Allison Gullo, MD
General and Geriatric Psychiatry
Phone: (503) 512-1218
Fax: (503) 512-1220

willamette PAIN & SPINE

2020 8th Avenue, Suite 200
West Linn, OR 97068

10001 SE Sunnyside Road, Suite 100
Clackamas, OR 97015

Welcome!

Your patient consultation appointment is scheduled for:

_____

Arrive 15 minutes early.

- Complete the enclosed paperwork and bring to your appointment along with your insurance card.
- Be prepared to pay your co-payment and/or co-insurance prior to your appointment.

We believe the more you know about the practice of Allison Gullo, MD and Willamette Pain and Spine Center (WPSC) the better we can partner with you and your other care providers to make a difference. Please take a few minutes to read and become familiar with the following information:

Clinic Hours: Monday – Thursday, 8:00am – 4:30pm Friday, 8:00 – 12:00

Appointments: Please arrive 15 minutes before your scheduled appointment time for your initial consultation appointment to allow for registration. Late arrivals or those needing additional time for registration may be rescheduled. Arriving on time allows her to stay on schedule so that all patients are treated in a timely manner. **If you need to cancel your appointment, please call 503-512-1218 at least 48 hours prior to your scheduled appointment time to avoid a $100 late cancellation fee.**

Telephone Calls: Dr. Gullo attempts to be thorough and complete during your visit. She will rarely be interrupted by phone calls or other matters during your visit. Patients are asked to respect one another's time by holding questions for scheduled office visits. You are encouraged to write your questions down so they can be addressed during your scheduled appointment. If your questions cannot wait, you may call (503) 512-1218 and leave a message. Non-urgent matters will be addressed no later than the end of the next business day. Please do not leave duplicate messages unless you have not heard back from us within 48 hours.

Emergencies: If you feel you are experiencing an emergent situation, please go directly to the nearest emergency room or urgent care facility. The provider at this facility will call and communicate with Dr. Gullo.

Forms: Most form completions require discussion between the provider and patient. Therefore, if you have a form related to your care with Dr. Gullo that needs to be completed, please call (503) 512-1218 so an appointment can be scheduled.

Prescriptions: The State of Oregon requires providers to inform patients of the material risks related to the use of narcotic medicines. This information is in the provider agreement you will receive and be asked to sign at your consultation appointment. Prescription refills will only be given at your scheduled appointments.

Test Results: All test results are reviewed by Dr. Gullo when received. Results will be discussed with you at your scheduled follow up visit. Urgent findings will be addressed sooner, as appropriate.

Code of Conduct: Every staff member at WPSC conducts themselves with respect toward patients, family members, referring physicians and staff. We expect behavior that respects the rights of other patients and our office staff. Unacceptable behavior includes the following and will not be tolerated:

- Excessive noise which is obtrusive to others
- Use of language, gestures or actions that are threatening, abusive, obscene or aggressive
- Offensive remarks of a racial, sexual or perverse nature
- Damage to property & theft
- Inappropriate behavior involving alcohol/substance misuse

YOUR APPOINTMENT IS SCHEDULED AT THIS LOCATION:

Monday

Sunnyside Plaza
10001 SE Sunnyside Rd. Suite 100
Clackamas, OR 97015

Directions:

From Interstate 205, take exit 14 Sunnybrook/Sunnyside Exit. Proceed to Sunnyside Rd. and turn east (the opposite direction of the Clackamas Town Center.) Drive 1 block to the light at Stevens Rd. and turn left. Take immediate right into the parking lot and proceed north to the back of the parking lot to our building.

Tuesday

Willamette Marketplace
2020 8th Ave Ste. 200
West Linn, OR 97068

Directions:

From Interstate 205, take exit 6 (10th Street Exit). Turn south toward Willamette Falls Drive. Turn right on 8th Ave. Turn Right at the 3rd drive way. We are located on the 2nd floor in the large medical building.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

Psychiatric Intake Form

(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. If assistance was required in filling this form out, please indicate on form with name and relationship.

Name: _____ Date: _____
Date of Birth: _____
Primary Care Physician: _____
Current Therapist/Counselor: _____
Therapist's Phone Number: _____

What are the problem(s) you are seeking help for?

1. _____
2. _____
3. _____

What are your treatment goals?

_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

____Depressed mood	____Racing thoughts	____Excessive worry	
____Unable to enjoy activities	____Impulsivity	____Anxiety attacks	
____Sleep pattern disturbance	____Increased risky behavior	____Avoidance	
____Loss of interest	____Increased libido	____Hallucinations	
____Concentration/forgetfulness	____Decreased need for sleep	____Suspiciousness	
____Change in appetite	____Excessive Energy	____Excessive Guilt	____Increased Irritability
____Fatique ____Crying spells	____Decreased libido	____Other_____	

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live?	___Yes	___No
Do you currently feel that you don't want to live?	___Yes	___No
Have you ever tried to kill or harm yourself before?	___Yes	___No

Memory Questions

Do you feel you have problems with memory?	___Yes	___No
If yes, please describe_____		
Does anyone in your family carry a diagnosis of dementia?	___Yes	___No

Your Medical History

Allergies_____
Current Weight _____ Height _____

List ALL current medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dose	Estimated Start Date

Current over-the-counter medications or supplements:

Current Medical Problems: _____

Past medical problems, nonpsychiatric hospitalization or surgeries: _____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when_____
Was the EKG ☐Normal ☐ Abnormal or ☐Unknown?

For women only: Date of last menstrual period _____ Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No. Are you planning to get pregnant in the near future? ☐ Yes ☐ No
Birth Control method _____
How many times have you been pregnant? _____How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with me? ☐ Yes ☐ No
Date and place of last physical Exam: _____

Personal and Family Medical History:

	You	Family	Which Family Member
Thyroid Disease	☐	☐	_____
Anemia	☐	☐	_____
Liver Disease	☐	☐	_____
Chronic Fatigue	☐	☐	_____
Kidney Disease	☐	☐	_____
Diabetes	☐	☐	_____
Asthma/respiratory problems	☐	☐	_____
Stomach or intestinal problems	☐	☐	_____
Cancer (type)	☐	☐	_____
Fibromyalgia	☐	☐	_____
Heart Disease	☐	☐	_____
Epilepsy or seizures	☐	☐	_____
Chronic Pain	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
Head Trauma	☐	☐	_____
Liver Problems	☐	☐	_____

Is there any additional personal or family medical history? ☐ Yes ☐ No If yes, please explain:

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Is there any history of brain injury, being knocked unconscious, or seizures? If yes, please explain:

Past Psychiatric History

Outpatient treatment ☐ Yes ☐ No. If yes, Please describe when, by whom, and nature of treatment.

Reason Dates treated by whom

Psychiatric Hospitalization ☐ Yes ☐ No. If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate by place a check mark next to medication.

Antidepressants

☐ Prozac (fluoxetine) ☐ Zoloft (sertraline) ☐ Luvox (fluvoxamine)
☐ Paxil (paraxetine) ☐ Celexa (citalopram) ☐ Lexapro (escitalopram)
☐ Effexor (venlafaxine) ☐ Cymbalta (duloxetine) ☐ Wellbutrin (bupropion)
☐ Remeron (mirtazapine) ☐ Serzone (nefazodone) ☐ Anafranil (clomipramine)
☐ Pamelor (nortrptyline) ☐ Tofranil (imipramine) ☐ Elavil (amitriptyline) ☐ Other

Mood Stabilizers

☐ Tegretol (carbamazepine) ☐ Lithium ☐ Depakote (valproate)
☐ Lamictal (lamotrigine) ☐ Topamax (topiramate)
☐ Other_____

Antipsychotics/Mood Stabilizers

☐ Seroquel (queiapine) ☐ Zyprexa (olanzepine) ☐ Geodon (ziprasidone)
☐ Abilify (aripiprozole) ☐ Clozaril (clozapine) ☐ Haldol (haloperidol)
☐ Prolixin (fluphenazine) ☐ Other: _____

Sedative/Hypnotics

☐ Ambien (zolpidem) ☐ Sonata (zaleplon) ☐ Rozerem (ramelteon)
☐ Restoril (temazepam) ☐ Desyrel (trazadone) ☐ Other:_____

ADHD medications

☐ Adderall (amphetamine) ☐ Concerta (methylphenidate) ☐ Ritalin (methylphenidate)
☐ Strattera (atomoxetine) ☐ Other:_____

Antianxiety medications

☐ Xanax (alprazolam) ☐ Ativan (lorazepam) ☐ Klonopin (clonazepam)
☐ Valium (diazepam) ☐ Tranxene (cloazepate) ☐ Buspar (buspirone)

Family Psychiatric History:

Has anyone in your family been diagnosed with or treat for:

Bipolar Disorder: ☐ Yes ☐ No Schizophrenia ☐ Yes ☐ No

Depression: ☐ Yes ☐ No
Anxiety ☐ Yes ☐ No
Anger ☐ Yes ☐ No
Suicide ☐ Yes ☐ No
Post-traumatic stress ☐ Yes ☐ No
Alcohol abuse ☐ Yes ☐ No
Other substance abuse ☐ Yes ☐ No
Violence ☐ Yes ☐ No
If yes, who had what problems?_____

Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No. If yes, who was treated and what medications and how effective was the treatment? _____

Substance Abuse:
Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No
If yes, for which substances?_____
If yes, where were you treated and when?

Any history of complicated withdrawal from substances including seizures or delirium tremens (DTs)? If yes, explain. _____

Are you currently using any alcohol, recreational drugs, or misusing prescription medications? ☐ Yes ☐ No
If yes, please describe._____

Tobacco History:
Do you currently use any tobacco products such as cigarettes, cigars, pipes, or chewing tobacco? If yes, how much and how often._____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically, or by neglect? ☐ Yes ☐ No

Educational History:
What is your highest educational level or degree attained?_____

Occupational History:
Are you currently: ☐ Working ☐ not working by choice Unemployed ☐ Disabled ☐ Retired
What is/was your occupation?_____
Where do you work?_____
Have you ever served in the military?_____
If so, what branch and when? _____
Honorable discharge ☐ Yes ☐ No Other type of discharge_____

Relationship History and Current Family:

Are you currently: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partnered

How long?_____

If not married, are you currently in a relationship? ☐ Yes ☐ No If yes, how long?_____

What is your spouse or significant other's occupation?_____

Describe your relationship with your spouse or significant other: _____

Have you had prior marriages? ☐ Yes ☐ No If so, how many?_____

How long?_____

Do you have children? ☐ Yes ☐ No If yes, list ages and gender

---

Describe your relationship with your children:_____

Legal:

Have you ever been arrested? ☐ Yes ☐ No

Do you have any pending legal problems? ☐ Yes ☐ No

Is there anything else that you would like the provider to know?

Emergency Contact: _____

Telephone #:_____

Please check any of the illnesses you have now or have had in the past and please indicate how much it interferes with your activities at present.

Illness	Have or have had	Does not interfere at all	Interferes a little	Interferes a great deal
Arthritis				
Glaucoma or Cataracts				
Breathing problems: (shortness of breath)				
Asthma				
Bronchitis				
Emphysema				
High Blood Pressure				
Tuberculosis				
Diabetes				
Circulation trouble in arms & legs				
Anemia				
Bleeding Problems				

Illness	Have or have had	Does not interfere at all	Interferes a little	Interferes a great deal
Thyroid Problems				
Cancer or Leukemia				
Digestive system Problems:				
Ulcers				
Heartburn				
Hiatal Hernia				
Colitis				
Diverticulitis				
Seizures				
Parkinson's Disease				
Constipation				
Urinary Problems:				
Wetness after coughing or sneezing				
Urgency				
Frequency				
Burning				
Prostate Problems				
Difficulty walking				
Dizziness				
Falling				
Broken bones				
Weight loss				
Unsteadiness				
List and other medical problems you have had which are not listed above:				

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
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 asleep, 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, feeling that you are a failure, or feeling that you 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 being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thinking that you would be better off dead or that you want to hurt yourself in some way	0	1	2	3
Totals				

10. If you checked off any problem on this questionnaire so far, 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
0	1	2	3

Beck Anxiety Inventory (BAI)

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

PATIENT REGISTRATION FORM

Primary Care Physician:	**Today's Date:**

PATIENT INFORMATION

Patient Name: Last First Middle	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? (Former Name): _____ _____	Age:	Date of Birth:	Gender: ❑ M ❑ F

Address:	Social Security #:	Home phone:

City:	State:	Zip:	Cell Phone:

Occupation:	Employer:	Work Phone:

RESPONSIBLE PARTY

Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:

Address:	Social Security #:	Home phone:

City:	State:	Zip:	Cell Phone:

Occupation:	Employer:	Work Phone:

INSURANCE INFORMATION
(Please give your card to the receptionist)

Primary Insurance:	Insurance Phone No.:	

Insurance Address, City, State, Zip:	ID #:	Group #:

Subscriber Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:

Employer:	Work Phone:

Secondary Insurance (if applicable):	Secondary Insurance Phone No.:	

Insurance Address, City, State, Zip:	ID #:	Group #:

Subscriber Name: Last First Middle	Gender: ❑ M ❑ F	Date of Birth:	Relationship to Patient:

Employer:	Work Phone:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/clinic. I understand that I am financially responsible for any balance. I also authorize Allison Gullo, MD/Willamette Pain and Spine Center or the insurance company to release any information required to process my claims.

Patient/Guardian signature: _____ Date: _____

Financial Policy

Thank you for choosing Allison Gullo, MD and Willamette Pain and Spine Center to assist you with your mental health care needs. We strive to provide you with the best care possible, and, in return, we ask that you assist us not only in monitoring your mental health care, but also by paying for our services in a responsible and timely manner.

The following is a statement of our financial policy. Our office requires that each patient read and sign a copy of this policy before we provide any treatment. Therefore, please read through this statement carefully and feel free to ask us any questions you may have relating to our policy before you sign:

- **Insurance cards must be presented at each and every visit.**
- **We do not accept personal checks. We do not accept personal checks or American Express, other payments accepted, Cash, Visa, Discover and MasterCard.**
- **It is your responsibility as the insurance holder to know your benefits. As a specialty office, not all services provided by our office are covered by every plan, therefore any service determined to not be covered will be patient responsibility.**
- **According to your insurance plan, you are responsible for any and all copayments, deductibles and coinsurances, are due at the time of service.**
- **If our providers do not participate in your insurance plan or you have no coverage, payment is due in full at time of service**.
- **All current and prior patient balances including coinsurance and deductibles are due at time of service; appointments will be rescheduled if payment is not collected. Please call your insurance company if you have any questions related to coinsurance and deductibles.**
- **An upfront service charge of $50 is required for filling out and processing any paperwork, if an appointment is not required by the provider, including, but not limited to:**
- **Disability**
- **FMLA**
- **Workers Compensation**
- **Forms will not be processed until payment is received in full**

Missed Appointments: You will be charged for missed appointments; follow-up appointments that are not cancelled at least 48-hours in advance, **is $50.00**. A New Patient Appointment that is not cancelled or missed with less than 48-hours advance notice will be **charged $100.00**. **If you are late 10 minutes or more for your appointment you will be rescheduled and charged a $50 missed appointment fee. Three or more missed appointments are grounds for termination of the patient/provider relationship.**

Patient Responsibility balances over 120 days will be discharged from care.

Print Name: _____ **Date:** _____

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of *Allison Gullo, MD and Willamette Pain and Spine Center's* Notice of Privacy Practices.

Name: _____ Date:_____

Signature: _____

I hereby acknowledge that I was offered and declined a copy of the Notice of Privacy Practice. I agree that Allison Gullo, MD and/or Willamette Pain & Spine Center made a good faith effort to provide me with this information. I understand I may request a copy of the Notice of Privacy Practices at any time and may also find it on the website at www.willamettepain.com; the medical office from which services are rendered.

Name: _____ Date: _____

Signature: _____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient
- ☐ Other:

INVITATION TO SELF-IDENTIFY

Federal guidelines require that we request the following information. Please mark ONE BOX that describes the race/ethnicity category with which you primarily identify.

❑	**Hispanic or Latino**: a person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture of origin, regardless of race.
❑	**White**: a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
❑	**Black or African American:** a person having origins in any of the black racial groups of Africa.
❑	**Native Hawaiian or other Pacific Islander**: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
❑	**Asian**: a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
❑	**American Indian or Alaska Native**: a person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment.
❑	**Two or More Races**: all persons who identify with more than one of the above five races.
❑	**Decline to Answer**

****For Patient Portal, please provide your email address to access your chart online****

Email:

Contact Telephone Numbers

Please complete relevant information and indicate the number at which you wish to be contacted first.

		Phone Messages OK?	Yes	No	Primary Contact Number
Home:	( )		❑	❑	❑
Cell:	( )		❑	❑	❑

Authorization to Release Information

❑ By checking this box, I have acknowledged that I wish to give consent to the individuals listed below to have access to my medical information (appointments, lab results, etc.) This includes mental health, drug and/or alcohol abuse and sexual content.

Name: Relation: Phone:

Name: Relation: Phone:

❑ By checking this box, I authorize Willamette Pain and Spine to release my medical records to my other health care providers and I authorize my other providers to release medical records to Willamette Pain and Spine, for the purposes of a managed treatment plan and/or continuity of care. The type of information to be disclosed may include: history and physical, medications, therapy, lab / pathology / imaging reports, clinician notes, problem list, and operative reports.

This authorization will remain in effect while I am under the care of Willamette Pain & Spine. I understand that I can change this authorization at any time. I understand that any changes must be in writing.

Print Patient Name: Date of Birth:

Signature: Date Signed:

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 decision about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can’t make decisions at all anymore.

14.

0 I don’t feel like I love 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 my physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot thinking 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 circles 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