Southern Colorado TMS Center, LLC
606 S Tejon St
Colorado Springs, CO 80903
(719) 359-8812

Patient History Form

TMS is a treatment that uses no medications and is well-tolerated with most side effects being quite mild. Since it is a medical procedure, we do need to know as much about you and your history as possible. This will help us provide you with a comfortable and pleasant experience. Please take a few minutes to fill out this form. If you need help, please involve a family member or friend or ask us for assistance. We will be glad to help and to answer any questions that you may have. We know that not all questions may apply to your situation but may only apply to other people. Thank you.

Name: _____Email: _____ Zip:____

Address: _____ City: _____ St:_____

Phone:_____Cell:_____ Other Phone:_____

Date of Birth : _____ Health Plan Name:_____

I am seeking TMS Treatment for the Problem of:

_____

The most important improvement I want from TMS is:

_____

My primary problem at this time is: (Check only one)

- ◉ Depression
- ○ Anxiety
- ○ Depression and Anxiety
- ○ Migraines
- ○ OCD
- ○ Bipolar Disorder
- ○ ADD/ ADHD
- ○ Tinnitus
- ○ Other

If your primary problem is other than those listed above, what is it?

_____

In addition to my primary problem, the next greatest problem is: (Check only one)

○ Depression	○ Anxiety	○ Depression and Anxiety
○ Migraines	○ OCD	○ Bipolar Disorder
◉ ADD/ ADHD	○ Tinnitus	○ Other

If your secondary problem is other than those listed above, what is it? Also, list any other problems from the list above which trouble you:

_____

Section 1:

On a Scale of 0-10, with 10 the worst, my (#1 problem you listed above)

on most days averages: _____

My current episode of (the #1 problem you listed above) began _____ years ago.

My first episode of (the #1 problem you listed above) began _____

years ago.

My first episode of (#1 problem listed above) (even if not diagnosed

by a doctor) began at age_____.

The triggering event for (the #1 problem you listed above) was:

_____

Age I was first diagnosed with (the #1 problem listed above)_____.

The number of separate episodes I have had of (the #1 problem listed

above):

- ◉ 1
- ○ 2-5
- ○ 6-10
- ○ greater than 10

I have tried to kill myself:

- ◉ Never
- ○ 1-2 times
- ○ More than 2 times

Date I last tried to kill myself (if never, leave blank): _____

The last time I felt good was ____ years ago.

Section 2: I currently have or have been told that I have had:

☐ Depression	☐ Eating Disorder	☐ Mania/hypomania
☐ Migraines	☐ OCD	☐ Bipolar Disorder
☐ ADD/ ADHD	☐ Memory Problems	☐ Panic Attacks
☐ OCD	☐ Hx of Abuse -Sex.	☐ Hx of Abuse -Phys/Emo
☐ Bulimia	☐ Anorexia Nervosa	☐ Other Eating Disorder
☐ Sleep Disorder	☐ Prob.falling asleep	☐ Prob. staying asleep
☐ General Anxiety	☐ Post-partum depression	

Section 3: My General Physical Health includes the following problems or illnesses:

_____

_____

Section 4: I have, am or have been told that I have:

☐ Pregnant currently	☐ Amblyopia (Lazy Eye)
☐ Restless Legs Syndrome	☐ Head Injury
☐ Problems with smell	☐ Problems with taste
☐ Loss of Consciousness	☐ Thyroid Hormone Problems
☐ Other Hormone Problems	☐ Coma
☐ Hearing Problems	☐ Heart Disease
☐ Migraine Headache	☐ Cochlear(Ear)Implant
☐ Infectious Disease	☐ Tension Headache
☐ Tinnitus(ear ringing)	☐ Cancer
☐ Cluster Headache	☐ Diabetes
☐ Sleep Apnea	☐ Brain Cyst
☐ Multiple Sclerosis	☐ Epilepsy
☐ Seizures	☐ Stroke w/ problems speaking
☐ Stroke with weakness	☐ Other stroke or TIA
☐ Pituitary Adenoma	☐ Parkinson's Disease
☐ Brain Surgery	☐ ALS (Lou Gehrig Disease)

- [ ] Cerebral Aneurysm
- [ ] Pacemaker/Defibrillator
- [ ] Chronic Pain
- [ ] Installed paincontrol stimulator
- [ ] Metal object in eye
- [ ] Posts in head/neck/mouth
- [ ] Installed pumps (eg,insulin)
- [ ] Tattoos of head/neck/face
- [ ] Other Neurologic Disease
- [ ] Aneurysm Clips
- [ ] Neuropathic Pain
- [ ] Vagus Nerve Stimulator
- [ ] Metal in my brain (eg,shrapnel)
- [ ] Installed metal dental work
- [ ] Permanent eye or lip liner
- [ ] Other

Section 5: I have had the following tests:

- [ ] EKG (heart)
- [ ] CT Scan of Head
- [ ] PET /SPECT of brain
- [ ] Psychological Tests
- [ ] EEG
- [ ] Head MRI
- [ ] Genetic testing

What was the date, purpose and results of each test you've taken?

_____

_____

_____

_____

Section 6: Concerning my use of alcohol or recreational drugs:
Please let us know if you are currently using or have used within the past five years

- [ ] Cigarettes
- [ ] Chew
- [ ] Alcohol
- [ ] Other
- [ ] Marijuana
- [ ] Speed
- [ ] Pain Killers
- [ ] Heroin
- [ ] Huff Gases
- [ ] Cocaine

Please answer the following:

- [ ] I believe I have a problem with alcohol or drugs
- [ ] Other people have annoyed me by criticizing my drinking/drug use

☐ At times, I've thought I should cut down on my drinking/drug use

☐ I have sometimes felt bad or guilty about my drinking/ drug use

☐ Sometimes I have to take a drink first thing in the morning to steady my nerves or to get rid of a hangover.

☐ It is hard for me to get through some days without using recreational drugs

☐ Other people think I have a problem with alcohol or drugs.

Section 7: <u>Current</u> Medications, etc.: Please list all medications, herbs vitamins and supplements that you currently take

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Name_____ Daily Dose_____ #Years _____ or #Months _____

Others: _____

_____

Section 8: History of Treatments. Please record what you have taken **<u>in the past</u>**. Contact your pharmacist or physician for a list if needed.

	<u>Daily Dose (mg.s)</u>	<u>Total Period You Took This Med</u>
☐ Celexa (citalopram)	Daily Dose_____	#Years _____ or #Months _____
☐ Lyrica (pregabalin)	Daily Dose_____	#Years _____ or #Months _____
☐ Lexapro (escitalopram)	Daily Dose_____	#Years _____ or #Months _____
☐ Neurontin (gabapentin)	Daily Dose_____	#Years _____ or #Months _____
☐ Luvox (fluvoxamine)	Daily Dose_____	#Years _____ or #Months _____

☐ Abilify (aripiprazole) Daily Dose_____ #Years _____ or #Months _____

☐ Paxil (paroxetine) Daily Dose_____ #Years _____ or #Months _____

☐ Clozaril (clozapine) Daily Dose_____ #Years _____ or #Months _____

☐ Prozac (fluoxetine) Daily Dose_____ #Years _____ or #Months _____

☐ Fanapt (iloperidone) Daily Dose_____ #Years _____ or #Months _____

☐ Viibryd (vilazodone) Daily Dose_____ #Years _____ or #Months _____

☐ Geodon (ziprasidone) Daily Dose_____ #Years _____ or #Months _____

☐ Welbutrin (buproprion) Daily Dose_____ #Years _____ or #Months _____

☐ Invega (paliperidone) Daily Dose_____ #Years _____ or #Months _____

☐ Zoloft (sertraline) Daily Dose_____ #Years _____ or #Months _____

☐ Latuda (lurisadone) Daily Dose_____ #Years _____ or #Months _____

☐ Effexor (venlafaxine) Daily Dose_____ #Years _____ or #Months _____

☐ Risperdal (risperidone) Daily Dose_____ #Years _____ or #Months _____

☐ Cymbalta (duloxetine) Daily Dose_____ #Years _____ or #Months _____

☐ Saphris (asenapine) Daily Dose_____ #Years _____ or #Months _____

☐ Pristiq (desvenlafaxine) Daily Dose_____ #Years _____ or #Months _____

☐ Seroquel (quetapine) Daily Dose_____ #Years _____ or #Months _____

☐ Remeron (mirtazapine) Daily Dose_____ #Years _____ or #Months _____

☐ Zyprexa (olanzapine) Daily Dose_____ #Years _____ or #Months _____

☐ Serzone (nefazadone) Daily Dose_____ #Years _____ or #Months _____

☐ Haldol (haloperidol) Daily Dose_____ #Years _____ or #Months _____

☐ Desyrel (trazadone) Daily Dose_____ #Years _____ or #Months _____

☐ Mellaril (thioridazine) Daily Dose_____ #Years _____ or #Months _____

☐ Elavil (amitriptyline) Daily Dose_____ #Years _____ or #Months _____

☐ Thorazine(chlorpromazine Daily Dose_____ #Years _____ or #Months _____

☐ Pamelor (nortriptyline) Daily Dose_____ #Years _____ or #Months _____

☐ Trilafon (perphenazine) Daily Dose_____ #Years _____ or #Months _____

☐ Norpramin(desipramine) Daily Dose_____ #Years _____ or #Months _____

☐ Adderall (amphetamine) Daily Dose_____ #Years _____ or #Months _____

☐ Tofranil (imipramine) Daily Dose_____ #Years _____ or #Months _____

☐ Dexadrine(d-amphetamine) Daily Dose_____ #Years _____ or #Months _____

☐ EMSAM (selegiline) Daily Dose_____ #Years _____ or #Months _____

☐ Intunivffenex (guanfacine) Daily Dose_____ #Years _____ or #Months _____

☐ Marplan (isocarboxazid) Daily Dose_____ #Years _____ or #Months _____

☐ Ritalin (methylphenidate) Daily Dose_____ #Years _____ or #Months _____

☐ Nardil (phenelzine) Daily Dose_____ #Years _____ or #Months _____

☐ Strattera (atomoxapine) Daily Dose_____ #Years _____ or #Months _____

☐ Parnate(tranylcypromine) Daily Dose_____ #Years _____ or #Months _____

☐ Catapres (clonidine) Daily Dose_____ #Years _____ or #Months _____

☐ Ativan (lorazepam) Daily Dose_____ #Years _____ or #Months _____

☐ Buspar (buspirone) Daily Dose_____ #Years _____ or #Months _____

☐ Valium (diazepam) Daily Dose_____ #Years _____ or #Months _____

☐ Klonopin (clonazepam) Daily Dose_____ #Years _____ or #Months _____

☐ Lithium Daily Dose_____ #Years _____ or #Months _____

☐ Estrogen Hormone Daily Dose_____ #Years _____ or #Months _____

☐ Depakote (valproate) Daily Dose_____ #Years _____ or #Months _____

☐ Progesterone Hormone Daily Dose_____ #Years _____ or #Months _____

☐ Keppra (levetiracetam) Daily Dose_____ #Years _____ or #Months _____

☐ Testosterone Hormone Daily Dose_____ #Years _____ or #Months _____

☐ Lamictal (lamotrigine) Daily Dose_____ #Years _____ or #Months _____

☐ Thyroid Hormone Daily Dose_____ #Years _____ or #Months _____

☐ Tegretol (carbamazepine) Daily Dose_____ #Years _____ or #Months _____

☐ Minipress (prazocin) Daily Dose_____ #Years _____ or #Months _____

☐ Trileptal (oxcarbazepine) Daily Dose_____ #Years _____ or #Months _____

☐ Zonegran (zonisamide Daily Dose_____ #Years _____ or #Months _____

☐ Light Box Daily Dose_____ #Years _____ or #Months _____

☐ ECT Daily Dose_____ #Years _____ or #Months _____

☐ rTMS Daily Dose_____ #Years _____ or #Months _____

☐ VNS Daily Dose_____ #Years _____ or #Months _____

☐ Other: Daily Dose_____ #Years _____ or #Months _____

Family Medical History- Including only relatives by blood, not marriage

☐ Depression	☐ Eating Disorder	☐ Mania/hypomania
☐ Migraines	☐ OCD	☐ Bipolar Disorder
☐ ADD/ ADHD	☐ Memory Problems	☐ Anxiety/Panic Attacks
☐ Sleep Disorder	☐ Sex Abuse Victim	☐ Phys/Emo Abuse Victim
☐ Bulimia	☐ Anorexia Nervosa	☐ Other Eating Disorder
☐ OCD	☐ Problem falling asleep	☐ Problem staying asleep
☐ Schizophrenia	☐ Diabetes	☐ ECT treatments
☐ TMS treatment		

Section 10: Please rate how true the statement is for you during the last week:

All the Time

There is no one I can depend on

It seems as if I can do nothing right

Everything I do turns out wrong

The people I care the most for are gone

I have been having thoughts of killing myself

I have thoughts about how I might kill myself

I have a plan to kill myself

Assessing The Impact of Depression in Your Life

What has your depression cost you over the course of your life?
What is depression costing you now?
What is it likely to cost you in the future if it remains as it is now?

Answering these kinds of questions provides an opportunity to take a careful inventory. Please do take the time to answer thoughtfully. Your answers will be of great assistance to us in assessing the appropriateness of TMS for your unique life and in answering your questions. Without accurate assessment we will not be able to provide accurate answers to your questions or make accurate recommendations.

We'll ask you to assess the impact of depression in your life in at least the four following areas:

-----Social-----
Relationships
Roles in Life (spouse, parent, coworker, student, friend, etc.)
Having Fun Together

-----Physical-----
Hobbies,
Recreation
Physical Health
Side effects of past and current treatments for depression

-----Profession / Career-----
Dreams and Goals
Employment

-----Financial-----
Lost Earnings
Lost Benefits
The Dollar Costs of Treatments for Depression Over The Years

Here are some questions to help you think this through. Some of these questions may be painful to think about and we realize that we are asking a lot of you. However, the answers we can provide for your questions and the recommendations we can make as to whether or not TMS could be a good fit for you depend on the accuracy and completeness of the answers which you give us to the following questions. So... we know it is hard but we ask you to try your best. By all means, ask a friend or family member to help think these through to the answers.

SOCIAL:

Have you missed out on family activities or social functions because you were too depressed to plan them or to attend?

What are a few examples?

☐ graduations	☐ family dinners	☐ holidays	☐ church/ temple mtgs
☐ celebrations	☐ birthdays	☐ anniversaries	☐ club gatherings
☐ parties	☐ other		

SOCIAL:

Have some relationships in your life been less than optimal because of depression?

Which?

☐ my parents ☐ my child(ren) ☐ my spouse ☐ siblings

☐ coworkers ☐ neighbors ☐ friends ☐ dating friends

☐ others ☐ extended family

SOCIAL: In which relationships did you once have much more fun together?

☐ my parents ☐ my child(ren) ☐ my spouse ☐ siblings

☐ coworkers ☐ neighbors ☐ friends ☐ dating friends

☐ others ☐ extended family

SOCIAL:

Have you missed a sense of closeness with some of the important people in your life?

With whom?

☐ my parents ☐ my child(ren) ☐ my spouse ☐ siblings

☐ coworkers ☐ neighbors ☐ friends ☐ dating friends

☐ others ☐ extended family

ROLES:

Has depression affected your ability to fulfill your roles as well as you wanted to? (spouse, parent, adult child of older parents, coworker, friend, romantic partner, etc).

How?

☐ as a parent ☐ with my parents ☐ as spouse ☐ as sibling

☐ as a coworker ☐ as a neighbor ☐ as a friend ☐ as aunt or uncle

ROLES:

Have those who love you spent time, energy or other resources worrying for you?

ROLES:

Does your family, extended family or significant others understand what this illness has been like for you?

Who seems to really understand?

☐ my parents ☐ my child(ren) ☐ my spouse ☐ siblings

☐ coworkers ☐ neighbors ☐ friends ☐ dating friends

☐ others ☐ extended family

How has this affected you? _____

_____

PHYSICAL:

Have you stopped hobbies or other activities at one time or another due to your depression?

Which Hobbies or Activities?

_____

PHYSICAL: How has this affected you? _____

_____

PHYSICAL: Which would you most look forward to starting again?

_____

PHYSICAL:

Have you been diagnosed with any other diseases like diabetes and/or heart disease?

How have these conditions further affected your life?

_____

PHYSICAL:

Have anti-depression treatments side effects affected your life for the worse?

What side effects, if any, are you currently experiencing from anti-depressant medications or other treatments?

☐ nausea ☐ weight gain ☐ decreased libido

☐ fatigue ☐ skin rash ☐ sexual dysfunction

☐ insomnia	☐ dry mouth	☐ blurred vision
☐ constipation	☐ dizziness	☐ anxiety
☐ restlessness	☐ diarrhea	☐ urinary retention
☐ agitation	☐ headaches	☐ confusion
☐ other	☐ rapid heart beats	

What side effects, if any, have you experienced in the past from anti-depressant medication or other treatments?

☐ nausea	☐ weight gain	☐ decreased libido
☐ fatigue	☐ skin rash	☐ sexual dysfunction
☐ insomnia	☐ dry mouth	☐ blurred vision
☐ constipation	☐ dizziness	☐ anxiety
☐ restlessness	☐ diarrhea	☐ urinary retention
☐ agitation	☐ headaches	☐ confusion
☐ other	☐ rapid heart beats	

DREAMS, GOALS:

Has your motivation and desire to accomplish more changed?

How? _____

EMPLOYMENT:

Has depression caused you to miss work or to be entirely unable to work?

How? When? Which Job or Career?

_____

EMPLOYMENT:

Has depression caused you to perform at less than your best?

How? When?

_____

EMPLOYMENT:

Is it jeopardizing your employment now?

Has your career suffered?

Have you been passed up for promotions or raises?

Have you missed out on other opportunities?

FINANCIAL:

Have you suffered lost income from not working?

How much loss of income have you suffered from not working or working less effectively, including all the years you have been unable to work? Write a dollar amount below. Even if it is ZERO, write something down.

_____

FINANCIAL:

Has your spouse's or family's earning power been affected by your depression (e.g., family members taking time from work or relocating to be available for you)?

How much? (a rough estimate will do). Even if it is ZERO ("0"), write something down:

_____

FINANCIAL: What have you spent on depression treatment in this and in previous episodes? (monthly copays, medication copays, home care assistance, etc.) Write a dollar amount below. Even if it is ZERO ("0"), write something down.

_____

----- Do try and make an accurate estimate of these amounts. -----

Providing serious answers to these questions will increase your determination to do whatever is necessary to overcome and break the grip of depression in your life. Serious answers will also assist us in determining your suitability for TMS treatment.

If you have actually been writing ZERO's ("0") to the last three questions, then I, Dr. Joe Hammock, who put this part of the website together, am totally not believing you.

:-)

So, make a serious attempt at an estimated answer to the last question in this section:
Overall, how much in dollars alone is it fair to estimate that unsuccessfully-treated depression has cost you and /or your family over the years?

_____

Do you remember the ancient proverb: "No king goes to war or builds a palace without first counting the cost"? Well, same idea, as we wrap up this health questionnaire:

Count up what it has cost....
Count up what a solution will cost and decide on a course of action...
Then... ACT!

Looking over the preceding 15 or so questions- Sum it up: What has untreated or unsuccessfully treated depression cost you and those you love thus far in your life, in dollars, time, friendship, closeness with loved ones, health...? A lot.

We,
John Fleming, MD,
Melissa Hammock, MA, MEd,
Joe Hammock, MA, PhD,
and our technical staff

want to help you change the rest of the story...

of your story...

of your family's story.

We want to help you write the next chapter...
this time with a happy ending!
:-)

So, one last, quick task before hitting the "Submit" button and then contacting me, Dr. Hammock, to set up a phone conference or join me in my comfortable SCTMSC interview office for coffee or tea and answered questions:

Two brief sets of questions which will give us an accurate estimate of how hard you are having to fight right now against depression and anxiety. Then, I promise, that's it.

Beck Depression Inventory:

Choose the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. If several statements in the group seem to apply equally well, choose the highest number for that group.

1. Sadness

- [x] 0. I do not feel sad.
- [ ] 1. I feel sad much of the time.
- [ ] 2. I am sad all the time.
- [ ] 3. I am so sad or unhappy that I can't stand it

2. Pessimism

- ☐ 0. I am not discouraged about my future.
- ☐ 1. I feel more discouraged about my future than I used to be
- ☐ 2. I do not expect things to work out for me
- ☐ 3. I feel my future is hopeless and will only get worse.

3. Past Failure

- ☐ 0. I do not feel like a failure.
- ☐ 1. I have failed more than I should have.
- ☐ 2. As I look back, I see a lot of failures.
- ☐ 3. I feel I am a total failure as a person.

4. Loss of Pleasure

- ☐ 0. I get as much pleasure as I ever did from the things I enjoy.
- ☐ 1. I don't enjoy things as much as I used to.
- ☐ 2. I get very little pleasure from the things I used to enjoy.
- ☐ 3. I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

- ☐ 0. I don't feel particularly guilty.
- ☐ 1. I feel guilty over many things I have done or should have done.
- ☐ 2. I feel guilty most of the time.
- ☐ 3. I feel guilty all the time.

6. Punishment Feelings

- ☐ 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. Self-Dislike

- ☐ 0. I feel the same about myself as ever.
- ☐ 1. I have lost confidence in myself.
- ☐ 2. I am disappointed in myself.
- ☐ 3. I dislike myself.

8. Self-Criticalness

- ☐ 0. I don't criticize or blame myself more than usual.
- ☐ 1. I am more critical of myself than I used to be.
- ☐ 2. I criticize myself for all my faults.
- ☐ 3. I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

- ☐ 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. Crying

- ☐ 0. I don't cry anymore than I used to.
- ☐ 1. I cry more than I used to.
- ☐ 2. I cry over every little thing.
- ☐ 3. I feel like crying, but I can't.

11. Agitation

- ☐ 0. I am no more restless or wound up than usual.
- ☐ 1. I feel more restless or wound up than usual.
- ☐ 2. I'm so restless or agitated that it's hard to stay still.
- ☐ 3. I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

- ☐ 0. I have not lost interest in other people or activities.
- ☐ 1. I am less interested in other people or things than before.
- ☐ 2. I have lost most of my interest in other people or things.
- ☐ 3. It's hard to get interested in anything.

13. Indecisiveness

- ☐ 0. I make decisions about as well as ever.
- ☐ 1. I find it more difficult to make decisions than usual.
- ☐ 2. I have much greater difficulty in making decisions that I used to.
- ☐ 3. I have trouble making any decisions.

14. Worthlessness

- ☐ 0. I do not feel I am worthless.
- ☐ 1. I don't consider myself as worthwhile or useful as I used to.
- ☐ 2. I feel more worthless as compared to other people.
- ☐ 3. I feel utterly worthless.

15. Loss of Energy

- ☐ 0. I have as much energy as ever.
- ☐ 1. I have less energy than I used to have.
- ☐ 2. I don't have enough energy to do very much.
- ☐ 3. I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

- ☐ 0. I have not experienced any change in my sleeping pattern
- ☐ 1.a. I sleep somewhat more than usual.
- 1.b. I sleep somewhat less than usual.
- ☐ 2.a. I sleep a lot more than usual
- 2.b. I sleep a lot less than usual.
- ☐ 3.a. I sleep most of the day.
- 3.b. I wake up one-two hours early and can't get back to sleep.

17. Irritability

- ☐ 0. I am no more irritable than usual.
- ☐ 1. I am more irritable than usual.
- ☐ 2. I am much more irritable than usual.
- ☐ 3. I am irritable all the time.

18. Changes in Appetite

- ☐ 0. I have not experienced any change in my appetite
- ☐ 1.a. My appetite is somewhat less than usual.
- 1.b. My appetite is somewhat greater than usual.
- ☐ 2.a. My appetite is much less than before.
- 2.b. My appetite is much greater than usual.
- ☐ 3.a. I have no appetite at all.
- 3.b. I crave food all the time.

19. Concentration Difficulties

- ☐ 0. I can concentrate as well as ever.
- ☐ 1. I can't concentrate as well as usual.
- ☐ 2. It's hard to keep my mind on anything for very long.
- ☐ 3. I find I can't concentrate on anything.

20. Tiredness or Fatigue

- ☐ 0. I am no more tired or fatigued than usual.
- ☐ 1. I get more tired or fatigue more easily than usual.
- ☐ 2. I am too tired or fatigued to do a lot of the things I used to do.
- ☐ 3. I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- ☐ 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 am much less interested in sex now.
- ☐ 3. I have lost interest in sex completely.

Zung Self-Rating Anxiety Scale (SAS)

For each item above, please choose the item which best describes how often you felt or behaved this way during the past several days. *(Please note the last 5 items are worded differently.)*

W.K. Zung. A rating instrument for anxiety disorders. Psychosomatics. 1971

1. I feel more nervous and anxious than usual.
- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

2. I feel afraid for no reason at all
- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

3. I get upset easily or feel panicky.
- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

4. I feel like I'm falling apart and going to pieces.
- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

5. My arms and legs shake and tremble
- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

6. I am bothered by headaches, neck and back pain.
- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

7. I feel weak and get tired easily.
- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

8. I can feel my heart beating fast.

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

9. I am bothered by dizzy spells

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

10. I have fainting spells or feel like it.

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

11. I get feelings of numbness and tingling in fingers and toes

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

12. I am bothered by stomach aches or indigestion

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

13. I have to empty my bladder often.

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

14. My face gets hot and blushes.

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

15. I have nightmares.

- ☐ 0. A little of the time
- ☐ 1. Some of the time
- ☐ 2. Good part of the time
- ☐ 3. Most of the time.

16. *I feel that everything is alright and nothing bad will happen*.

- ☐ *0. Most of the time*
- ☐ *1. Good part of the time*
- ☐ *2. Some of the time*
- ☐ *3.. A little of the time*

17. *I feel calm and can sit still easily.*

- ☐ *0. Most of the time*
- ☐ *1. Good part of the time*
- ☐ *2. Some of the time*
- ☐ *3. A little of the time*

18. *I can breathe in and out easily.*

- ☐ *0. Most of the time*
- ☐ *1. Good part of the time*
- ☐ *2. Some of the time*
- ☐ *3. A little of the time*

19. *My hands are usually dry and warm.*

- ☐ *0. Most of the time*
- ☐ *1. Good part of the time*
- ☐ *2. Some of the time*
- ☐ *3. A little of the time*

20. *I fall asleep easily and get a good night's rest.*

- ☐ *0. Most of the time*
- ☐ *1. Good part of the time*
- ☐ *2. Some of the time*
- ☐ *3. A little of the time*

W.K. Zung. A rating instrument for anxiety disorders. Psychosomatics. 1971