



Consulting Group, LLC

Individual, Marriage & Family Therapy  
Kenneth A. Finch, Ph.D., LMHC License # MH0004869  
Dallas A. Finch, LCSW License # SW13235

**CLIENT INFORMATION**

Who referred you to this office? \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Number of Years: \_\_\_\_\_ Enjoy Job? Yes  No

**PERSON RESPONSIBLE FOR PAYMENT IF DIFFERENT FROM ABOVE**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**GENERAL CONTACT AND EMERGENCY CONTACT INFORMATION**

Provider can call me at the following phone number: \_\_\_\_\_

- Provider can leave their name and phone number only when they call.
- Provider can leave a detailed message when they call.

- |   |  |
|---|--|
| Provider can mail me information such as billing.                             | Provider can email me information.                 |
| <input type="checkbox"/> Provider can mail information to my home address.    | <input type="checkbox"/> Provider can email me.    |
| <input type="checkbox"/> Provider cannot mail information to my home address. | <input type="checkbox"/> Provider cannot email me. |

Our office would like to send appointment reminders. Please select one:

- Text: \_\_\_\_\_
- Email: \_\_\_\_\_

The appointment reminder will include only the date and time of your appointment and your service provider name. We will not encrypt the messages. Health care information sent by regular email or text could be lost, delayed, intercepted, delivered to the wrong address or number, or arrive incomplete or corrupted. If you understand these risks and would like to receive any appointment reminder by email or text, I need you to confirm you accept responsibility for these risks and will not hold us responsible for any event that occurs after we send the message.

Patient Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_



In case of emergency, I authorize Provider to contact:

At ( ) Relationship to patient: \_\_\_\_\_

Patient Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

**Acknowledgement of HIPAA Notice of Privacy Practice**

I, \_\_\_\_\_, acknowledge receipt of the HIPAA Notice of Privacy Practice.

\_\_\_\_\_  
Signature of client or legal guardian/representative

\_\_\_\_\_  
Date

**Acknowledgement of Payment Policy & Release of Information**

I, \_\_\_\_\_, acknowledge receipt of payment policy regarding fees and payment for services. I understand that I am financially responsible for all charges. I hereby authorize Kenneth A. Finch, Ph.D., or Dallas A. Finch, LCSW to release all information necessary to secure their payment or my reimbursement and my information may be made available for retrieval by my insurance company or person responsible for payment.

\_\_\_\_\_  
Signature of client or legal guardian/representative

\_\_\_\_\_  
Date

**Acknowledgement of Exceptions Therapist-Client Relationship**

I, \_\_\_\_\_, acknowledge that there are circumstances that create exceptions to the therapist-client confidentiality, as follows:

1. Any reasonable suspicion of child abuse, physical or sexual is required by the State of Florida to be reported to the Department of Health and Rehabilitative Services.
2. If you disclose to me that you intend to harm someone, I am required to warn the intended victim of the possible danger.
3. If you disclose to me that you intend to harm yourself in a suicidal situation, confidentiality will be broken.
4. In some cases, consultation during peer supervision will be sought in behalf of client's treatment.
5. If outside referral is deemed necessary, you will be asked to sign a release form for me to provide information about your case. NO information is released without your permission.
6. Records may be subpoenaed in some court cases.
7. If you utilize third-party payment to reimburse yourself: information you have authorized for release may be available for retrieval by your insurance company.

\_\_\_\_\_  
Signature of client or legal guardian/representative

\_\_\_\_\_  
Date



**AUTHORIZATION FOR RELEASE / REQUEST OF INFORMATION**

**CLIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**AUTHORIZATION FOR** (check as appropriate):

\_\_\_\_ Request for information \_\_\_\_ Release of information

I authorize Finch & Finch Consulting Group, LLC to request/release information and/or records of the individual name above.

This information may be released to / requested from the following:

FACILITY/PERSON: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

THE INFORMATION & RECORDS ARE FOR THE PURPOSE OF: \_\_\_\_\_

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INFORMATION TO BE RELEASED INCLUDES: (check one)

\_\_\_\_ Specific information (such as billing, treatment summary, referral): \_\_\_\_\_

\_\_\_\_ All information

I understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed again and no longer protected by those regulations.

I understand that I have the right to inspect or copy any information I have authorized to be used. I understand that if I agree to sign this authorization, that I have a right to receive a copy of the signed form.

