Integrated Behavioral Services, INC
9403 Kenwood Rd, suite A120 Cincinnati, Ohio 45242

Patient Information

Today's Date _____/_____/_____
Name (Last, First, Middle)_____
Home Address _____
_____
Home PH# ( ) _____/_____ OK to call? Yes_____ No _____
Work/Cell PH# ( ) _____/_____ OK to call? Yes_____ No _____
Birthdate: _____/_____/_____ Age:_____ SSN#:_____/_____/_____
Email: _____

Marital Status:_____ How Long?:_____ Other Marriage(s): _____
(Dates)_____
Occupation: _____
Work Address: _____
Education: _____

Members of immediate Family	Relationship	Birth date	Age
1.			
2.			
3.			
4.			

Family history of Mental Illness? Yes ___ No___
Please describe _____
_____
Person responsible for the bill: _____
Primary Care Physician: _____
Primary Care Physician Address: _____
Primary Care Physician PH #: ( ) _____/_____
Previous psychiatrist: _____ Previous/Current Therapist:_____
Current Medications: _____
_____
Allergic to: _____
Current treated illness: _____
Have you ever had/ or been involved with any alternative medicine treatments or providers?
Yes____ No____ If yes what provider and what for? _____
Emergency Contact: _____ Relationship:_____
Emergency Contact PH#: ( ) _____/_____
Do you have a living will? Yes_____ No_____

ACKNOWLEDGEMENT: I UNDERSTAND AND AGREE TO PAY ANY CANCELLATION FEES WHICH WILL BE CHARGED FOR APPOINTMENTS THAT I MISS OR CANCEL WITH LESS THAN 24 HOUR NOTICE.

SIGNED:_____ DATE:_____/_____/_____
RESPONSIBLE PARTY

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I _____ _____, hereby request and authorize
(Print name) (D.O.B.)
Integrated Behavioral Services, Inc. to:

☐ **Disclose Information To** ☐ **Obtain Information From** ☐ **Verbally speak with**

_____ _____
PCP Referring Physician and/or Therapist Phone Number

_____ _____
Street / Mailing Address Suite

_____ _____
City State Zip Code

Please notate what you wish to have released from the following Information:

☐ Psychiatric Evaluation ☐ Psychological Testing ☐ Inpatient Hospitalization

☐ Medical History ☐Treatment Compliance ☐ Coordination of Care

Other _____

This consent to release the above information will expire one (1) year after the date following my signature below, or sooner by my choice, in which case this will expire on _____.
I understand that I may revoke, in writing, my consent at any time except to the extent that action has already been taken.

I also give my permission to release information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological. conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS - related complex (ARC) and/or testing for antibodies to the AIDS virus (HIV).

_____ _____
Patient/ and or Guardian Signature Date

IF YOU DO NOT WISH TO GIVE CONSENT FOR US TO CORRESPOND TO ANYONE PLEASE CHECK BELOW AND SIGN, UNDERSTANDING THAT IF YOU WISH TO REVOKE THIS AT ANY TIME WE NEED WRITTEN CONSENT TO DO SO.

☐ **I DO NOT GIVE MY CONSENT TO RELEASE ANY MEDICAL INFORMATION.**

_____ _____
Patient/ and or Guardian Signature Date

INTEGRATED BEHAVIORAL SERVICES POLICES

1. **Reminder calls are courtesy calls**. **You are responsible for knowing your appointment time**. We will not return calls to patients with Call Block.

2. If you have a life-threatening emergency after hours and need to contact your doctor immediately, call the answering service at **513-618-7401** to have your doctor paged.

3. There will be a charge for medical records, forms that need to be filled out, and any letters that need to written by the doctor or clinician. The turn around time for medical records, forms, and letters is one week to ten days.

4. If you are having side effects from medication prescribed, please call our office. There is no charge for this type of call. If, however, you want to change the dosage of your medication you will need to make an appointment.

5. Prescription refills will only be during limited hours. No refill requests will be done on Saturdays, or holidays. All mail orders will only be done by fax or during a scheduled appointment; we do not mail, or call in mail orders.

