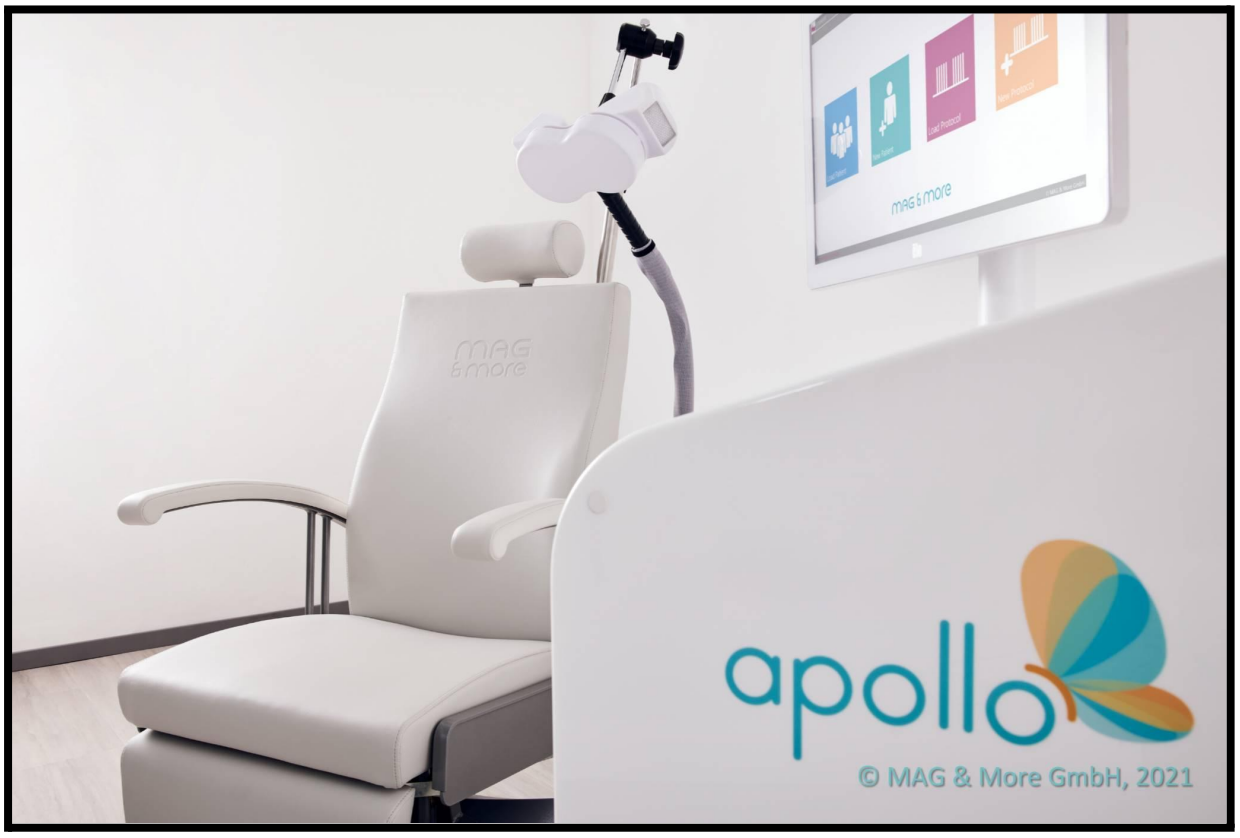
Sweetgrass PSYCHIATRY

# Transcranial Magnetic Stimulation Prospective Patient Packet

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*Updated March 2023*

# TMS Prospective Patient Questionnaire

Thank you for your interest in our program and for taking the time to fill out this form. This information is necessary to determine if you are an appropriate candidate for this treatment and if so, to obtain insurance authorization. Please bring this form to your appointment or submit it over the Onpatient portal.

