



**First Alliance  
Healthcare of Ohio**

5900 Landerbrook Drive Suite 301  
Mayfield Heights OH 44124

Office: 216-417-8813  
Web: [www.firstalliancehc.com](http://www.firstalliancehc.com)

### CLIENT REFERRAL FORM

| CLIENT INFORMATION                                                                         |                                   |                |
|--------------------------------------------------------------------------------------------|-----------------------------------|----------------|
| Name:                                                                                      |                                   | DOB:           |
| Age:                                                                                       |                                   |                |
| Gender (per insurance carrier):                                                            | Marital Status:<br>single         |                |
| Race:<br>Black                                                                             | Ethnicity:<br>African American    |                |
| Language preference:<br>English                                                            | Legal Guardian (Name and Number): |                |
| SSN:                                                                                       | Medicaid (MMIS):                  |                |
| Provider Name:                                                                             | Member ID:                        |                |
| Insurance Verified: <input type="checkbox"/> No or <input checked="" type="checkbox"/> Yes | Reference Number:                 |                |
| Insurance Verified by: Denise Wilder                                                       |                                   |                |
| REFERRAL INFORMATION                                                                       |                                   |                |
| Address:                                                                                   | Apt:                              |                |
| City:                                                                                      | State:                            | Zip Code:      |
| Phone Number(s):                                                                           | Email address:                    |                |
| Presenting Concern(s):                                                                     |                                   |                |
| Referred By: {Choose One} :                                                                | Contact Number:                   | Referral Date: |
| Notes:                                                                                     |                                   |                |



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## CONSENT FOR TREATMENT

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Last 4 of SS#: \_\_\_\_\_

☐ Self

☐ Minor/Conservator

I consent for treatment for myself or my minor/conservator at First Alliance Healthcare. I understand that mental health services sometimes carry a risk of side effects and I understand that I am entitled to an explanation regarding possible side effects. I hereby give consent for mental health treatment and or substance use services (which may include services, supports). Services may include one or more of the following:

- Diagnostic Evaluation and Diagnostic Evaluation Update
- Psychiatry/Medication Management
- Psychoeducation Support Services (Therapeutic Behavioral Services - TBS; Psychosocial Rehabilitation – PSR)
- Intensive Outpatient Treatment (IOP)
- Mobile Response Stabilization Services (MRSS)
- Community Psychiatric Service Treatment (CPST)
- Laboratory Analysis
- Psychotherapy (Individual, Family, Group, Crisis)
- Medical Assisted Treatment (MAT)
- Substance Use Disorder (SUD) Services (Assessment & ASAM LOC; Case Management; Individual and/or Group Counseling)
- Peer-Recovery Support Services (PRS)
- Assertive Community Treatment (ACT)
- Mental Health Day Treatment

I understand that I will receive only those services for which I give consent and only those services will appear on the individualized treatment plan. I am aware that I have the right to refuse or withdraw consent for treatment at any time and I am responsible for the potential consequences of such refusal or withdrawal.

I understand that my personal identifiable information will be kept confidential consistent with Federal and State laws and the minimum necessary may be used or disclosed according to the following laws:

- The Health Insurance Portability and Accountability Act (HIPAA) 1996 is federal law. HIPAA Privacy rules how my protected health information (PHI) can be used or disclosed. First Alliance Healthcare of Ohio may use or disclose my PHI for treatment purposes, to bill or process claims for services provided, and as necessary for the operations of First Alliance Healthcare of Ohio. I understand that I have the right to limit or revoke this consent at any time.



- Ohio Law (ORC. 5122.31 (A)(7)) authorizes First Alliance Healthcare of Ohio to exchange my protected health information (PHI) with other providers of treatment and health services to facilitate the continuity of care without a release of information. My information pertaining education, housing, employment, and addiction services cannot be shared under this law and require a specific release of information.

I understand that all information shared with service providers at First Alliance Healthcare of Ohio is confidential and no information will be released without my consent. During the course of treatment at First Alliance Healthcare of Ohio, it may be necessary for my service provider to communicate with providers at **First Alliance Healthcare of Ohio**. While written authorization will not be requested, prior to any discussion with **First Alliance Healthcare of Ohio** providers, I understand that only provider will discuss all communications with me. In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

- A. When there is risk of imminent danger to myself or to another person, the service provider is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the provider is legally required to take steps to protect the child and to inform the proper authorities.
- C. When a valid court order is issued for medical records, the provider and the agency are bound by law to comply with such requests.

If I have any questions regarding this consent form or about the services offered at **First Alliance Healthcare of Ohio**, I may discuss them with my provider or the Clinical Supervisor. I have read and understand the above. I consent to receive the treatment offered to me by **First Alliance Healthcare of Ohio**. I understand that I may stop treatment at any time.

The consent/or treatment process has been thoroughly explained to me and I understand that I may stop treatment at any time.

---

**Client Name (Print)**

---

**Client/Legal Guardian Signature**

---

**Date**



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## **PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM**

Thank you for choosing **First Alliance Healthcare of Ohio** for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our Client Financial policies.

### **Client Financial Responsibilities**

- The Client (or Client's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the Client is required to provide the most correct and updated information regarding insurance. If we are unable to process payment through your insurance for any reason we will bill you for the services provided at the following rates:

|                                               |                |          |
|-----------------------------------------------|----------------|----------|
| 1. Individual Psychotherapy                   | 1-hour Session | \$ 55.00 |
| 2. Group Psychotherapy                        | 1-hour Session | \$ 75.00 |
| 3. Family Psychotherapy                       | 1-hour Session | \$ 75.00 |
| 4. Diagnostic Evaluation                      | Flat fee       | \$ 50.00 |
| 5. Community Psychiatric Supportive Treatment | 1-hour Session | \$ 35.00 |
| 6. Therapeutic Behavioral Services            | 1-hour Session | \$ 35.00 |
| 7. Psychosocial Rehabilitation                | 1-hour Session | \$ 35.00 |
| 8. Assertive Community Treatment              | 1-hour Session | \$ 75.00 |
| 9. Intensive Home-Based Therapy               | 1-hour Session | \$ 75.00 |
| 10. Substance Use Disorder Assessment & ASAM  | Flat fee       | \$ 50.00 |
| 11. Substance Use Disorder Services           | 1-hour Session | \$ 35.00 |
| 12. Intensive Outpatient Treatment            | Hourly Rate    | \$ 75.00 |

- Clients are responsible for payment of copays, coinsurance, deductibles and all other procedures or treatment not covered by their insurance plan
- Copays are due at the time of service
- Coinsurance deductibles and non-covered items are due 30 days from receipt of billing
- Clients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:  
Charge for returned checks - \$30.00

By my signature below, I hereby authorize assignment of financial benefits directly to **First Alliance Healthcare of Ohio** and any associated healthcare entities for service rendered as allowed under standard third-party contracts. I understand that I am financially responsible for charges not covered by this assignment.

### **Client Acknowledgement and Authorization**

We respect Client confidentiality and only release personal health information about you in accordance with the State and Federal law. The attached notice describes our policies related to the use of the records of your care and how you may get access to this information. Please review this policy carefully. By my signature below, I acknowledge that I have received and read the privacy notice provided by **First Alliance Healthcare of Ohio** to release medical and other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third party payors, and or other physicians or healthcare entities to participate in my care.

\_\_\_\_\_  
**Client Name**

\_\_\_\_\_  
**Client/Legal Guardian Signature**

\_\_\_\_\_  
**Date**



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**ACKNOWLEDGEMENT OF RECEIPT OF:**

1. Consumer Rights Policy and OHMAS Consumer Rights Statement; and
2. HIPAA Privacy Rules for the Protection of Health and Mental Health Information

I acknowledge that I received:  
(Please initial below)

☒ \_\_\_\_\_ Consumer Rights Policy and OHMAS Consumer Rights Statement

☒ \_\_\_\_\_ HIPAA Privacy Rules for the Protection of Health and Mental Health Information

My signature below acknowledges that I have received agency orientation which includes a copy of the First Alliance Healthcare of Ohio Consumer Rights Policy and the Department of Mental Health Consumer Rights Statement. As a new consumer I understand and have received a copy of the HIPAA Privacy Rules for the Protection of Health and Mental Health information. I have been made aware of all the programs that have been offered at the agency and how they can be beneficial.

**Client Name (Printed):** \_\_\_\_\_

**Client Signature:** \_\_\_\_\_

**Parent/Legal Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Reason for Refusal to sign:** \_\_\_\_\_



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## **STATEMENT OF PROVIDER CHOICE**

I, **x** \_\_\_\_\_ (Parent/Legal Guardian, if minor/conservator) have consented to receive one or more of following service(s) from **First Alliance Healthcare of Ohio**:

Services may include one or more of the following:

Diagnostic Evaluation (DE) and Diagnostic Evaluation Update  
Pharmacological Management Services: Psychiatric Evaluations; Medication Management; Medical Somatic; Medical Assisted Treatment (MAT)  
Psychotherapy (Individual, Family, Group, Crisis)  
Psychoeducation Support Services: Therapeutic Behavioral Service (TBS) and/or Psychosocial Rehabilitation (PSR)  
Substance Use Disorder Assessment and ASAM Level of Care (ASAM LOC)  
Substance Use Disorder Services (Case Management; Psychotherapy; Individual Counseling; Group)  
Intensive Outpatient Treatment (IOP)  
Peer-Recovery Support Services  
Laboratory Analysis  
Mobile Response Stabilization Services (MRSS)  
Mental Health Day Treatment  
Community Psychiatric Service Treatment (CPST)

I attest that I have been provided with the information necessary to make an informed choice about service, informed about the range of other services in a way that is non-coercive and protects my right to self-determination.

My selection of a service provider was based solely upon my identified needs, diagnosis, preference, and provider availability.

By signing this Statement of Provider Choice, I acknowledge that I was given choice of provider and that the screening discussed location, available times, specialty, culture, and linguistic preferences with me.

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date**



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## **CONSENT TO TELEHEALTH**

**Client's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Last four SS#:** \_\_\_\_\_

### **Introduction**

Telehealth is the form of telemedicine that allows clients to access mental health care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

### **Expected Benefits:**

- Improved access to mental health care by enabling a client to remain in his/her home or office.
- Improved convenience for the client.
- More efficient management of mental health care within the community setting.
- Obtaining expertise of a distant specialist.

### **Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for the effective communication between the client and the mental health professional. Effective communication is vital to the provision of mental health services by the mental health professional;
- Cultural and/or language differences between the client and the mental health professional may affect communication and service delivery.
- Delays in mental health assessment and treatment could occur due to deficiencies or failures of the
- equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in judgmental errors by the mental health professional;

**Please initial after reading this page:** \_\_\_\_\_

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to tele- mental health and that no information obtained in the use of tele-therapy which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a Telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that no video and/or audio recordings of Telehealth sessions will be made.
5. I understand that a variety of alternative methods for the provision of mental health services may be
  - a. available to me, and that I may choose one or more of these at any time.
6. I understand that an alternative method for the provision of mental health services may be used by my
  - a. mental health professional when deemed necessary.
7. I understand that it is my duty to inform my mental health professional of any other healthcare providers involved in my medical/ mental health care.
8. I understand that I may expect the anticipated benefits from the use of Telehealth in my care, but that no results can be guaranteed or assured.
9. I understand that First Alliance Healthcare of Ohio cannot ensure confidentiality at the site where the client is located and when unapproved equipment software is used by the client, when Telehealth procedures are not followed by the client.
10. I understand that First Alliance Healthcare of Ohio is not responsible for overages on client data usage plans, when Wi-Fi is not used by the client.
11. I understand that my mental health professional providing Telehealth is a qualified mental health professional with specialized training in the provision of distance mental health.
12. I understand that First Alliance Healthcare of Ohio is located at 11201 Shaker Blvd Suite 308; Suite 308; Cleveland, OH 44104; phone number: 216-417-8813
13. I understand that in times of crisis, or as desired during business hours, I may reach my mental health professional by business cell or desk phone.
14. I understand that in times of crisis outside of normal work hours of my mental health professional I may call the Mobile Crisis Hotline at 216-216-417-8813 or call 911.

**Client Consent to the Use of Telehealth**

I have read and understand the information provided above regarding Telehealth, have discussed it with my mental health professional as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of tele-therapy in my medical care. I hereby authorize First Alliance Healthcare of Ohio to use Telehealth in the course of my mental health diagnosis and treatment.

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Guardian Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**FAH Witness**

\_\_\_\_\_  
**Date**

### PHOTOGRAPH AND TRANSPORTATION PERMISSION

This permission slip must be signed by the parent or guardian of the child. If you do not give permission, please indicate in the appropriate space of the form.

Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last 4 of SS#: \_\_\_\_\_

#### PERMISSION TO USE PHOTOGRAPH

I, \_\_\_\_\_ (Parent/Legal Guardian, if minor/conservator) grant First Alliance Healthcare of Ohio, its representatives, and employees the right to take photographs of me in connection with any activities I may participate in connected with services offered by First Alliance Healthcare of Ohio. I authorize First Alliance Healthcare of Ohio, its assigns, and transferees to copyright, use and publish the same in print and/or electronically.

☒ I agree that First Alliance Healthcare of Ohio may use such photographs of for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content:

- ☒ with my name.  
☐ without my name.

☐ I **DO NOT GIVE** permission to First Alliance Healthcare to have client named above photographed.

#### PERMISSION TO TRANSPORT

☒ I hereby **GIVE** my full permission to First Alliance Healthcare to have client named above transported.

☐ I **DO NOT GIVE** permission to First Alliance Healthcare to have client named above transported.

\_\_\_\_\_  
Client Name (Print)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Legal Guardian Name (Print)

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date:

## Authorization to Release and/or Exchange Confidential Information

Client's Name (Last, First)

Date of Birth

Phone Number

Social Security Number (last four  
digits)

I, the undersigned, hereby authorize First Alliance Healthcare of Ohio to use or disclose my personal health information and/or confidential information as described below to:

Name of Recipient

Phone

Fax

Address (Street)

(City) (State)(Zip)

Email

☐ If marked, I further authorize the **EXCHANGE** of information and for the party identified as Recipient above to also disclose my personal health information and/or confidential information to First Alliance Healthcare of Ohio.

### Type of Information to be Released/Exchanged:

- |                                                                |                                                          |                                                          |
|----------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Mental Health Assessments/Evaluations | <input type="checkbox"/> Partial Hospitalization Records | <input type="checkbox"/> Alcohol/Drug Assessment (LOC)   |
| <input type="checkbox"/> Treatment Plan/ITP/Treatment Updates  | <input type="checkbox"/> HIV/AIDS Related Diagnosis      | <input type="checkbox"/> Alcohol/Drug Treatment Summary  |
| <input type="checkbox"/> Progress Notes                        | <input type="checkbox"/> Court Reports                   | <input type="checkbox"/> Alcohol/Drug Treatment Plan     |
| <input type="checkbox"/> Psychological Information             | <input type="checkbox"/> Psychiatric Information         | <input type="checkbox"/> Alcohol/Drug Progress Notes     |
| <input type="checkbox"/> General Medical Records               | <input type="checkbox"/> Employment Records              | <input type="checkbox"/> Alcohol/Drug Discharge Plan     |
| (except HIV/AIDS related diagnosis and treatment)              | <input type="checkbox"/> School Reports/Records/IEP/IFIE | <input type="checkbox"/> Urinalysis/Breathalyzer Results |
| <input type="checkbox"/> Discharge Summary                     | <input type="checkbox"/> Other (specify):                |                                                          |

### Dates of Service to Release

(FROM): \_\_\_\_\_ (TO): \_\_\_\_\_

### Purpose for Disclosure:

- |                                                 |                                                       |
|-------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Care/Treatment/Ongoing | <input type="checkbox"/> Treatment Planning           |
| <input type="checkbox"/> Assessment/Evaluation  | <input type="checkbox"/> To follow up on a referral   |
| <input type="checkbox"/> Continuity of Care     | <input type="checkbox"/> Other, please specify: _____ |

(Purpose for disclosure must be completed prior to processing, e.g., continuity of care, personal use, legal)

I understand and acknowledge that the requested information may contain information regarding physical and mental illness, HIV test results or diagnosis, AIDS or AIDS related conditions, alcohol and/or drug dependence/abuse\*. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

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I understand that I may see and copy the information described on this form if requested in writing. I also understand that the provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. The health care providers listed above will not receive financial or in-kind compensation in exchange for using or disclosing my health care information.

I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

I understand I have a right to revoke this authorization (in writing) at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. If not revoked, **this authorization will expire one year from the date written below** or on the following date, event, or condition (if earlier): \_\_\_\_\_.