6. ***There will be a charge IN THE EQUAL AMOUNT OF YOUR VISIT, if you cancel your appointment less than 24 hours in advance or if you do not show for your scheduled appointment time. If you are 5 or more minutes late for your scheduled appointment time, the doctor will not see you and you will be charged THE EQUAL AMOUNT OF YOUR VISIT.***

7. ***All fees are your responsibility and must be paid before scheduling your next appointment. If you miss two appointments, OR if you miss an appointment and have entered into a medication contract with our practice your professional relationship with our office will be terminated.***

8. Payment is due at the time of service. If you cannot pay at the time of your visit, you will need to reschedule. There is a $25 returned check fee.

9. Any balance due prior to 11.1.12 must be paid prior to being seen or scheduled. Any questions about balances will be handled by the office staff.

10. It is your responsibility to notify I.B.S. immediately of any change in your address, telephone number, as well as any other important information. You must notify us if you have MEDICARE as Dr. Wu has opted out of Medicare as of 10.1.12 and no services will be covered, and you must sign the **Medicare OPT-OUT agreement.**

11. If you have not continued in therapy for a period of 12 months, unless specified, we will consider our relationship terminated.

I HAVE READ AND UNDERSTAND I.B.S. POLICIES

SIGNED: _____DATE:_____

INTEGRATED BEHAVIORAL SERVICES, INC.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices

_____

Signature

_____

Print Name

_____

Date

TREATMENT CONSENT

By signing below, I certify that I have read and understand the terms stated in the Treatment Consent Form. I agree and consent to participate in the mental health services offered and provided at/by _____, a mental health provider.

I understand that I am consenting and agreeing only to those services that the above named health provider is qualified to provide within: the scope of the provider's license, certification and training. I understand and agree to the fee structure, cancellation / late cancellation policy, no-show policy and payment policy. I agree to abide by the terms stated above.

X_____ _____/_____/_____

Patient Name: _____ DOB: _____

INFORMED CONSENT FOR MEDICATION

_____ M.D. has recommended that I take the medications listed below for the following condition(s) _____ _____.

The following have been explained to me or given to me in written form:

1. Benefits and risks of the medication(s).
2. Most common side effects of the medication(s).
3. Possible consequences if I do not take the medication(s) as prescribed.
4. Alternatives to this treatment and why the doctor is recommending treatment.

I understand that side effects may occur and that I should promptly notify the above named doctor of any expected changes in my clinical condition.
I also understand that I should notify the doctor of changes in my physical health, especially when pregnant or breast feeding. I understand that I need to notify the doctor if I am planning on becoming pregnant or if I become pregnant.

Medication(s) prescribed: _____
_____
_____

_____ _____
Patient/Parent/Legal Guardian Date

_____ _____
Witness Date

MEDICATION CONTRACT

I _____, have agreed to use the following medications as prescribed by the doctor. I understand that I must comply with the following guidelines. I understand that I WILL be terminated from the practice and only 30 days of medication will be given if I fail to follow these guidelines.

- I will follow with the treatment plan that Dr. Wu gives, which includes attending all appointments, adhering to the cancellation policy, and I will also take the medications at the dose and frequency prescribed.

- I will not increase or change how I take my medications without the approval of the doctor.

- I will arrange for refills at the prescribed interval ONLY during my appointment time OR at times given by office. I will not ask for early refills.

- I will obtain all refills for these medications only at
  - _____ (**pharmacy)**
  - _____ (**phone number)**

  with full consent for the doctor and pharmacy to exchange information in writing or verbally. I will also notify office of change of pharmacy.

- I will not request medications prescribed by Dr. Wu from other providers. I understand that if I do Dr. Wu has permission to contact the physicians involved.

- I will protect my prescriptions and medications; I understand that lost or stolen prescriptions will not be replaced with out proper documentation.

- I understand that early refills will not be authorized, and it is up to the discretion of the doctor.

_____ _____

Patient/Parent/Legal Guardian Date

_____ _____

Witness Date

Financial Policy

1. Patients are to pay for services received in full at the time of service.
2. All payments amounts are due at the time of service. We accept cash, check, Visa, MasterCard, and Discover.
3. There is a $25 service charge for any returned check. If a check has been returned, we will only accept cash, Visa, MasterCard, and Discover.
4. We understand you may need to cancel your appointment from time to time. Due to the nature of our specialized practice, we request one business day notice for cancellations. Failure to do so will result in a no show fee OF THE EQUAL AMOUNT OF YOUR VISIT for the doctor. (THIS FEE IS NOT CHARGED TO NEW PATIENTS, HOWEVER YOU WILL NOT BE RESCHEDULED) We have answering service and voicemail are available to you after hours. Further appointments can not be made until the no-show fee is paid.
5. Medication will be given at the time of your appointment. There will be a $10 fee for each prescription not received at your appointment time.
6. If you are more than 5 minutes late for your appointment you will need to reschedule your appointment and will be charged a late fee OF THE EQUAL AMOUNT OF YOUR VISIT for the doctor. (THIS FEE IS NOT CHARGED TO NEW PATIENTS, HOWEVER YOU WILL NOT BE RESCHEDULED)
7. Fee's for service:
    a. Initial diagnostic exam is $290
    b. Medication management appointments with the doctor are $100.
    c. Psychotherapy as followed:
        i. 30 minute- $170
        ii. 45-50 minute- $240
    d. Marriage counseling: $300
8. Fee's for service for Yoga:
    a. Yoga for the Real Beginner (6 week class):
        i. Yoga I- $175 (75 min per session)
        ii. Yoga II- $200 (90 min per session)
    b. Resilience Training: (8 week program, 2 hours per week)
        i. $500 per series
    c. Yoga Therapy: (75 min session, individual or group)
        i. $275 for current IBS patients
        ii. $350 for referrals or mind-body only clients
        iii. $250 for follow up sessions
9. There will be a fee attached for all non-clinical, ancillary services. (ex- court appearances, depositions, subpoenas, preparation of reports, consultation with other professional or agencies, telephones calls, etc.)
10. IBS follows the Ohio Dept. of Health guidelines for charging fees for the copying of medical records. This fee must be paid in advance. It will take 10 business days to complete a request for the copying of medical records but no more than 30days. There is a fee for all forms needed to be completed by the doctor. The fee will depend on the form.
11. All letters written by the doctor require a $200.00 prepaid deposit. The total charge for the letter maybe more or less than the deposit; depending on the time involved. The fee is $50.00 per 15 minutes. The balance must be paid before receiving the letter. If the fee is less than the deposit, you will be reimbursed the difference.

_____ _____

Patient Date

INTEGRATED BEHAVIORAL SERVICES, INC.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICATION INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Integrated Behavioral Services, Inc. is required by law to maintain the privacy and confidentially of your protected health information and to provide to our patients with notice of legal duties and privacy practices with respect to your protected health information.

Disclosure of your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We will use and disclose your protected health care information to provide, coordinate, or manage your health care and any related services. This includes that coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary to a home health agency that provides care for you. For example, your protected health information may be provided to another psychiatrist/therapist/physician to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Healthcare Operations
We may disclose, as needed, your protected health information in order to support the business activities of IBS. These activities include, but or not limited to: quality assessment activities, employee review activities, licensing and conducting or arranging for other business activities. In addition, we may confirm your upcoming appointments by telephone, unless otherwise instructed by you in writing. We may use disclose you protected health information, as necessary, to contact you to remind you of your appointment or to notify you of any changes in your appointment. We may also call you by your first name in the waiting room when your physician/therapist is ready to see you.

Emergencies
We may disclose your health care information to notify or assist notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing and controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease and infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding
.

Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership
In the event that Integrated Behavioral Services, Ins. is sold or merged with another organization, your health information will become property of the new owner.

Your Health Information Rights
You have the right to inspect and copy your protected health information:
Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in a civil criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request restrictions on certain uses and disclosures of you health information. Please be advised, however, that Integrated Behavioral Services, Inc. is not required to agree to the restrictions that you request.

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

You have the right to inspect and copy your health information.

You have the right to request that Integrated Behavioral Services, Inc. amend your protected information. Please be advised Integrated Behavioral Services, Inc. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be advised with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have the right to receive an accounting of disclosures of your protected health information made by Integrated Behavioral Services, Inc.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Integrated Behavioral Services, Inc. reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make new provisions effective for all information that it maintains. Until such amendment is made, Integrated Behavioral Services, Inc. is required by law to comply with this Notice.

Integrated Behavioral Services, Inc. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact the office manager at 513-272-0066. If she is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your privacy rights, or how Integrated Behavioral Services, Inc. has handled your health information should be directed to the office manager by calling this office at 513-272-0066. If the office manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of 07/01/2009.

I have read the Privacy Notice and understand my rights contained in this notice.

By way of my signature, I provide Integrated Behavioral Services, Inc. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operation as described in the Privacy notice.

You may print this privacy notice for your records.

Please print and sign the subsequent form, from registration forms, acknowledging you have received/read this and bring to your appointment.

MADRS

NAME:_____
DATE: _____

1. **Apparent Sadness** – representing despondency, gloom, despair (more than just ordinary transient low spirits), reflected in speech, facial expression and posture. Rated by depth and inability to brighten up.
   - 0 – no sadness
   - 1 –
   - 2 – apparent sadness
   - 3 –
   - 4 – looks dispirited but does brighten up without difficulties
   - 5 –
   - 6 – looks miserable all the time, extremely despondent

2. **Reported Sadness** – representing decreased mood, regardless of whether it is reflected in appearance or not, includes low spirits, despondency, or the feeling of bring beyond help and with out help. Rate according to intensity, duration and the extern to which the mood is reported to be influenced by events.
   - 0 – occasional sadness in keeping with circumstances
   - 1 –
   - 2 – sad or low but brightens up without difficulties
   - 3 –
   - 4 – pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances.
   - 5 –
   - 6 – continuous or unvarying sadness, misery, or despondency

3. **Inner Tension** – representing feelings of ill-defined discomfort, edginess, inner turmoil, mental tension mounting to either panic, dread, or anguish. Rate according to intensity, frequency, duration and the extent of reassurances called for
   - 0 – placid, only fleeting inner tension
   - 1 –
   - 2 – occasional feelings of edginess, and ill-defined discomfort
   - 3 –
   - 4 – continuous feeling of inner tension, or intermittent panic, which the patient can only master with some difficulty
   - 5 –
   - 6 – unrelenting dread or anguish: overwhelming panic

4. **Reduced Sleep** – representing the experience of reduced duration or depth of sleep compared to the subject's own normal sleep pattern when well.
   - 0 – sleeps as usual
   - 1 –
   - 2 – slight difficulty drooping off to sleep or slightly reduced, light, or fitful sleep
   - 3 –
   - 4 – sleep reduced or broken by at least 2 hours
   - 5 –
   - 6 – less than 2 or 3 hours sleep

5. **Reduced Appetite** – representing a feeling of a loss of appetite compared with when well. Rate by loss of desire for food or the need to force oneself to eat.
   - 0 – normal or increased appetite
   - 1 –
   - 2 – slightly reduces appetite
   - 3 –
   - 4 – no appetite, food is tasteless
   - 5 –
   - 6 – needs persuasion to eat at all

6. **Concentration Difficulties** – representing difficulties in collecting one's own thoughts mounting to incapacitating lack of concentration. Rate according to intensity, frequency, and degree of incapacity produced.
    - 0 – no difficulties in concentration
    - 1 –
    - 2 – occasional difficulties in collecting one's thoughts
    - 3 –
    - 4 – difficulties in concentrating and sustaining thoughts which reduces ability to read or hold a conversation
    - 5 –
    - 6 – unable to read or converse without difficulty

7. **Lassitude** – representing a difficulty in getting started or slowness initiating and performing everyday activities.
    - 0 – hardly any difficulty in getting started. no sluggishness
    - 1 –
    - 2 – difficulties in starting activities
    - 3 –
    - 4 – difficulties in starting simply routine activities, which are carried out with effort
    - 5 –
    - 6 – complete lassitude, unable to do anything without help

8. **Inability to Feel** – representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotions to circumstances or people is reduced.
    - 0 – normal interest in the surroundings and in other people.
    - 1 –
    - 2 – reduced ability to enjoy usual interest
    - 3 –
    - 4 – loss of interest in surroundings, loss of felling for friends and acquaintances
    - 5 –
    - 6 – the experienced of being emotionally paralyzed inability to feel anger, or pleasure and a complete or even painful failure to feel for close relatives and friends

9. **Pessimistic Thoughts** – representing thoughts of guilt, inferiority, self-reproach, sinfulness, remorse and ruin.
    - 0 – no pessimistic thoughts
    - 1 –
    - 2 – fluctuating ideas of failure, self-reproach, or self-depreciation
    - 3 –
    - 4 – persistent self-accusations, or definite but still rational ideas of guilt or sin, increasing pessimistic about the future.
    - 5 -
    - 6 – delusions or ruin, remorse, or unredeemable sin; self accusation which are absurd and unshakable

10. **Suicidal Thoughts** – representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts and preparation for suicide. Suicidal attempts should not, in themselves influence the rating.
    - 0 – enjoys life or takes it as it comes
    - 1 –
    - 2 – weary of life, only fleeting suicidal thought
    - 3 –
    - 4 – probably better off dead, suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intentions
    - 5 –
    - 6 –explicit plans for suicide when there is an opportunity, active preparation for suicide

THE MOOD QUESTIONNAIRE DATE:		
NAME: DATE OF BIRTH:		
INSTRUCTIONS: Please answer each question as best you can.	**YES**	**NO**
1. Has there ever been a period of time when you were not your usual self and …		
…you felt so good or so hyper that other people thought your were not your normal		
…self or you were so hyper that you got into trouble?		
…you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual and found you didn't really miss it?		
…you were more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had much more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephoned		
friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were usual for you or that other people might		
thought were excessive, foolish or risky?		
…spending money got you or your family into trouble?		
2. If you checked YES to more than one of the above, have several		
of these ever happened during the same period of time?		
3. How much of a problem did any of these cause you - like being able to work;		
having family, money, or legal troubles; getting into arguments or fights?		
Please circle one response only.		
No problem Minor problem Moderate problem Serious problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles)		
had manic-depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		
This instrument is designed for screening purposes and is not to be used as a diagnostic tool.		
See last pages of pad for scoring algorithm		

Epworth Sleepiness Scale

Name: _____

Date: _____

Your age: (Yr) _____ Your sex: Male Female

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation: -

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

Situation **Chance of dozing**

Sitting and reading.....

Watching TV……

Sitting inactive in a public place (e.g. a theater or a meeting)……..

As a passenger in a car for an hour without a break…….

Lying down to rest in the afternoon when circumstances permit……..

Sitting and talking to someone……..

Sitting quietly after a lunch with out alcohol

In a car, while stopped for a few minutes in the traffic……

Total …….

Score:	
0-10	Normal range
10-12	Borderline
12-24	Abnormal

Adult Self - Report Scale **Scale ASRS Symptom Checklist**

Patient Name : _____ Today's Date: _____

Please answer the questions below rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often	Score
1. How often do you make careless mistakes when you have to work on a boring or difficult project?						
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
3. How often do you have difficulty concentrating on what people say to you even when they are speaking to you directly?						
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?						
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
7. How often do you misplace or have difficulty finding things at home or at work?						
8. How often are you distracted by activity or noise around you?						
9. How often do you have problems remembering appointments or obligations?						
					Part A - Total	
0. How often do you fidget or squirm with your hands or feet when you have to to sit down for a long time?						
1. How often do you leave your seat in meetings or other situations in which you are expected to remain seated.						
2. How often do you feel restless or fidgety?						
3. How often do you have difficulty unwinding and relaxing when you have time to your self?						
4. How often do you feel overly active and compelled to do things, like you were driven by a motor?						
5. How often do you find yourself talking too much when you are in social situations?						
6. When you're in a conversation. How often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
7. How often do you have difficulty waiting your turn in situations when turn taken is required?						
8. How often do you interrupt others when they are busy?						
						Part B - Total

Hamilton Anxiety Rating Scale

Patient's Name | Date of First Report

Diagnosis | Date of This Report

Current Therapy

Instructions — *This checklist is to assist the physician in evaluating each patient with respect to degree of anxiety and pathological condition. Please fill in the appropriate rating.*

0 None
1 Mild
2 Moderate
3 Severe
4 Severe, grossly disabling

Item		Rating	Item		Rating
Anxious Mood	Worries, anticipation of the worst, fearful anticipation, irritability.		**Somatic (Sensory)**	Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, picking sensation.	
Tension	Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.		**Cardiovascular Symptoms**	Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.	
Fear	Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.		**Respiratory Symptoms**	Pressure or constriction in chest, choking feelings, sighing, dyspnea.	
Insomnia	Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.		**Gastrointestinal Symptoms**	Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, loosness of bowels, loss of weight, constipation.	
Intellectual (Cognitive)	Difficulty in concentration, poor memory.		**Genitourinary Symptoms**	Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.	
Depressed Mood	Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.		**Autonomic Symptoms**	Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.	
Behavior at Interview	Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos.		**Somatic (Muscular)**	Pains and aches, twitchings, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.	
				Total Score