400 Massasoit Avenue, Suite 305, East Providence RI 02914
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Phone: (401) 294-0451 • Fax: (401) 294-0461
Receptionist@RICBT.com • www.RICBT.com

Packet for Psychiatrists at RICBT

Pamela Bochiechio, MD, Kimberley Chiappone, MD, or Melissa Ludwig, MD

I look forward to meeting with you as an independent psychiatrist affiliated with RICBT. Please read and complete each of the steps listed below as thoroughly as possible. This will take some time - between 30 and 60 minutes. However, it is important to making your work with me as effective as possible. By giving much of this information before your evaluation appointment, it will make it easier to cover more ground in that first session. I don't, though, want any of this to be a barrier to care. If you have any trouble or if a section is too sensitive, just leave it blank, bring it with you, and I will help you discuss things in person.

Pleas read and sign the *Services Agreement* form. You are welcome to ask me at your first appointment any questions you might have. Complete and sign the *Coordination of Care* forms. Complete and sign the *Payment Form*. Complete the Initial Evaluation Questionnaire (about your concerns and goals).

Today's Date:

Patient Name:

Age:

Date of Birth:

Address:

Mobile Phone:

Home Phone:

Email:

Check to receive important practice updates and our newsletter by email: ☐

Current or past RICBT Clinician(s):

Your pharmacy (where you pick up medication prescriptions) name and address:

Do you have any allergies (medications, foods, etc.)?

Emergency contact person. Please indicate the name of an emergency contact person for you, their relationship to you, their address, phone, and email.

Please download Adobe Reader to complete on the computer in order to save and print correctly.

Services Agreement: Psychiatrists at RICBT

Pamela Bochiechio, MD, Kimberley Chiappone, MD, or Melissa Ludwig, MD

Independent Psychiatry Services located at RICBT
This Agreement contains important information about my professional services and business policies.
I am a licensed psychiatrist practicing independently. I am physically based at RICBT and collaborate with the practice group, but the care I provide is independent of any care you may or may not receive as a patient at RICBT. This is because I am responsible for any psychiatric or medication treatment you may receive from me; RICBT cannot be held responsible for any treatment provided by me. At the same time, the psychiatry services I provide are designed to foster coordination of care with any of your RICBT providers. Your medical record with me is integrated with any treatment records that might result from receiving services at RICBT. Signing this Services Agreement also indicates you understand the close relationship and that care will generally be coordinated between myself and any RICBT clinicians you have. This document serves as an authorization to exchange information between me and your RICBT clinicians.

The Evaluation
To start, we will meet for about an hour so that I can meet you, conduct a psychiatric evaluation and get a sense of your goals for treatment. After the evaluation I will discuss my initial diagnostic impressions with you and my recommendations for treatment. This session is an opportunity for you to get a sense of me as well, to be sure you feel comfortable working with me and that you agree with my diagnoses and recommendations for treatment. I may determine that I am not the right treatment provider for you. The nature of your struggles could be outside of my scope of practice or difficult to manage effectively in an outpatient, private practice setting. If this is the case, I will make recommendations for other providers or treatment settings that will better suit your needs. So, the initial evaluation is just this - an evaluation - and only at the end of this first session will you and I decide if we will continue on into treatment.

Contacting Me
Due to the nature of my work, I am often not immediately available by telephone. When I am unavailable, you may leave a message on my voicemail (401.294.0451 x50 for Dr. Bochiechio, x77 for Dr. Chiappone, or x68 for Dr. Ludwig) or with the RICBT receptionist. I will make every effort to return your call within 24 hours. In an emergency or if you can't wait for me to return your call, contact your primary care physician, the nearest hospital emergency room, or call 911. If I will be away for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Limits on Confidentiality
The law protects the privacy of all communications between a patient and a psychiatrist. In most situations, I can only release information about your treatment to others if you sign a written authorization for specific information to be released to specific individuals or institutions. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I will make every effort to avoid revealing the identity of a patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- You should be aware that I collaborate with other mental health professionals at RICBT and that the RICBT administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as treatment planning, scheduling, billing and quality assurance. All of the mental health professionals at RICBT are bound by the same rules of confidentiality. All RICBT staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning our professional services, such information is protected by the psychiatrist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or a subpoena of which you have been officially notified and failed to inform me that you are opposing the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If you threaten to harm yourself, I may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation or disability claim, information that is directly related to that claim must, upon appropriate request, be provided to the Workers' Compensation Commission or the disability insurance company.