I understand that I have a right to cancel this authorization at any time by presenting my written notice of cancellation. I understand that the cancellation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of the information is voluntary. I understand that I may refuse to sign this authorization and that this refusal will not affect my ability to obtain treatment, payment or healthcare options. I understand that the above information may be disclosed by the recipient of the information. Most healthcare providers must follow federal rule protecting the privacy of health information. However, Finch & Finch Consulting Group, LLC cannot guarantee that others receiving the information will protect it.

\_\_\_\_\_  
Client/Guardian

\_\_\_\_\_  
Date



**Consent to Treatment:** Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment or services at any time.

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

### **Court Policy & Fee's**

Please be advised that the therapists of Finch & Finch Consulting Group, LLC do not participate in person, by phone or in writing in any court related matter that the client of Finch & Finch Consulting Group, LLC may be a party to or become a party to in any way. The therapists of Finch & Finch Consulting Group, LLC do not write letters regarding their client's treatment to any entity, including court. The therapists of Finch & Finch Consulting Group, LLC at no time will offer an opinion or recommendation in any court matter, especially as it relates to custody.

If a court order is served and is requesting that a therapist of Finch & Finch Consulting Group, LLC be present in person and or there is a request for records, the client's consent will be requested before turning over confidential information. When obtaining this consent, the client will be told exactly what has been requested by court and there is no guarantee that the information will be kept confidential. This includes a client's mental health history; current status and inclusive records and may not be in the best interests of the client. The therapist client relationship does not render the therapist as an advocate. The therapist will withhold any opportunity to engage in a dual relationship with the client.

Please be advised that should a therapist from Finch & Finch Consulting Group, LLC be ordered by court to write a letter to the court, the time shall be billed at \$200 per hour.

Please be advised that should a therapist from Finch & Finch Consulting Group, LLC be court ordered to appear in court, the fee stipulation is as follows:

- \$2,000 per day plus \$200 per hour for travel to and from the court.
- \$200 per hour for preparation

All therapists of Finch & Finch Consulting Group, LLC will **NOT** be ON-CALL at any time. Should a case be trialed, the therapist will be paid in full for each day as well as an additional \$1,000 per day as it hinders the therapist's or intern's ability to be available to their other clients.

All court fees must be received prior to the court date. Should the court calendar the hearing for another date, the therapist or intern must be re-issued a court order with the new court hearing date.

Should the therapists or interns be on vacation, the party initiating the court order must take reasonable steps to avoid imposing undue burden or expense on a person subject to the subpoena.

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



**REASON FOR SEEKING PROFESSIONAL HELP:**

**MY PROBLEM BEGAN (Date):** \_\_\_\_\_ **WHAT HAPPENED?** \_\_\_\_\_

**I HOPE TO CHANGE:** \_\_\_\_\_

**PROBLEM LIST: (check if applies to you)**

- |  |   |  |  |
|--|---|--|--|
| <b>Environment:</b>                    | <b>Relationship:</b>                    | <b>Mood:</b>                                 | <b>Self-perception:</b>                        |
| <input type="checkbox"/> social        | <input type="checkbox"/> father         | <input type="checkbox"/> anxious/panic       | <input type="checkbox"/> poor self-esteem      |
| <input type="checkbox"/> emotional     | <input type="checkbox"/> mother         | <input type="checkbox"/> depression          | <input type="checkbox"/> lack personal hygiene |
| <input type="checkbox"/> behavior      | <input type="checkbox"/> siblings       | <input type="checkbox"/> poor concentration  | <input type="checkbox"/> being held back       |
| <input type="checkbox"/> relationships | <input type="checkbox"/> spouse         | <input type="checkbox"/> lack energy         | <input type="checkbox"/> hypersexual           |
| <input type="checkbox"/> school        | <input type="checkbox"/> girl/boyfriend | <input type="checkbox"/> withdrawal          | <input type="checkbox"/> decreased libido      |
| <input type="checkbox"/> work          | <input type="checkbox"/> boss           | <input type="checkbox"/> sleep problems      | <input type="checkbox"/> suicidal thoughts     |
| <input type="checkbox"/> church        | <input type="checkbox"/> coworker       | <input type="checkbox"/> lack interest to do | <input type="checkbox"/> homicidal thoughts    |

- |  |  |   |
|--|--|---|
| <b>Emotions:</b>                               | <b>Behaviors:</b>                              | <b>Other:</b>   |
| <input type="checkbox"/> excess anger          | <input type="checkbox"/> aggressive/violent    | <input type="checkbox"/> fear of dying                          |
| <input type="checkbox"/> fear of harm          | <input type="checkbox"/> inappropriate sexual  | <input type="checkbox"/> fear of going crazy                    |
| <input type="checkbox"/> fear of being watched | <input type="checkbox"/> antisocial            | <input type="checkbox"/> feeling that you are not real          |
| <input type="checkbox"/> grief                 | <input type="checkbox"/> substance abuse       | <input type="checkbox"/> feeling things around you are not real |
| <input type="checkbox"/> hopeless              | <input type="checkbox"/> self-mutilation       | <input type="checkbox"/> loss of time                           |
| <input type="checkbox"/> helpless              | <input type="checkbox"/> self-induced vomiting | <input type="checkbox"/> flashbacks                             |
| <input type="checkbox"/> low frustration       | <input type="checkbox"/> poor impulse control  | <input type="checkbox"/> difficulty trusting self/others        |
| <input type="checkbox"/> up and down           | <input type="checkbox"/> over/under eating     | <input type="checkbox"/> compulsive/obsessive                   |

**CHILD**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> temper outbursts     | <input type="checkbox"/> problems with authority/school | <input type="checkbox"/> strange behavior          |
| <input type="checkbox"/> unhappy              | <input type="checkbox"/> problems with authority/home   | <input type="checkbox"/> strange thoughts          |
| <input type="checkbox"/> daydreaming          | <input type="checkbox"/> problems with the law          | <input type="checkbox"/> school performance change |
| <input type="checkbox"/> clumsy               | <input type="checkbox"/> lying                          | <input type="checkbox"/> fearful                   |
| <input type="checkbox"/> overactive           | <input type="checkbox"/> truancy                        | <input type="checkbox"/> shy                       |
| <input type="checkbox"/> slow                 | <input type="checkbox"/> drug/alcohol use               | <input type="checkbox"/> soiling pants/bed wetting |
| <input type="checkbox"/> short attention span | <input type="checkbox"/> sexual trouble/problems        | <input type="checkbox"/> conflict with siblings    |
| <input type="checkbox"/> undependable         | <input type="checkbox"/> disobedient                    |  |
| <input type="checkbox"/> peer conflict        | <input type="checkbox"/> mean to others                 |  |
| <input type="checkbox"/> stubborn             | <input type="checkbox"/> lacks initiative               |  |

Do you desire to explain any of the above or note further symptoms that you are currently experiencing?

\_\_\_\_\_

\_\_\_\_\_



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

**MEDICAL HISTORY: (if you need more writing space for history, notebook paper is fine)**

Past mental health Outpatient treatment (date) \_\_\_\_\_ Provider \_\_\_\_\_

Duration \_\_\_\_\_ diagnosis/problem \_\_\_\_\_

Past Inpatient/Hospitalization treatment for mental health (date) \_\_\_\_\_ Provider \_\_\_\_\_

Duration \_\_\_\_\_ diagnosis/problem \_\_\_\_\_

Past suicide attempt(s) and date \_\_\_\_\_

Current Medication(s) dosage \_\_\_\_\_

Serious Illness/Surgery & date \_\_\_\_\_

Used the following for # of years: \_\_\_\_\_ cigarettes \_\_\_\_\_ alcohol \_\_\_\_\_ marijuana \_\_\_\_\_ cocaine/crack

(Female only) Year & #: \_\_\_\_\_ pregnancy \_\_\_\_\_ miscarriage(s) \_\_\_\_\_ abortion(s)

**FAMILY OF ORIGIN HISTORY:**

Diabetes: M/F/Bro/Sis

Depression: M/F/Bro/Sis

Downs Syndrome: M/F/Bro/Sis

Epilepsy: M/F/Bro/Sis

Migraines: M/F/Bro/Sis

Alcoholism/Drugs: M/F Bro/Sis

Allergies: M/F/Bro/Sis

Thyroid: M/F/Bro/Sis

Sleep Disorder: M/F/Bro/Sis

Seizures: M/F/Bro/Sis

Hearing: M/F/Bro/Sis

Mental Retardation: M/F/Bro/Sis

Anxiety: M/F/Bro/Sis

Vision: M/F/Bro/Sis

Panic Attacks: M/F/Bro/Sis

Eating Disorder: M/F/Bro/Sis

Cerebral Palsy: M/F/Bro/Sis

Hydrocephalus: M/F/Bro/Sis

Parents married at age M \_\_\_ F \_\_\_ # of BRO \_\_\_ # of SIS \_\_\_ My order in family 1,2,3,4,5,6,7,8,9

Current age of siblings \_\_\_\_\_

Describe M as you remember her growing up \_\_\_\_\_

Describe F as you remember him growing up \_\_\_\_\_

Describe relationship with BRO/SIS growing up \_\_\_\_\_

**MILITARY HISTORY:** M F Years? \_\_\_\_\_ Branch? \_\_\_\_\_ Retired? \_\_\_\_\_

**CLIENT MILITARY HISTORY:** Years? \_\_\_\_\_ Branch? \_\_\_\_\_ Retired? \_\_\_\_\_

**PAST/CURRENT CLIENT LEGAL HISTORY** (dates) court charges \_\_\_\_\_

pending \_\_\_\_\_ probation \_\_\_\_\_ jail \_\_\_\_\_ car accident(s) \_\_\_\_\_

divorce \_\_\_\_\_ bankruptcy \_\_\_\_\_

**CHILDHOOD DEVELOPMENT:** Did you experience any of the following and at what age?

nail biting \_\_\_\_\_ thumb sucking \_\_\_\_\_ bedwetting \_\_\_\_\_ soiling \_\_\_\_\_

truancy \_\_\_\_\_ stealing \_\_\_\_\_ fire setting \_\_\_\_\_ animal cruelty \_\_\_\_\_

alcohol use \_\_\_\_\_ drug use \_\_\_\_\_ running away \_\_\_\_\_ fighting \_\_\_\_\_

juvenile court \_\_\_\_\_ foster home \_\_\_\_\_

By whom & what age(s)? Emotional neglect \_\_\_\_\_ Physical abuse? \_\_\_\_\_

Sexual abuse \_\_\_\_\_ Rape \_\_\_\_\_

Acts of Nature or witness to trauma or violence? \_\_\_\_\_

Mother's pregnancy, any complications? \_\_\_\_\_



Was anger expressed in family explosive? Y N by M F other OR anger was repressed? Y N by M F other  
Explain \_\_\_\_\_

Was discipline expressed in family harsh? Y N by M F other OR discipline was fair? Y N by M F other  
Explain \_\_\_\_\_

Received emotional support from M? Y N F? Y N Other? \_\_\_\_\_  
Explain \_\_\_\_\_

Love was expressed by and whom? Hugging M F Kissing M F Kidding M F Verbally M F  
Gifts M F Explain \_\_\_\_\_

Was there a shortage of the following? Money Food Clothes Shelter  
Explain \_\_\_\_\_

**SCHOOL HISTORY:** Home town \_\_\_\_\_ repeated grade \_\_\_\_\_  
learning disabilities \_\_\_\_\_ behavior problems \_\_\_\_\_  
I enjoyed Jr. High: Y N I enjoyed High School: Y N I enjoyed college: Y N  
School activities \_\_\_\_\_  
Major/Special Training \_\_\_\_\_

**FINANCIAL/WORK HISTORY:** list any age & order of first job \_\_\_\_\_  
\_\_\_\_\_

Current financial status: poor \_\_\_\_\_ adequate \_\_\_\_\_ good \_\_\_\_\_  
Explain \_\_\_\_\_

**RELIGION/FAITH HISTORY:** Attended church as a child? Y N What denomination? \_\_\_\_\_  
With whom and how often? \_\_\_\_\_  
When did you stop attending or change? \_\_\_\_\_

**LEISURE/SOCIAL:** How did you spend time taking care of you during childhood and now?  
\_\_\_\_\_

**RELATIONSHIP HISTORY:** Age of first date \_\_\_\_ Did you date much prior to marriage Y N  
Age of first marriage \_\_\_\_ # of years dated prior to marriage \_\_\_\_ # of years married \_\_\_\_  
Reasons for divorce \_\_\_\_\_  
Age of second marriage \_\_\_\_ # of years dated prior to marriage \_\_\_\_ # of years married \_\_\_\_  
Reasons for divorce \_\_\_\_\_  
Age of third marriage \_\_\_\_ # of years dated prior to marriage \_\_\_\_ # of years married \_\_\_\_  
Reasons for divorce \_\_\_\_\_  
Age of fourth marriage \_\_\_\_ # of years dated prior to marriage \_\_\_\_ # of years married \_\_\_\_  
Reasons for divorce \_\_\_\_\_  
Current relationship is \_\_\_\_ good \_\_\_\_ satisfactory \_\_\_\_ poor Explain \_\_\_\_\_

Sexual satisfaction is \_\_\_\_ good \_\_\_\_ satisfactory \_\_\_\_ poor Explain \_\_\_\_\_

Past or current extra-marital affairs (when and how long)? \_\_\_\_\_  
Explain \_\_\_\_\_

Domestic violence problems? Y N Explain \_\_\_\_\_

**CURRENT HOUSEHOLD INCLUDES:** (name, age and relationship to you)

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**Appendix 1: The Mood Disorder Questionnaire**

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

| 1. | Has there ever been a period of time when you were not your usual self and...   | YES                      | NO                       |
|----|---|--------------------------|--------------------------|
|    | _____   |                          |                          |
|    | ... you felt so good or hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were so irritable that you shouted at people or started fights or arguments?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you felt much more self-confident than usual?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you got much less sleep than usual and found you didn't really miss it?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were much more talkative or spoke faster than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... thoughts raced through your head or you couldn't slow down your mind?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were so easily distracted by things around you that you had trouble concentrating or staying on track?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ...you had much more energy than usual?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were much more active or did more things than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?   | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you were much more interested in sex than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?  | <input type="checkbox"/> | <input type="checkbox"/> |
|    | ... spending money got you or your family into trouble?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | If you checked YES to more than one of the above, have several of these ever happened during the same period of time?   |                          |                          |
| 3. | How much of a problem did any of these ever cause you? Ex: Being unable to work, having family, money or legal troubles, getting into arguments or fights.<br><i>Please circle only one response.</i><br>No problem    Minor problem    Moderate problem    Serious problem |                          |                          |



Name \_\_\_\_\_ Date \_\_\_\_\_

Please take a few minutes to complete the following statements. The answers may help your therapist better understand your health. This questionnaire offers you choices. There are no right or wrong answers. Simply check the circle next to the choice that best describes the way you felt **during the past week**. Take as long as you would like to give the most honest answer.

|   | None or<br>a little<br>of the<br>time | Some of<br>the time   | Good part<br>of the<br>time | Most or<br>all of the<br>time |
|---|---------------------------------------|-----------------------|-----------------------------|-------------------------------|
| 1. I feel more nervous and anxious than usual.                        | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 2. I feel afraid for no reason at all.                                | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 3. I get easily upset or feel panicky.                                | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 4. I feel like I'm falling apart or going to pieces.                  | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 5. I feel like everything is all right and nothing bad will happen. * | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 6. My arms and legs shake and tremble.                                | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 7. I am bothered by headaches, neck and back pains.                   | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 8. I feel weak and get tired easily.                                  | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 9. I feel calm and can sit still easily. *                            | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 10. I can feel my heart beating fast.                                 | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 11. I am bothered by dizzy spells.                                    | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 12. I have fainting spells or feel faint.                             | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 13. I can breathe in and out easily. *                                | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 14. I get feelings of numbness and tingling in my fingers and toes.   | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 15. I am bothered by stomachaches or indigestion.                     | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 16. I have to empty my bladder often.                                 | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 17. My hands are usually dry and warm. *                              | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 18. My face gets hot and blushes.                                     | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 19. I fall asleep easily and get a good night's rest.                 | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |
| 20. I have nightmares.  | <input type="radio"/>                 | <input type="radio"/> | <input type="radio"/>       | <input type="radio"/>         |

Name \_\_\_\_\_ Date \_\_\_\_\_

| Please check a response for each of the 20 items.                       | None OR a little of the time | Some of the time        | Good part of the time   | Most OR all of the time |  |
|---|------------------------------|-------------------------|-------------------------|-------------------------|--|
| 1. I feel downhearted, blue and sad.                                    | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 2. Morning is when I feel the best.                                     | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 3. I have crying spells or feel like it.                                | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 4. I have trouble sleeping through the night.                           | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 5. I eat as much as I used to.  | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 6. I enjoy looking at, talking to, and being with attractive women/men. | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 7. I notice that I am losing weight.                                    | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 8. I have trouble with constipation.                                    | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 9. My heart beats faster than usual.                                    | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 10. I get tired for no reason.  | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 11. My mind is as clear as it used to be.                               | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 12. I find it easy to do the things I used to do.                       | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 13. I am restless and can't keep still.                                 | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 14. I feel hopeful about the future.                                    | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 15. I am more irritable than usual.                                     | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 |  |
| 16. I find it easy to make decisions.                                   | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 17. I feel that I am useful and needed.                                 | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 18. My life is pretty full.   | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| 19. I feel that others would be better off if I were dead.              | <input type="radio"/> 1      | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 1 |  |
| 20. I still enjoy the things I used to.                                 | <input type="radio"/> 4      | <input type="radio"/> 3 | <input type="radio"/> 2 | <input type="radio"/> 1 |  |
| RAW SCORE   |                              |                         |                         |                         |  |
| SDS INDEX   |                              |                         |                         |                         |  |