**Patient's Name:** **Date of Birth:**

Insurance Carrier:

Current Family Physician and Phone Number:

Current Psychiatrist and Phone Number:

Current Therapist and Phone Number:

May we send your TMS intake note and periodic updates to your psychiatrist _____

May we send your TMS intake note and periodic updates to your primary care physician _____

Allergies (Food and Medicine):

**Current Clinical Symptom History:** *Please check/circle all the symptoms you have experienced over the past 2 weeks:*

**Depression**- sleep disturbance, loss of interest, excessive guilt, low energy, loss of concentration, appetite changes, thoughts of wishing you were not alive, lasting greater than 2 weeks.

**Mania**- highly distractibility, decreased need for sleep, high energy, grandiosity, rapid thinking that is out of control, excessive talkativeness, hypersexuality, excessive increased activity that lasts 4 or more days.

**Psychosis**- seeing or hearing things that other people can't see or hear, disorganized thinking that makes it difficult to attend to basic tasks that have occurred for 1 month or longer

**Substance use**- How frequent? For how long? Current use?

Tobacco-_____

Alcohol-_____

Cocaine/amphetamines/stimulants-_____

Marijuana-_____

Opioids (not prescribed)-_____

Synthetic substances-_____

**<u>Medications you are taking now</u>: or you may attach an updated list**

1. _____
2. _____
3. _____
4. _____
5. _____

**<u>Medications you've taken before,</u>** maximum dosage, and length of taking, year, and any side effects.

Prozac (fluoxetine)
_____

Zoloft (sertraline)
_____

Paxil (paroxetine)
_____

Celexa (citalopram)
_____

Lexapro (escitalopram)
_____

Wellbutrin, Aplenzin (bupropion)
_____

Remeron (mirtazapine)
_____

Effexor (venlafaxine)
_____

Cymbalta (duloxetine)
_____

Pristiq (desvenlafaxine)
_____

Trazodone
_____

Pamelor (Nortriptyline)
_____

Elavil (Amitriptyline)
_____

Brintellix/Trintellix (vortioxetine)
_____

Viibryd (vilazodone)
_____

Fetzima (levomilnacipran)
_____

Parnate or Nardil
_____

Emsam (selegiline)
_____

Lithium
_____

Abilify (aripiprazole)
_____

Seroquel (quetiapine)

_____

Zyprexa (olanzapine)

_____

Buspar (buspirone)

_____

Vraylar (cariprazine)

_____

Lamictal (lamotrigine)

_____

Rexulti (brexpiprazole)

_____

Auvelity (dextromethorphan-buproprion)

_____

Have you ever tried ECT, Spravato/esketamine, ketamine or TMS?

_____

Past Medical and Surgical History (Prior Diagnoses made by a Physician):

_____

_____

_____

_____

Have you ever had a seizure?_____

Do you have any metal in your body? _____

Examples include:

- Aneurysm clips or coils, Stents
- Implanted Stimulators, Electrodes to monitor your brain activity
- Ferromagnetic implants in your ears or eyes
- Bullet fragments, Other metal devices or objects implanted in the head
- Facial Tattoos with metal ink or Permanent makeup

Have you ever had a head injury (including neurosurgery)?_____

Do you have any implanted devices such as a cardiac pacemaker, medical pumps, cochlear implants, or a cardiac defibrillator?

_____

Is it possible that you are pregnant or may become pregnant during treatment?

_____

Have you ever had a stroke or any other brain-related condition?

_____

Hospitalizations (when/where/psychiatric or not)

_____

History of Illnesses your Family has and who (mother, father, sibling, child):

_____

# Authorization to Release Clinical Information

As part of our TMS treatment care plan and for optimal treatment outcomes, we value coordination of care and ensuring that your psychiatrist, therapist, and/or primary care provider are aware of your treatment progress.

**PATIENT:**_____**DOB:**_____

**I hereby authorize Sweetgrass Psychiatry to:**

_____ obtain information from the following listed below

_____ release information to the following listed below

_____ all of my health information

_____ only specific health information:_____

**Psychiatry Practice / Clinician's name:** _____

**Phone:**_____**Fax:** _____

**Therapy Practice / Therapist's name:** _____

**Phone:**_____**Fax:** _____

**Primary Care Practice / Clinician's name:** _____

**Phone:**_____**Fax:** _____

**This authorization ends when I request to end it in writing.**

_____

**Patient's signature** **Date**


## Sweetgrass Psychiatry

*710 Johnnie Dodds Blvd, Suite 200, Mount Pleasant SC 29464*

*Confidential phone: (843) 800-1303, Confidential fax: (888) 316-7716*

*Email (not confidential/not HIPAA compliant): info@sweetgrasspsychiatry.com*

Sweetgrass PSYCHIATRY

# Frequently Asked Questions About TMS

**What is Transcranial Magnetic Stimulation (TMS)?** TMS is a non-invasive treatment for depression that uses a magnetic coil to directly stimulate and change the activity of brain cells. Patients typically receive 6 weeks of daily treatments (Monday-Friday) which last about 30 minutes in total (18.5 min for actual treatment). TMS has been FDA approved for the treatment of depression since 2008. When beginning TMS, a physician will spend an initial session determining the patient's individual treatment dose based on brain excitability called the motor threshold.

**How effective is TMS?** Many studies have shown that TMS is more effective than medications for treating treatment resistant depression. In patients who have tried 2-3 medications, the response rate to another medication is 10-15%. In one of the largest studies of patients treated with TMS for depression, around 60% of participants reduced their symptoms by at least 50% (responded) and around 30% of participants no longer met criteria for depression (remitted). While response and remission rates can vary, a course of TMS treatment can keep patients symptom-free for up to a year or more.

**How quickly does TMS work?** Some people notice changes as early as treatment day #1, while others do not notice changes until closer to the end of treatment. Average response occurs between treatments #20-#30.

**What are the side effects of TMS?** Common side effects include headache and discomfort of the scalp. A rare side effect of TMS is seizures, which is currently estimated to occur in 1/30,000 treatments (0.003%). TMS is a loud treatment, and wearing earplugs during treatment protects hearing.

**Who is a good candidate for TMS?** Patients who continue to be severely depressed despite trying multiple antidepressants are good candidates for TMS. Unfortunately, many patients have intolerable systemic side effects to medications, such as sexual dysfunction, night sweats, weight gain, nausea and more. Because TMS is directly applied to the brain, patients do not have these types of side effects.

Unlike Electroconvulsive Therapy (ECT), (which is another type of brain stimulation for treatment resistant depression), TMS does not affect cognitive function or require sedation, which makes it a good choice for patients who need to be able to work or drive.

**Who is <u>not</u> a good candidate for TMS?** TMS should **not** be used in patients who have pacemakers, implantable cardioverter defibrillators (ICDs or are using wearable cardioverter defibrillators (WCD)) or other implants. It should also not be used by anyone who has magnetic-sensitive metal in their head or within 12 inches of the magnetic coil that cannot be removed. Examples of this kind of metal include aneurysm clips or coils, stents, implanted stimulators, electrodes to monitor brain activity, ferromagnetic implants in your ears or eyes, bullet fragments, facial tattoos with metal ink or permanent makeup or other metal devices or objects implanted in the head. It should not be used in patients who have had a vascular, traumatic, tumoral, infectious, or metabolic lesion of the brain

TMS should be used with caution in pregnant patients and patients who have epilepsy or a history of seizures.

TMS is not FDA approved for patients who have bipolar disorder and can increase risk of developing mania.

TMS on an outpatient basis should not be used in individuals with active suicidal ideation with a plan and/or intent.

**Do I continue to take medications during TMS?**
Patients will work with their providers to determine if any medication changes need to be made for their TMS treatment. Generally, patients who have benefited from their antidepressants will stay on their medications. As some medications change brain cell excitability, it is important to let the TMS treatment team know if any medication changes have been made to ensure safety and efficacy of TMS.

**Can I eat or drink before TMS?**
Yes! We just ask that you not have food or gum in your mouth during the treatment.

**Can I drive to and from my TMS appointments?**
Yes! It is safe to drive immediately after your TMS appointment.

**Can my loved one or pet come to my TMS appointment?**
We welcome one loved one in the room with you but we request that they wear ear plugs. We ask that you leave your pet at home to protect the safety of your pet as they cannot wear hearing protection and respect the safety of other patients and staff.

**How much does TMS cost?**
Out of pocket costs vary significantly depending on your insurance company. Please speak with our billing department for assistance with your verification of benefits and potential out of pocket costs. We cannot estimate your bill with 100% accuracy until the claims are filed and received back.

**Who will administer my TMS treatments?**
During the initial visit, a physician will determine your treatment dose and the exact location of the magnetic coil. The following daily sessions will be administered by trained technicians who will work under a physician's supervision.

**What happens after I complete my TMS treatments?**
We will often recommend a short taper of TMS treatments. Upon completion of your TMS treatment course, you will continue to follow up with your referring outpatient psychiatrist for medication management and follow up with your outpatient therapist. If you have a relapse in depression, we welcome you to call our clinic to schedule a follow up to determine need for an additional TMS course.

# Please list any questions here for your initial consultation:

_____
_____
_____
_____
_____
_____
_____
_____

# Transcranial Magnetic Stimulation Consent Form

This is a patient consent for a medical procedure called TMS Therapy. This consent form outlines the treatment that your physician has prescribed for you, the risks of this treatment, the potential benefits of this treatment, and alternative treatments that are available for you if you decide not to be treated with Apollo TMS Therapy. Please read this document carefully and bring any questions or concerns before signing and beginning treatment.

**About Transcranial Magnetic Stimulation (TMS).** TMS Therapy is a non-invasive medical procedure. A TMS treatment session is conducted using an FDA cleared device called the Apollo TMS Therapy System. This system provides energy to a "treatment coil" or magnet that delivers a pulsed magnetic field to stimulate and change the activity of brain cells. These magnetic fields are comparable to those used in magnetic resonance imaging (MRI) machines. TMS Therapy is a safe and effective treatment for those patients with Major Depressive Disorder who have not benefitted from prior antidepressant medications. Specifically, TMS Therapy is FDA approved and has been shown to relieve depression symptoms in adult patients who have been previously treated with at least one antidepressant medication given at a high enough dose and for a long enough period of time in the current episode, but did not get better.

**During Treatment:** During a TMS treatment session, the physician or a trained member of the Sweetgrass Psychiatry staff will place a magnetic coil gently against the patient's scalp on the left front region of the patient's head. The magnetic fields that are produced by the magnetic coil are pointed at a region of the brain that scientists think may be responsible for causing depression. This treatment does not involve any anesthesia or sedation and patients remain awake and alert during the treatment.

**Motor Threshold.** The initial TMS visit will be a longer, typically 60-90 minutes, visit where the patient's individual treatment dose is determined. The physician will place a magnetic coil on the left side of the patient's head and will assess the amount of energy needed to excite neurons, or "motor threshold." This is visible outwardly by the twitching in the muscles of the patient's hand. Sometimes the motor threshold will need to be reassessed during a future appointment based on the doctor's recommendations.

**Subsequent Treatments.** The treatment itself will consist of "pulses" that may last up to 4 seconds with intermittent rest periods ranging from 1-30 seconds between each series of pulses. The entire treatment lasts around 20-30 minutes, depending on your treatment parameters. Typically treatment parameters consist of TMS treatment 5 times per week for 6 weeks and then 2 times per week for 3 weeks (typically a total of 36 treatments). Your treatment progression is evaluated weekly and is subject to change depending on your doctor's recommendations based on this evaluation.

**Common Side Effects.** During the treatment, you may experience tapping or painful sensations at the treatment site while the magnetic coil is turned on. These types of sensations were reported by about one third of the patients who participated in the research studies. Please inform the physician or a member of the Sweetgrass Psychiatry team if this occurs. The doctor may then adjust the dose or make changes to where the coil is placed in order to help make the procedure more comfortable for you. Headaches were reported in half of the patients who participated in the clinical trial for the device. Both discomfort and headaches got better over time in the research studies, and you may take common over-the-counter pain medications such as acetaminophen or ibuprofen if a headache occurs.

**Ear Protection.** Because the Apollo TMS Therapy System produces a loud click with each magnetic pulse, we require earplugs or similar hearing protection devices with a rating of 30dB or higher of noise reduction during treatment.

**Medical Contraindications and Risks.** The TMS Therapy System should **not** be used in patients who have pacemakers, implantable cardioverter defibrillators (ICDs or are using wearable cardioverter defibrillators (WCD)) or other implants, or by anyone who has magnetic-sensitive metal in their head or within 12 inches of the magnetic coil that cannot be removed. Failure to follow this restriction could result in serious injury or death. Examples of this kind of metal include:

- Aneurysm clips or coils, Stents
- Implanted Stimulators
- Electrodes to monitor your brain activity
- Ferromagnetic implants in your ears or eyes
- Bullet fragments
- Other metal devices or objects implanted in the head
- Facial Tattoos with metal ink or Permanent makeup

Standard amalgam dental fillings are not affected by the magnetic field and are acceptable in patients being considered for treatment with the Apollo TMS Therapy System.

**Epilepsy/Seizures.** TMS should be used with caution if at all in patients who have a history of epilepsy or seizures. Seizures have been reported to occur rarely with TMS. There were no seizures in the initial clinical trials, which involved over 10,000 patient treatment sessions. The current estimated risk of seizure is 1 in 30,000 treatments (0.003%) or 1 in 1,000 patients (0.1%).

**Pregnancy.** TMS should be used with caution if at all in patients who are pregnant. Please tell a staff member if you think you might be pregnant.

**Previous Brain Injury.** TMS should be used with caution if at all in patients who have had a vascular, traumatic, tumoral, infectious, or metabolic lesion of the brain. Failure to follow this restriction could result in serious injury or death.

**Personal Changes During Treatment.** Please alert your physician or TMS technician if you have had any changes to your sleep or are significantly sleep deprived, if you have changed your alcohol or recreational drug use intake, if you have had changes to your medication doses or amounts, or if you have had any changes in your medical history. Failure to do so may result in an inadequate or excessive treatment dose and increase your risk of seizures.

**Psychiatric Changes.** Please alert your treatment team if you are experiencing changes in your mood or thoughts of suicide. If you develop thoughts of suicide outside of our regular business hours, you agree to contact 911, suicide hotline at 988, or mobile crisis or go to your nearest emergency room.

**Efficacy.** The beneficial outcome of FDA trials for treating major depression with TMS show that approximately 1 out of 2 patients experienced significant improvement in depression symptoms following rTMS treatment while approximately 1 out of 3 patients experienced complete symptom relief after the full TMS therapy. TMS is not effective for all patients with depression. Any signs or symptoms of worsening depression should be reported immediately to your doctor. You may want to ask a family member or caregiver to monitor your symptoms to help you spot any signs of worsening depression. Safety and efficacy has not been established in the clinical trial for the device for patients with these characteristics:

- Age less than 22
- Suicide plan or recent suicide attempt
- On concurrent antidepressant medication, i.e., cannot tolerate discontinuation of current antidepressant medication
- History or concurrent use of electroconvulsive therapy or vagus nerve stimulation
- Depression secondary to a general medical condition or substance-induced

- Seasonal affective disorder
- History of substance abuse,
- Post-traumatic stress disorder
- Psychotic disorder, including schizoaffective disorder, bipolar disorder, or major depression with psychotic features
- Neurological disorders, including a history of seizures, cerebrovascular disease, primary or secondary tumors in CNS, cerebral aneurysm, dementia, or movement disorders
- History of increased intracranial pressure or head trauma;

**Alternative Treatments.** There are alternative forms of depression treatment to TMS that include medications, Spravato/ketamine, psychotherapy, vagus nerve stimulation, and electroconvulsive therapy.

**Ongoing Treatment.** During my TMS treatment course, I agree to continue my regular psychotherapy appointments and correspond with my outpatient psychiatrist as needed. I also agree to attend regular medical appointments as scheduled.

**Discontinuation.** You may discontinue treatment at any time. It is helpful to know most patients experience results by the fourth week of treatment. Some patients may experience results in less time while others may take longer.

**TMS fees.** I understand that Sweetgrass Psychiatry will be obtaining insurance prior authorization for TMS and billing my insurance for this treatment on my behalf. I am ultimately financially responsible for out of pocket fees associated with this treatment not covered by my insurance policy, including deductibles, copayments, if I lose or cancel my health insurance plan or if my prior authorization runs out. It is my responsibility to notify the clinic immediately with any changes in my insurance policy.

**Missed appointments/Late cancellations.** I understand that Sweetgrass reserves a TMS room and a dedicated technician for me for each appointment. I will be charged a no show or late cancellation fee (if I cancel my TMS appt less than 24 business hours in advance) at prevailing rates if I miss my appointment.

**Insurance pre-authorization**. For insurance pre-authorization, insurance companies require the following (this is not a complete list of requirements, but most minimum requirements for TMS therapy):

- A confirmed diagnosis of Major Depressive Disorder
- Prior trials of antidepressant medications with little or no benefit from depression symptoms OR medication discontinuation due to side effects (each insurance requires a specific number of antidepressant trials - for example, Medicare requires a minimum of two (2) antidepressants with little or no benefit or inability to continue to medication due to side effects.
- No history of seizures
- A history of psychotherapy with little or no benefit (physician, therapist, counselor, outpatient mental health visits, etc.)
- No TMS Therapy contraindications

Upon receipt of patient medical records, Sweetgrass Psychiatry will submit a prior authorization to your insurance provider per your authorization. By signing this form, you authorize Sweetgrass Psychiatry to submit a prior authorization request to your insurance provider for TMS services and/or for services to be provided to you by one of our physicians or healthcare providers.

**By signing this, you acknowledge, you have been made aware of the following:**

- HIPPA Notice and Patient Privacy Acts
- TMS Therapy Contraindications
- TMS Therapy Hearing Protection
- Indications for and any side effects of TMS Therapy, including an explanation of TMS Therapy for the treatment of major depression or other diagnosis that I may be receiving TMS Therapy for.

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I have read the information contained in this Medical Procedure Consent Form about TMS Therapy and its potential risks. I have discussed it with my physician who has answered all of my questions. I understand there are other treatment options for my depression available to me and these have also been discussed with me.

I therefore permit my physician or a member of the Sweetgrass Psychiatry staff to administer this treatment to me.

_____ /_____

**PATIENT/GUARDIAN SIGNATURE** **DATE**

_____

**PRINT FULL NAME**

# Beck's Depression Inventory

**Patient name:** **Date:**

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

| | | |
|---|---|---|
| 1. | 0 | I do not feel sad |
| | 1 | I feel sad |
| | 2 | I am sad all the time and I can't snap out of it |
| | 3 | I am so sad and unhappy that I can't stand it |
| | | |
| 2. | 0 | I am not particularly discouraged about the future |
| | 1 | I feel discouraged about the future |
| | 2 | I feel I have nothing to look forward to |
| | 3 | I feel the future is hopeless and that things cannot improve |
| | | |
| 3. | 0 | I do not feel like a failure |
| | 1 | I feel I have failed more than the average person |
| | 2 | As I look back on my life, all I can see is a lot of failures |
| | 3 | I feel I am a complete failure as a person |
| | | |
| 4. | 0 | I get as much satisfaction out of things as I used to |
| | 1 | I don't enjoy things the way I used to |
| | 2 | I don't get real satisfaction out of anything anymore |
| | 3 | I am dissatisfied or bored with everything |
| | | |
| 5. | 0 | I don't feel particularly guilty |
| | 1 | I feel guilty a good part of the time |
| | 2 | I feel quite guilty most of the time |
| | 3 | I feel guilty all of the time |
| | | |
| 6. | 0 | I don't feel I am being punished |
| | 1 | I feel I may be punished |
| | 2 | I expect to be punished |
| | 3 | I feel I am being punished |
| | | |
| 7. | 0 | I don't feel disappointed in myself |
| | 1 | I am disappointed in myself |
| | 2 | I am disgusted with myself |
| | 3 | I hate myself |
| | | |
| 8. | 0 | I don't feel I am any worse than anybody else |
| | 1 | I am critical of myself for my weaknesses or mistakes |
| | 2 | I blame myself all the time for my faults |
| | 3 | I blame myself for everything bad that happens |
| | | |
| 9. | 0 | I don't have any thoughts of killing myself |
| | 1 | I have thoughts of killing myself, but I would not carry them out |
| | 2 | I would like to kill myself |
| | 3 | I would kill myself if I had the chance |
| | | |

| | | |
|---|---|---|
| 10. | 0 | I don't cry any more than usual |
| | 1 | I cry more now than I used to |
| | 2 | I cry all the time now |
| | 3 | I used to be able to cry, but now I can't cry even though I want to |
| | | |
| 11. | 0 | I am no more irritated by things than I ever was |
| | 1 | I am slightly more irritated now than usual |
| | 2 | I am quite annoyed or irritated a good deal of the time |
| | 3 | I feel irritated all the time |
| | | |
| 12. | 0 | I have not lost interest in other people |
| | 1 | I am less interested in other people than I used to be |
| | 2 | I have lost most of my interest in other people |
| | 3 | I have lost all of my interest in other people |
| | | |
| 13. | 0 | I make decisions about as well as I ever could |
| | 1 | I put off making decisions more than I used to |
| | 2 | I have 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 that I look any worse than I used to |
| | 1 | I am worried that I am looking old or unattractive |
| | 2 | I feel there are permanent changes in my appearance that make me look unattractive |
| | 3 | I believe that I look ugly |
| | | |
| 15. | 0 | I can work about as well as before |
| | 1 | It takes an extra effort to get started at doing something |
| | 2 | I have to push myself very hard to do anything |
| | 3 | I can't do any work at all |
| | | |
| 16. | 0 | I can sleep as well as usual |
| | 1 | I don't sleep as well as I used to |
| | 2 | I wake up 1-2 hours earlier than usual and find it hard to get back to sleep |
| | 3 | I wake up several hours earlier than I used to and cannot get back to sleep. |
| | | |
| 17. | 0 | I don't get more tired than usual |
| | 1 | I get tired more easily than I used to |
| | 2 | I get tired from doing almost anything |
| | 3 | I am too tired to do anything |
| | | |
| 18. | 0 | My appetite is no worse than usual |
| | 1 | My appetite is not as good as it used to be |
| | 2 | My appetite is much worse now |
| | 3 | I have no appetite at all anymore |
| | | |
| 19. | 0 | I haven't lost much weight, if any, lately |
| | 1 | I have lost more than five pounds |
| | 2 | I have lost more than ten pounds |

| | | |
|---|---|---|
| | 3 | I have lost more than fifteen pounds |
| 20. | 0 | I am no more worried about my health than usual |
| | 1 | I am worried about physical problems like aches, pains, upset stomach, or constipation |
| | 2 | I am very worried about physical problems and it's hard to think of much else |
| | 3 | I am so worried about my physical problems that I cannot think of anything else |
| | | |
| 21. | 0 | I have not noticed any recent change in my interest in sex |
| | 1 | I am less interested in sex than I used to be |
| | 2 | I have almost no interest in sex |
| | 3 | I have lost interest in sex completely |

**INTERPRETING THE BECK DEPRESSION INVENTORY**

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you 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 |

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| **Over the last 2 weeks, how often have you been bothered by any of the following problems?** *(Use "✔" to indicate your answer)* | **Not at all** | **Several days** | **More than half the days** | **Nearly every day** |
|---|---|---|---|---|
| **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 or 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 — or that you are a failure or 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 the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| **9.** Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |

**FOR OFFICE CODING** *0* **+** _____ **+** _____ **+** _____

**=Total Score:** _____

**If you checked off 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** |
|---|---|---|---|

Patient name: Date:

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