I understand there may be charges for the copying and release of information and accept financial responsibility for those charges. I understand and agree that a copy of this authorization shall have the same force and effect as the original.

|                                                               |              |      |
|---------------------------------------------------------------|--------------|------|
| Signature of Client                                           | Printed Name | Date |
| Signature of Parent/Legal Guardian/ Personal Representative** | Printed Name | Date |

\* Prohibition Against Re-Disclosure: This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute and alcohol or drug abuse client. \*\* If other than client's signature, a copy of legal paperwork verifying the client's personal representative MUST accompany the request unless otherwise on file with provider (e.g., court appointed guardian, durable power of attorney for healthcare, grandparent power of attorney). Exception: Parent signing for client under the age of eighteen and the County agency holding custody.

**Revocation of Authorization for Release of Information**

At the date and time noted below, I hereby revoke permission for First Alliance Healthcare of Ohio to further release information to the above-noted person, except to the extent the program has already acted in reliance upon it.

Client/Parent/Legal Guardian/Personal Representative\*\*

## CLIENT ORIENTATION CHECKLIST

**Instructions:** Please check and have Client sign off on the following:

- ☒ Reviewed Consent for Treatment and intake paperwork (Financial Responsibility; Provider Choice; Photograph and Transportation Permission; etc.)
- ☒ Reviewed Telehealth Informed Consent
- ☒ Provided written information about whom and how to contact staff in case of an emergency
- ☒ Provided hours and days of operation where applicable
- ☒ Reviewed program rules and expectations
- ☒ Discussed availability of after hour services
- ☒ Reviewed individual's responsibility for participation in treatment and discharge planning
- ☒ Completed tour of building including introductions to staff and other program participants
- ☒ Reviewed fire safety and emergency preparedness procedures
- ☒ Other:
- ☒ **Comments/Notes:**

### Client Agreement:

- ☒ Rules were received and reviewed with me by a staff member and I agree to follow them.
- ☒ I have been given a tour of the Agency and introduced to staff and clients that are present.

**Signature denotes the above information has been reviewed and explained to me.**

- ☒ I acknowledge the following activities have been completed with me during the Orientation process.

\_\_\_\_\_  
**Client Name (Print)**

\_\_\_\_\_  
**Client Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent/Legal Guardian Name (Print)**

\_\_\_\_\_  
**Parent/Legal Guardian Signature**

\_\_\_\_\_  
**Date:**

# 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<br>days | More<br>than half<br>the days | Nearly<br>every<br>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<br>have let yourself or your family down                                                                             | 0          | 1               | 2                             | 3                      |
| 7. Trouble concentrating on things, such as reading the<br>newspaper or watching television                                                                                       | 0          | 1               | 2                             | 3                      |
| 8. Moving or speaking so slowly that other people could have<br>noticed? Or the opposite — being so fidgety or restless<br>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<br>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<br>at all<br><input type="checkbox"/> | Somewhat<br>difficult<br><input type="checkbox"/> | Very<br>difficult<br><input type="checkbox"/> | Extremely<br>difficult<br><input type="checkbox"/> |
|-----------------------------------------------------|---------------------------------------------------|-----------------------------------------------|----------------------------------------------------|

## GAD-7 Anxiety

| Over the <u>last two weeks</u> , how often have you been bothered by the following problems? | Not at all | Several days | More than half the days | Nearly every day |
|----------------------------------------------------------------------------------------------|------------|--------------|-------------------------|------------------|
| 1. Feeling nervous, anxious, or on edge                                                      | 0          | 1            | 2                       | 3                |
| 2. Not being able to stop or control worrying                                                | 0          | 1            | 2                       | 3                |
| 3. Worrying too much about different things                                                  | 0          | 1            | 2                       | 3                |
| 4. Trouble relaxing                                                                          | 0          | 1            | 2                       | 3                |
| 5. Being so restless that it is hard to sit still                                            | 0          | 1            | 2                       | 3                |
| 6. Becoming easily annoyed or irritable                                                      | 0          | 1            | 2                       | 3                |
| 7. Feeling afraid, as if something awful might happen                                        | 0          | 1            | 2                       | 3                |

Column totals    \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ =

*Total score*    \_\_\_\_\_

If you checked any problems, how difficult have they 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

☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at [ris8@columbia.edu](mailto:ris8@columbia.edu). PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

## Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”

GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety