PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

For Office Use Only:

Medical Records # _____ Form received by (Coordinator):

Please Fill in Completely: Some of the information requested/questions on the form may seem irrelevant and/or intrusive. However, the information requested on this form is relevant to understand the underlying reasons that might have contributed to mental health issues and to enable us to provide the necessary services. We request you to help us to help you.

Who are you seeing? _____ Date and time of Appointment_____

Practice Location: ☐ Annapolis ☐ Baltimore ☐ Columbia ☐ Gaithersburg ☐ Towson

DEMOGRAPHIC INFORMATION

Patient Name: First _____ MI _____ Last _____ Suffix _____

Date of Birth: ____/____/_____ Age: _____

Gender: ☐ Male ☐ Female

Ethnicity: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Caucasian ☐ Hispanic/Latino
☐ Multi-ethnic ☐ Native Hawaiian/Pacific Islander ☐ Other

Religious Affiliation: ☐ Buddhism ☐ Christianity ☐ Hinduism ☐ Islam ☐ Judaism ☐ Mormonism ☐ None
☐ Others_____

Occupation _____ Highest level of education_____

Are you currently on disability or SSI? ☐ No ☐ Yes if yes, please specify_____

Have ever had legal problems? ☐ No ☐ Yes If yes, please specify_____

Relationship/Marital Status: ☐ Single ☐ Married ☐Divorced ☐Widowed ☐ In a relationship ☐ Other

Current house living situation: ☐ With Significant other ☐ With significant other and kids
☐ With Parents ☐ Alone ☐ Dorm / Shared apartment ☐ Group/Foster/Community home

Family structure when growing up: ☐ Intact Parents ☐ Single parent- Mother ☐ Single parent- Father
☐ Grand Parents ☐ Extended Family ☐ Group/Foster/Community home ☐ Other_____

Where were you born and raised? _____

Were there any problems with your birth? ☐ No ☐ Yes if yes, please specify_____

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

CONTACT INFORMATION

Patient Name: First _____ MI _____ Last _____ Suffix _____

Address Line 1: _____ Line 2: _____

City: _____ St: _____ Zip: _____

Phone: Cell _____ Work: _____ Home: _____

Email: _____

Emergency Contact:

Name: _____ Relationship: _____

Address:_____

Phone: _____ Email: _____

PAYER INFORMATION

Is the payer EAP? ☐ No ☐ Yes If yes, Company name: _____

Authorization number: _____ Effective Date: _____

Is this for workman's Comp? ☐ No ☐ Yes
Is this for legal Case? ☐ No ☐ Yes
Is this for Disability? ☐ No ☐ Yes
Are you self-pay (not using insurance)? ☐ No ☐Yes

If using INSURANCE, please fill in the following section completely. **Please provide insurance card and Photo ID. Please ask for additional form if more than 1 insurance. If not using Insurance Please bring Photo ID.**

Insurance Company Name _____ Phone _____

Member ID# _____ Group # _____

Policyholder's Name _____ SS# _____ Birthday _____

Relationship to Patient ☐ SELF ☐ SPOUSE ☐ PARENT ☐ OTHER (specify) _____

Policyholder's Employer _____ Policyholder's Gender ☐ Male ☐ Female

NEW PATIENT INTAKE FORM

ACCESS TO APPOINTMENT AND ACCOUNT INFORMATION

Patient Name: _____ Birthdate: ____/____/_____

(Leave this section blank if you do not wish to give permission for access to your appointment or account information. No verbal requests will be accepted for this per HIPAA regulation).

I give permission to share my appointment and account information for a period of 1 (one) year to the following person(s). I may withdraw said permission at any time in writing.

Name & Relationship: _____ Phone _____

Name & Relationship: _____ Phone _____

_____ _____

Patient signature

Signature of parent / guardian responsible for minor child or dependent adult

Date: ____/____/_____

PLEASE READ EACH ITEM BELOW CAREFULLY AND THEN SIGN THIS DOCUMENT.

I understand that I am responsible for my entire fee. I authorize Psych Associates of Maryland, LLC to bill my Insurance company directly and receive compensations for services rendered.

As some Insurance Companies may require preauthorization, I will call my Insurance Company to inform them of my choice to utilize services from Psych Associates of Maryland, LLC.

Payment of Deductibles and/or Copay/Coinsurance is expected at the time of service. In the event that my account becomes delinquent and is forwarded to an attorney for collection, I am responsible for the attorney fees and all court costs.

I will be responsible for full payment of the missed appointment fee when 24 hours' notice is not given for cancellation.

I authorize Psych Associates of Maryland, LLC to send treatment plans to my Insurance Company and exchange information when it pertains to my treatment.

I understand that Psych Associates of Maryland, LLC is an independent practitioners' group. I give my full consent to the Physicians, Psychologists, Social Workers, Psychotherapist, Nurse Practitioners and Physician Assistants within the group to exchange information to facilitate treatment.

I give permission for Psych Associates of Maryland and its employees, independent contractors to give me medical treatment.

I understand that I can revoke this consent at any time with written notice.

I have received copies of all documents I signed today as part of the registration procedure.

_____ _____

Patient signature

Signature of parent / guardian responsible for minor child or dependent adult

Date: ____/____/_____

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

HEALTH CARE PROVIDERS / TEAM INFORMATION

PRIMARY CARE PHYSICIAN (PCP) ☐ **I currently do not have a PCP**

Name: _____ license type:_____

Address:_____

Phone: _____ Email: _____

PSYCHIATRIST – Leave blank if none ