUBSTANCE

_____It is my responsibility to store and dispose of controlled substances in the appropriate manner. I will store controlled substances in a secure place and out of the reach of children and other family members. To safely dispose of unused medications, I may return the medications to a local pharmacy, a local police station, a "drug-take back day" station, or I may safely dispose of them by dissolving them in a "Dettera" bag, which may be available for purchase at a pharmacy.

FOR WOMEN IN THE AGES BETWEEN 15 AND 45

_____ It is my responsibility to tell my practitioner if I am, or have reason to believe that I am pregnant, or if I am thinking about getting pregnant during the course of my treatment with controlled substances, as there is risk to a fetus of exposure to controlled substances during pregnancy, including the risks of fetal dependency on the controlled substance and neonatal abstinence syndrome (withdrawal).

IF THE CONTROLLED SUBSTANCE IS AN OPIOID

_____ Due to the risk of possible fatal overdose resulting from the use of controlled substances, the opioid overdose antidote naloxone is available without a prescription at a Nevada pharmacy. I understand I can obtain this medication from a pharmacist at any time.

_____In addition to all of the above, there are increased risks that the minor may abuse or misuse the controlled substance or divert the controlled substance for use by another person. I have been informed about ways to detect such abuse, misuse or diversion.

I have read and understand each of the statements written above and have had an opportunity to have all my questions answered. By signing, I provide consent for the prescription of controlled substances for the treatment of pain.

_____ _____ _____

Patient Signature Patient name printed Date

Bone & Joint Specialists

Patient Name: _____ Date: _____

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 difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

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 circled 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