Twin Oaks
HEALTH SOLUTIONS

Steps for your appointment:

1) Please fill out all New Patient forms in their entirety.

2) If you have any recent labs (within 12 months), please bring them to your appointment.

3) If you are married or in a relationship, *please bring your spouse or significant other* with you to your appointment.
(There will be lots of information covered concerning your unique condition as well as the fundamentals of the program.)

4) Please arrive on time.

5) We require a 24-hour notice to change or cancel your appointment.

6) Please return this New Patient Packet to Twin Oaks Health Solutions *at least 24 hours before your appointment*. This allows Dr. Sauer time to review your information.

Note: *If these steps are not followed it may compromise the full value of your consultation and therefore we will kindly reschedule your appointment.*

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Fargo, ND 58104

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Clinic directions

Heading South from I-29

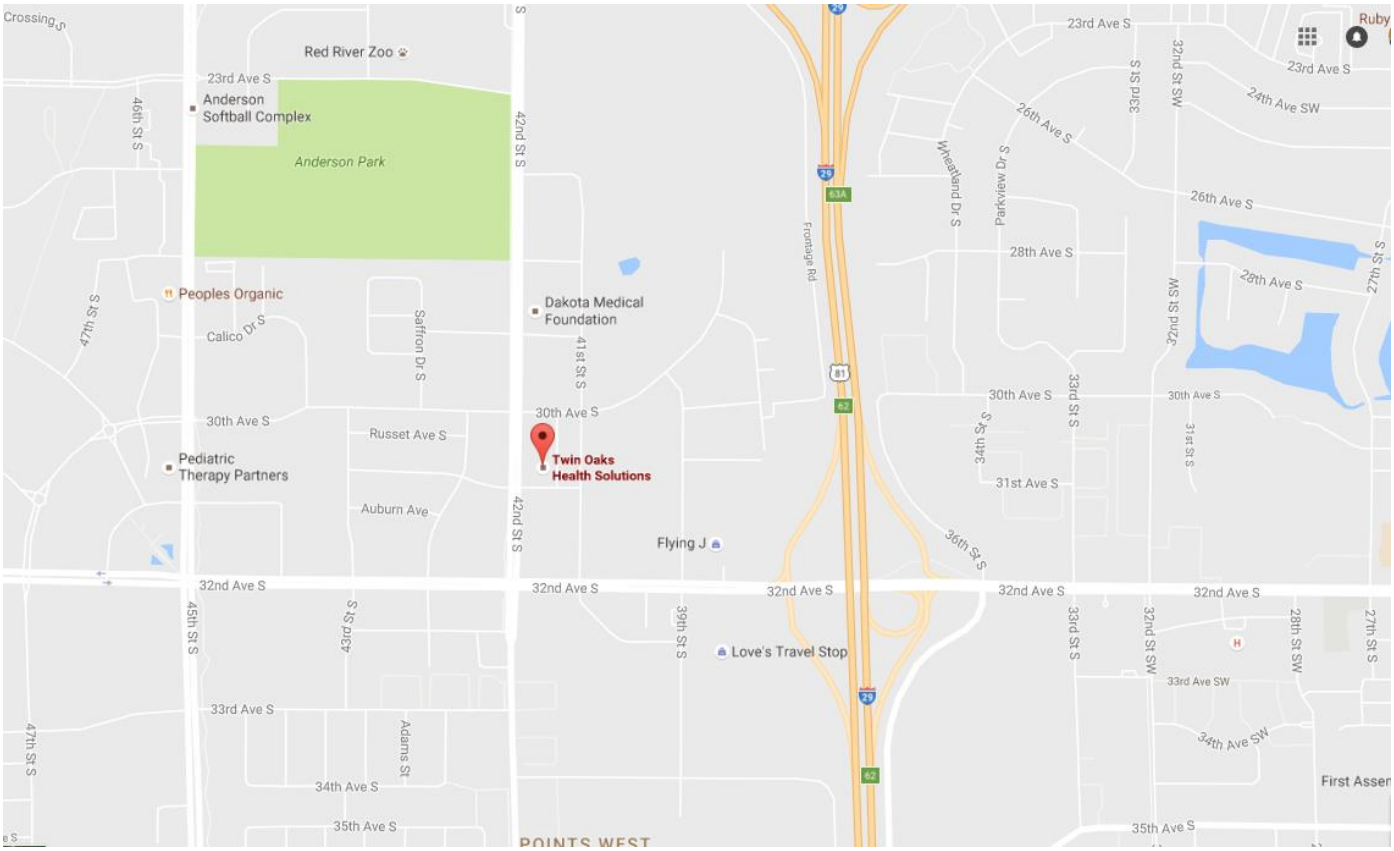
Head south on I-29 S
Use the right lane to take exit 62 for 32nd Avenue South E/32nd Avenue South W
Turn right onto 32nd Ave S (signs for 32nd Avenue South W)
Turn right onto 42nd St SW
Turn right at the 1st cross street onto 31st Ave S
Turn left into parking lot.

Heading North from I-29

Head north on I-29 N
Take exit 62 for 32nd Ave S
Turn left onto 32nd Ave S
Turn right onto 42nd St SW
Turn right at the 1st cross street onto 31st Ave
Turn left into parking lot.

Heading East (From 32nd Avenue)

Head east on 32nd Ave S toward 31st Ave S
Turn left onto 42nd St SW
Turn right at the 1st cross street onto 31st Ave
Turn left into parking lot.



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Acknowledgement of Receipt
Of
Notice of Privacy Practices

I, _____ have received a copy of
(Name of Patient)

Twin Oaks Health Solutions, Wellness Notice of Privacy Practice

_____
(Signature of Patient or Guardian)

_____
Staff Will Fill Out Section if Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situation kept us from obtaining the patient's signature.

_____ Language barriers kept us from obtaining the patient's signature.

_____ Other:
_____

_____

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HIPAA FORM

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to Dr. Forrest Sauer or Twin Oaks Health Solutions, LLC.

I consent to the use or disclosure of my protected health information by the Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of the Chiropractor. I understand that analysis, diagnosis or treatment of me by the Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. The Chiropractor is not required to agree to the restrictions that I may request. However, if the Chiropractor agrees to a restriction that I request, the restriction is binding on the Chiropractor.

I have the right to revoke this consent, in writing, at any time, except that the Chiropractor has taken action in reliance on this Consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. The protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of the Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Chiropractor. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

The Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of the Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____
Printed Name of Patient

_____ _____/_____/_____
Signature of Patient or Personal Representative Date of Signing

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Pre-Exam Questions or Concerns

Please check the following that most relate to your situation:

1. **The following best describes my current motivation in being proactive toward resolving my condition(s):**

_____ I am motivated and ready to make positive lifestyle changes.
_____ I am ready, but need more information concerning:
  _____ Time constraints
  _____ Financial constraints
  _____ Motivation
  _____ Other
_____ I am unable to move forward at this time due to:_____

2. **How would you describe your family support:**

_____ My spouse fully supports me and my decision concerning a lifestyle program.
_____ My spouse is not really involved, but wants me to get the help I need.
_____ My spouse needs more information to be supportive.
_____ I am single, but do have a support system with friends.
_____ I am single and do not have a support system.

Note: Prior to your Report of Findings, we do all we can to educate you about your case, as well as the protocols and procedures to be used toward helping you achieve your health and wellness goals. As a courtesy to us, please discuss any issues concerning finances and/or time with your significant other and plan in accordance to enable your decision to move forward on your Report of Findings visit.

3. **Please list any other concerns you may have so that we may be able to help you achieve your goals:**

_____
_____
_____
_____

Thank you for your honest responses, as they will help us help you!

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Patient Introduction

Personal Information:

Your Name: _____ ☐ Male ☐ Female

Birth Date: _____/_____/_____ SS #_____-_____-_____

Street Address: _____Unit/Apt:_____

City:_____State: _____Zip: _____

Phone Home:_____ Bus/Cell: _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Occupation: _____

Employer: _____

Current MD: _____

How did you hear about us? _____

Emergency Contact Information:

Contact Name: _____ Phone:_____

Relationship to Patient:_____

Initial Consultation

Main Complaints: (In order of importance)

1) _____ 2) _____

3) _____ 4) _____

How long have you suffered with this problem? _____

Any other complaints: _____

_____

Medications? If you are currently taking any, please list them. (If more than 12, please continue on the back of this form)

1._____	5. _____	9. _____
2. _____	6. _____	10. _____
3. _____	7. _____	11. _____
4. _____	8. _____	12. _____

Herbs or Nutritional Supplements? If you are currently taking any, please list them. (If more than 9 please continue on the back of this form.)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6._____	9. _____

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How many alcoholic beverages do you consume per week?_____

How many Caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

List three worst foods you eat during the average week:

_____ _____ _____

List the three healthiest foods you eat during the average week:

_____ _____ _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

Would you like improvement with any of the following?

☐ Digestion: Reflux, Gas, Constipation, Diarrhea
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well-Being
☐ Energy

What have you tried doing to resolve this problem that <u>Did Not</u> work?

_____

_____

Have you become discouraged or stressed about handling this problem?

_____

_____

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____

Family: _____

Hobbies: _____

Life: _____

When it's at it's worst, how much older does this make you feel?

_____

Do you know how this problem may have started? _____

_____

What effect does this have on your body functions? _____

_____

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Are you here visiting us to:

a) Resolve my immediate problem
b) Life style program for optimized living
c) Both
d) Other: _____

How have you taken care of your health in the past?

☐ Medications
☐ Routine medical
☐ Exercise
☐ Diet and Nutrition
☐ Holistic
☐ Vitamins
☐ Chiropractic
☐ Other: _____

How did the previous methods work for you? _____

_____

Without changing your health, what areas in your life do you see it impacting?

☐ Job
☐ Kids
☐ Marriage
☐ Sleep
☐ Freedom
☐ Future abilities
☐ Finances
☐ Time

Are there any health conditions you are afraid this might turn into?

☐ Diminished Future abilities
☐ Stress
☐ Weight gain
☐ Heart disease
☐ Depression
☐ Surgery
☐ Arthritis
☐ Cancer
☐ Diabetes
Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific: _____

_____

_____

What would be different or better without this problem?

☐ Diminished stress
☐ More energy
☐ Self esteem
☐ Confidence
☐ Sleep
☐ Work
☐ Outlook
☐ Family

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If we were to sit down and discuss your life <u>3 years</u> from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____

_____

_____

_____

What potential barriers do you foresee that would prevent these things from happening?

_____

_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____

_____

What are your strengths that will enable you to accomplish your goals?

_____

_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?

_____ Do you feel that you are coachable and would enjoy a mentor in helping you?

_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

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Family Health History

Please review the conditions listed below and indicate those that are **current health problems** of a family member by the designation **C** under his or her column. The designation **P** should be used to indicate a **past problem**. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Children		
Allergies						
Anxiety						
Asthma						
ADHD						
Back trouble						
Bed wetting						
Cancer						
Colic						
Constipation						
Depression						
Diabetes						
Disc problems						
Ear infections						
Emotional issues						
Emphysema						
Epilepsy						
Headaches						
Heart trouble						
Heart burn						
High blood pressure						
IBS						
Indigestion						
Infertility						
Insomnia						
Kidney trouble						
Neck pain						
Nervousness						
Obesity						
Pinched nerve						
Scoliosis						
Sinus trouble						
Other						

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Metabolic/Neurologic Assessment Form

Please circle the appropriate number on all questions below.
0 as the least/never to 3 as the most/always.

Category I *CH*

Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relieved by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard, dry, or small stool	**0**	**1**	**2**	**3**
Coated tongue or "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul-smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Use laxatives frequently	**0**	**1**	**2**	**3**

Category III CT

Intolerance to smells	**0**	**1**	**2**	**3**
Intolerance to jewelry	**0**	**1**	**2**	**3**
Intolerance to shampoo, lotion, detergents, etc.	**0**	**1**	**2**	**3**
Multiple smell and chemical sensitivities	**0**	**1**	**2**	**3**
Constant skin outbreaks	**0**	**1**	**2**	**3**

Category V

Stomach pain, burning, or aching 1-4 hours after eating	**0**	**1**	**2**	**3**
Feel hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief by using antacids, food, milk, or carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	**0**	**1**	**2**	**3**
Use of antacids	**0**	**1**	**2**	**3**

Category VII BI

Greasy or high-fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and/or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Burpy, fishy taste after consuming fish oils	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**

Category II Int Int

Increasing frequency of food reactions	**0**	**1**	**2**	**3**
Unpredictable food reactions	**0**	**1**	**2**	**3**
Aches, pains, and swelling throughout the body	**0**	**1**	**2**	**3**
Unpredictable abdominal swelling	**0**	**1**	**2**	**3**
Frequent bloating and distention after eating	**0**	**1**	**2**	**3**
Abdominal intolerance to sugars and starches	**0**	**1**	**2**	**3**

Category IV St

Excessive belching, burping, or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested food found in stools	**0**	**1**	**2**	**3**

Category VI SI

Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness last 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**

Category VIII Hep

Acne and unhealthy skin	**0**	**1**	**2**	**3**
Excessive hair loss	**0**	**1**	**2**	**3**
Overall sense of bloating	**0**	**1**	**2**	**3**
Bodily swelling for no reason	**0**	**1**	**2**	**3**
Hormone imbalances	**0**	**1**	**2**	**3**
Weight gain	**0**	**1**	**2**	**3**
Poor bowel function	**0**	**1**	**2**	**3**
Excessively foul-smelling sweat	**0**	**1**	**2**	**3**
Fatigue after meals	**0**	**1**	**2**	**3**

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Stool color alternates from clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed?	**Yes / No**			

Category IX SM

Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep going/get started	**0**	**1**	**2**	**3**
Get light-headed if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, or have tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory/forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**

Category XI AF

Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**

Category XIII pH

Edema and swelling in ankles and wrists	**0**	**1**	**2**	**3**
Muscle cramping	**0**	**1**	**2**	**3**
Poor muscle endurance	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Frequent thirst	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Abnormal sweating from minimal activity	**0**	**1**	**2**	**3**
Alteration in bowel regularity	**0**	**1**	**2**	**3**
Inability to hold breath for long periods	**0**	**1**	**2**	**3**
Shallow, rapid breathing	**0**	**1**	**2**	**3**

Category XV HT

Heart palpitations	**0**	**1**	**2**	**3**
Inward trembling	**0**	**1**	**2**	**3**
Increased pulse even at rest	**0**	**1**	**2**	**3**
Nervous and emotional	**0**	**1**	**2**	**3**
Insomnia	**0**	**1**	**2**	**3**
Night sweats	**0**	**1**	**2**	**3**
Difficulty gaining weight	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category XII AH

Cannot fall asleep	**0**	**1**	**2**	**3**
Perspire easily	**0**	**1**	**2**	**3**
Under a high amount of stress	**0**	**1**	**2**	**3**
Weight gain when under stress	**0**	**1**	**2**	**3**
Wake up tired even after 6 or more hours of sleep	**0**	**1**	**2**	**3**
Excessive perspiration or perspiration with little or no activity	**0**	**1**	**2**	**3**

Category XIV HOT

Tired/sluggish	**0**	**1**	**2**	**3**
Feel cold—hands, feet all over	**0**	**1**	**2**	**3**
Require excessive amounts of sleep to function properly	**0**	**1**	**2**	**3**
Increase in weight even with low-calorie diet	**0**	**1**	**2**	**3**
Gain weight easily	**0**	**1**	**2**	**3**
Difficult, infrequent bowel movements	**0**	**1**	**2**	**3**
Depression/lack of motivation	**0**	**1**	**2**	**3**
Morning headaches that wear off as the day progresses	**0**	**1**	**2**	**3**
Outer third of eyebrow thins	**0**	**1**	**2**	**3**
Thinning of hair on scalp, face, or genitals, or excessive hair loss	**0**	**1**	**2**	**3**
Dryness of skin and/or scalp	**0**	**1**	**2**	**3**
Mental sluggishness	**0**	**1**	**2**	**3**

Category XVI *(Males Only)* PS

Urination difficulty or dribbling	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Pain inside of legs or heels	**0**	**1**	**2**	**3**
Feeling of incomplete bowel emptying	**0**	**1**	**2**	**3**
Leg twitching at night	**0**	**1**	**2**	**3**

Category XVII *(Males Only)*

Decreased libido	**0**	**1**	**2**	**3**
Decreased number of morning erections	**0**	**1**	**2**	**3**
Decreased fullness of erections	**0**	**1**	**2**	**3**
Difficulty maintaining morning erections	**0**	**1**	**2**	**3**
Spells of mental fatigue	**0**	**1**	**2**	**3**
Inability to concentrate	**0**	**1**	**2**	**3**
Episodes of depression	**0**	**1**	**2**	**3**
Muscle soreness	**0**	**1**	**2**	**3**
Decreased physical stamina	**0**	**1**	**2**	**3**

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Category XVIII *(Menstruating Females Only)*

Perimenopausal	**Yes / No**
Alternating menstrual cycle lengths	**Yes / No**
Extended menstrual cycle (greater than 32 days)	**Yes / No**
Shortened menstrual cycle (less that 24 days)	**Yes / No**
Pain and cramping during periods	**0 1 2 3**
Scanty blood flow	**0 1 2 3**
Heavy blood flow	**0 1 2 3**
Breast pain and swelling during menses	**0 1 2 3**
Pelvic pain during menses	**0 1 2 3**
Irritable and depressed during menses	**0 1 2 3**
Acne	**0 1 2 3**
Facial hair growth	**0 1 2 3**
Hair loss/thinning	**0 1 2 3**

Section A BF

Is your memory noticeably declining?	**0 1 2 3**
Are you having a hard time remembering names and phone numbers?	**0 1 2 3**
Is your ability to focus noticeably declining?	**0 1 2 3**
Has it become harder for you to learn new things?	**0 1 2 3**
How often do you have a hard time remembering your appointments?	**0 1 2 3**
Is your temperament generally getting worse?	**0 1 2 3**
Is your attention span decreasing?	**0 1 2 3**
How often do you find yourself down or sad?	**0 1 2 3**
How often do you become fatigued when driving compared to in the past?	**0 1 2 3**
How often do you become fatigued when reading compared to in the past?	**0 1 2 3**
How often do you walk into rooms and forget why?	**0 1 2 3**
How often do you pick up your cell phone and forget why?	**0 1 2 3**

Section C SM

Section C1

How often do you get irritable, shaky, or have light-headedness between meals?	**0 1 2 3**
How often do you feel energized after eating?	**0 1 2 3**
How often do you have difficulty eating large meals in the morning?	**0 1 2 3**
How often does your energy level drop in the afternoon?	**0 1 2 3**
How often do you crave sugar and sweets in the afternoon?	**0 1 2 3**
How often do you wake up in the middle of the night?	**0 1 2 3**
Unexplained weight gain	**0 1 2 3**
Increase in fat distribution around chest and hips	**0 1 2 3**
Sweating attacks	**0 1 2 3**
More emotional than in the past	**0 1 2 3**

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal?	**____Years**
Since menopause, do you ever have uterine bleeding?	**Yes / No**
Hot flashes	**0 1 2 3**
Mental fogginess	**0 1 2 3**
Disinterest in sex	**0 1 2 3**
Mood swings	**0 1 2 3**
Depression	**0 1 2 3**
Painful intercourse	**0 1 2 3**
Shrinking breasts	**0 1 2 3**
Acne	**0 1 2 3**
Increased vaginal pain, dryness, or itching	**0 1 2 3**

Section B St

How high is your stress level?	**0 1 2 3**
How often do you feel you have something that must be done?	**0 1 2 3**
Do you feel you never have time for yourself?	**0 1 2 3**
How often do you feel you are not getting enough sleep or rest?	**0 1 2 3**
Do you find it difficult to get regular exercise?	**0 1 2 3**
Do you feel uncared for by the people in your life?	**0 1 2 3**
Do you feel you are not accomplishing your life's purpose?	**0 1 2 3**
Is sharing your problems with someone difficult for you?	**0 1 2 3**

Section 1 St

Are you losing interest in hobbies?	**0 1 2 3**
How often do you feel overwhelmed?	**0 1 2 3**
How often do you have feelings of inner rage?	**0 1 2 3**
How often do you have feelings of paranoia?	**0 1 2 3**
How often do you feel sad or down for no reason?	**0 1 2 3**
How often do you feel like you are not enjoying life?	**0 1 2 3**
How often do you feel you lack artistic appreciation?	**0 1 2 3**
How often do you feel depressed in overcast weather?	**0 1 2 3**
How much are you losing your enthusiasm for your favorite activities?	**0 1 2 3**

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How often do you have difficulty concentrating before eating?	**0 1 2 3**
How often do you depend on coffee to keep yourself going?	**0 1 2 3**
How often do you feel agitated, easily upset, and nervous between meals?	**0 1 2 3**
How often do you get fatigued after meals?	**0 1 2 3**
How often do you crave sugar and sweets after meals?	**0 1 2 3**
How often do you feel you need stimulants, such as coffee, after meals?	**0 1 2 3**
Section C2 Per SM	**0 1 2 3**
How often do you have difficulty losing weight?	**0 1 2 3**
How much larger is your waist girth compared to your hip girth?	**0 1 2 3**
How often do you urinate?	**0 1 2 3**
Have your thirst and appetite increased?	**0 1 2 3**
How often do you gain weight when under stress?	**0 1 2 3**
How often do you have difficulty falling asleep?	**0 1 2 3**

Section 3 GABA **0 1 2 3**

How often do you feel anxious or panicked for no reason?	**0 1 2 3**
How often do you have feelings of dread or impending doom?	**0 1 2 3**
How often do you feel knots in your stomach?	**0 1 2 3**
How often do you have feelings of being overwhelmed for no reason?	**0 1 2 3**
How often do you have feelings of guilt about everyday decisions?	**0 1 2 3**
How often does your mind feel restless?	**0 1 2 3**
How difficult is it to turn your mind off when you want to relax?	**0 1 2 3**
How often do you have disorganized attention?	**0 1 2 3**
How often do you worry about things you were not worried about before?	**0 1 2 3**

How much are you losing your enjoyment for your favorite foods?	**0 1 2 3**
How much are you losing your enjoyment of friendships and relationships?	**0 1 2 3**
How often do you have difficulty falling into deep, restful sleep?	**0 1 2 3**
How often do you have feelings of dependency on others?	**0 1 2 3**
How often do you feel more susceptible to pain?	**0 1 2 3**
How often do you have feelings of unprovoked anger?	**0 1 2 3**
How much are you losing interest in life?	**0 1 2 3**

Section 2 Dp

How often do you have feelings of hopelessness?	**0 1 2 3**
How often do you have self-destructive thoughts?	**0 1 2 3**
How often do you have an inability to handle stress?	**0 1 2 3**
How often do you have anger and aggression while under stress?	**0 1 2 3**
How often do you feel you are not rested, even after long hours of sleep?	**0 1 2 3**
How often do you prefer to isolate yourself from others?	**0 1 2 3**
How often do you have unexplained lack of concern for family and friends?	**0 1 2 3**
How easily are you distracted from your tasks?	**0 1 2 3**
How often do you have an inability to finish tasks?	**0 1 2 3**
How often do you feel the need to consume caffeine to stay alert?	**0 1 2 3**
How often do you feel your libido has been decreased?	**0 1 2 3**
How often do you lose your temper for minor reasons?	**0 1 2 3**
How often do you have feelings of worthlessness?	**0 1 2 3**

Section 4 Ach

Do you feel your visual memory (shapes & images) has decreased?	**0 1 2 3**
Do you feel your verbal memory has decreased?	**0 1 2 3**
Do you have memory lapses?	**0 1 2 3**
Has your creativity decreased?	**0 1 2 3**
Are you experiencing excessive urination?	**0 1 2 3**
Has your comprehension diminished?	**0 1 2 3**
Do you have difficulty calculating numbers?	**0 1 2 3**
Do you have difficulty recognizing objects & faces?	**0 1 2 3**
Do you feel like your opinion about yourself has changed?	**0 1 2 3**

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