There are some situations in which I am legally obligated to take actions to attempt to protect others from harm. I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to know or suspect that a child has been abused or neglected, the law requires that I file a report with the Department for Children, Youth and Families. Once such a report is filed, I may be required to provide additional information.

If I believe that a patient presents a risk to a person or his/her family, I may be required to take protective actions including warning the potential victim(s), contacting the police, or seeking hospitalization of the patient. If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Breach Notification

If I become aware of, or suspect, a breach of security involving Protected Health Information (PHI), I will conduct a risk assessment. I will keep a written record of that risk assessment. Unless I determine that there is a low probability that PHI has been compromised, I will provide any required notice to patients and Health and Human Services (HHS). I will also re-assess our privacy practices to ensure continued security.

Offer to Receive the Notice of our Privacy Policies

The Rhode Island Notice Form describes the policies and practices to protect the privacy of your health information, as mandated by a federal law called the Health Insurance Portability and Accountability Act (HIPAA). Signing the Services Agreement indicates that you have been made aware that a copy of this Form is available in the waiting room, is posted on the RICBT.com web site, and will be given to you at any point if you request it.

Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your clinical record. You may examine and/or receive a copy of your clinical record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in the presence of a mental health professional so you can discuss the contents. In most circumstances, I charge a record preparation fee of $75.

Patient Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides you with rights with regard to your

clinical record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and the Notice of Privacy Policies form. I can discuss any of these rights with you.

Technology and Social Media Policy
The RICBT office may use email to communicate with you about some administrative issues, if you provide us your email. If you do exchange email with RICBT, it means that you are accepting the risk for any issues that may emerge with respect to confidentiality of the information exchanged. However, please note that I do not communicate with patients by email or text messages; I prefer to use phone calls and voice messages. Though RICBT has general social media pages on Facebook and Twitter that you might wish to follow, I do not accept patient requests to follow me on social media sites.

Minors and Parents
Some of our psychiatrists work with patients under 18 years of age and some do not. Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in mental health treatment is often crucial to successful progress, particularly with teenagers, it is sometimes helpful to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, parents will only be provided with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. They will also be provided with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless the child is in danger or is a danger to someone else, in which case, parents will be notified.

Billing and Payments
RICBT handles billing and payment issues for me. The practice accepts cash, checks, and credit cards (MasterCard and Visa). Checks can be made out to RICBT. Receipts are available from the receptionist (Receptionist@RICBT.com). Payment is expected at each session. If someone else is paying for your treatment (e.g., a parent, relative or friend), it is still your responsibility to ensure that payment will be available at each session. All communication regarding your account will go through you. Payment schedules for other professional services will be agreed to when they are requested. Overdue balances are subject to a billing fee of $10 per month. A $25 fee will be added for returned checks. For unpaid balances over 60 days, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Cancellations and Missed Appointments
To reschedule an appointment, contact the RICBT receptionist at (401) 294-0451 or by email at Receptionist@RICBT.com. If you need to cancel or reschedule your appointment, we appreciate as much notice as possible so the appointment time can be offered to someone else. There is a $75 charge for all missed appointments and late cancellations (less than 24 business-hours notice), regardless of your reason for the cancellation. The payment reflects time reserved and is not a judgment about the merits of the reason. As a courtesy, I will waive this fee once every six months.

Health Insurance
In order to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage. Medical benefits can be different than mental health benefits, so your responsibility with me may be different than with other RICBT providers. Your signature at the end of this document authorizes us to submit claims and receive payments on your behalf.

There are two types of insurance situations: *in-network* and *out-of-network*. Please make sure you understand your situation with me. *In-network* means that patients typically pay a flat dollar copay, a percentage

coinsurance, or the full in-network session allowance (if there is a deductible). *Out-of-network* means that patients are responsible for my full fee at session. You then have two choices: 1) If you would like to submit your claims yourself and receive reimbursement directly from your insurance company, my receipt has all the information required to do so. 2) If your insurance plan is one that RICBT submits to and you would like us to submit your claims for you, we would be happy to do so. Either way, your insurance company will reimburse you directly, based on your plan's out-of-network benefits. My fee is independent of any out-of-network reimbursement you might receive. The RICBT billing team does their very best to help patients understand their benefits, but plans vary widely. Please call your insurance company if you have any questions about your own plan's benefits.

It is essential that you let us know immediately whenever you have new insurance information, as plan benefits can vary tremendously and a referral or prior authorization is sometimes required. You are ultimately responsible for any sessions that your insurance does not cover. Please note that Missed Sessions (sessions cancelled with less than 24 business hours notice) are not submittable to insurance and are therefore your responsibility.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that your physician provides to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans, summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing this Agreement, you agree that we can provide requested information to your carrier. It is important to remember that you always have the right to pay for services yourself to avoid the problems described.

Termination of Treatment

There are times when treatment must end for some reason. Perhaps a patient moves out of town, feels he or she no longer requires psychiatric treatment, or decides to engage in treatment with a different provider. There are also times when I come to realize that the treatment is no longer effective for some reason and that it must come to an end. This is usually because the patient and I cannot come to an agreement regarding the way treatment should continue going forward. Other, less common reasons for the termination of a treatment relationship would include a patient having consistent difficulties keeping his or her appointments, misusing a medication I have prescribed (abusing it, selling it, taking more than prescribed, etc.), being generally unable or unwilling to let me know if he/she feels unsafe (suicidal or homicidal/aggressive thoughts or urges to engage in serious self-harm behaviors for example) ***before acting on*** these thoughts, or becoming threatening or hostile to me or to the staff. If you are having thoughts of leaving treatment, I would ask you to meet and discuss this with me so I might address any concerns you are having and do my best to help ensure proper ongoing follow-up if necessary. If I come to feel our treatment must end I will discuss this with you in person if possible, or I will send you a letter regarding the need to terminate treatment and why. I will also offer recommendations for ongoing treatment and will be available for urgent psychiatric issues for the subsequent 30 days.

Your signature below indicates that you have read the information in this Agreement and agree to abide by its terms during our professional relationship. **Your signature also indicates that you understand and accept our policy regarding charges for late cancellations and missed appointments.**

Today's Date:

Printed name of patient:

Signature of patient or authorized representative:

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Communication Between your Primary Care Physician (PCP) and your Psychiatrist at RICBT

Please note that we are required to have this form on file for you. It is very important to your health and safety that I am free to coordinate care with your other healthcare providers.

○ I do not currently have a PCP.

○ I authorize the use, disclosure, and exchange of my health information to my PCP. I also authorize sending a Coordination of Care Letter, which includes my preliminary diagnoses and treatment plan (and may include information about substance use and HIV status).

PCP name, address, phone, and fax:

If you have reason for wanting us to withhold information from your PCP about your diagnoses or treatment plan (including substance use or HIV status) in our Coordination of Care Letter, please check this box: ☐

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize my psychiatrist to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Printed name of patient:

Signature of patient or authorized representative:

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Communication Between your Psychologists/Psychotherapists Outside of RICBT and your Psychiatrist at RICBT

(My psychiatrist will coordinate care internally with your psychologist(s)/psychotherapist(s) at RICBT.)

○ I do not currently see mental health providers outside of RICBT.

○ I authorize the use, disclosure, and exchange of my health information to my psychologist or psychotherapist. I also authorize sending a Coordination of Letter, which includes my preliminary diagnoses and treatment plan (and may include information about substance abuse and HIV status).

Psychologist/Psychotherapist name, address, phone, and fax:

If you have reason for wanting us to withhold information from your psychologist/psychotherapist about your diagnoses or treatment plan (including substance use or HIV status) in our Coordination of Care Letter, please check this box: ☐

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize my psychiatrist to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Printed name of patient:

Signature of patient or authorized representative:

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Communication Between your Other Healthcare Providers Outside of RICBT and your Psychiatrist at RICBT (e.g., OB/GYN, neuropsychologist, past psychiatrist)

- ◯ There are no other providers with whom I would like you to coordinate my care.
- ◯ I authorize the use, disclosure, and exchange of my health information with these additional providers.

  Please note their **name, specialty, address, phone, and fax:**

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize my psychiatrist to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Printed name of patient:

Signature of patient or authorized representative:

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Communication Between your Family Members and your Psychiatrist at RICBT

We encourage you to involve your family members in your treatment. It can often be useful to bring a family member in to share their perspective on issues. Please discuss the options with your psychiatrist.

○ I do NOT authorize any communication with any of my family members or friends.

○ I authorize communication with the family members indicated below about:

- ☐ Routine scheduling or billing issues
- ☐ Any aspect of my treatment

Please include names, relationship to you, and phone numbers.

This authorization will have a duration of consent for the duration of active treatment. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email. Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from RICBT or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke this authorization at any time. To revoke, I must contact RICBT and put my revocation in writing. I understand that it will not apply to information that has already been released. I also understand that if I authorize my psychiatrist to disclose information, the recipient of the information might disclose it to others, and that any information disclosed may no longer be protected by the federal rule on the privacy of medical records.

Today's Date:

Printed name of patient:

Signature of patient or authorized representative:

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RICBT Payment and/or Credit Card Authorization Form

Once you put a credit card on file with us, you don't need to present the card at each session. You may also pay by cash or check at the time of service or pay in advance for a number of sessions.

Payment preference:

- ◯ I would like to pay by cash or check (payable to RICBT) before or at the time of service.
- ◯ I would like to put a credit card on file that will be charged after each session.

  Card type:
  - ◯ MasterCard
  - ◯ Visa

  Check if this is a debit card: ☐ Check if this is an FSA/HSA card: ☐

  Name of patient:

  Name on credit card:

  Billing address of cardholder (if different from patient address):

  Credit Card Number:

  Expiration Date (MM/YY):

  ☐ I would like an email receipt sent to:

Today's Date:

Signature:

RICBT Initial Evaluation Questionnaire (for Patients 18 years and over)

This questionnaire asks you to share details about your problems and life history. This information is critical to conducting a thorough evaluation. By completing this form before the initial meeting, much time will be saved and more ground will be covered in the first few sessions. Broadly, our goal is to get to know you. Please write in as much or little detail as you would like.

Patient Name: **Today's Date:**

Date of Birth:

Current problems and concerns. Please describe the key problems for which you are currently seeking treatment and when they began. Feel free to note situations that are difficult for you, as well as problematic moods, thoughts, and behaviors.

Your current family and living environment. Please note immediate family members (parents, spouse, children, or close relatives). What are their names and ages? Where do they live? Please describe the personalities and styles of the people you live with and your relationship with them. Note the level of conflict, tension, or stress in your living environment. Which patterns at home may contribute to your difficulties?

Your developmental history. Please tell us about your family growing up and your childhood. Where were you born? Please describe the personalities of family members, their emotional style, and how people related to each other. Please describe with what emotional or mental health problems people in your family of origin and close relatives struggle.

Major stressors or traumatic events. Please note any highly upsetting and traumatic events you have endured. Were you sexually, physically, or emotionally abused at any point in your life?

Your current work, school, and social environment. What is your current occupational or educational status? Please describe what work or school is like for you and what things about it may contribute to your difficulties. How would you describe your current friend and social support network?

Current physical health. Please describe your current physical health and any current problems with it.

Past physical health problems. Please describe any significant past medical problems and treatments (e.g., surgeries).

Current medications. Please list all psychiatric and non-psychiatric medications you are currently taking. Please include the dosage, prescriber, and reason for taking. Indicate if you are not on any medications.

Past psychiatric medications. Have you been on any psychiatric medications in the past?

Substance use and addictive behaviors.

Check here if you currently smoke cigarettes or use nicotine products (any amount): ☐

Check here if would you like a referral to a smoking cessation program: ☐

Please note any other issues you have or have had with substances such as alcohol, marijuana, cocaine, prescription medications, gambling, pornography, or other addictive patterns.

Mental health treatment history. Please describe your past experiences in inpatient and outpatient treatment. Please note psychologists, therapists, or counselors you have seen, approximate dates of treatment and number of sessions, what led you to seek treatment, and what it was like for you. For inpatient or day hospital programs, please note which facility or program you were in, the dates of treatment, and what led you to be in the hospital.

History of self-injury and suicidal feelings. Sometimes people hurt or injure themselves when they are upset or stressed. Do you do anything like that? Have you had times where you were thinking a lot about suicide? If so, please briefly describe when and whether you made a suicide attempt or a suicidal gesture. Have you ever been so upset that you thought about hurting others? If you feel unsafe before your first appointment here, please go to your nearest hospital emergency room, call your primary care doctor, and/or let us know if you need guidance.

Other symptoms. Please note any difficulties with your concentration, memory, appetite, sleep, or sexual functioning. Note any other symptoms you haven't yet noted in this questionnaire.

Other things your clinician should know? Please describe anything else that is important to know in understanding your life and your difficulties.

Patient Health Questionnaire (PHQ)

Patient Name:

Today's Date:

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

2. Feeling down, depressed, or hopeless

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

3. Trouble falling or staying asleep, or sleeping too much

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

4. Feeling tired or having little energy

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

5. Poor appetite or overeating

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

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

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

9. Thoughts that you would be better off dead, or of hurting yourself in some way

   ◯ Not at all ◯ Several days ◯ More than half the days ◯ Nearly every day

If you noted 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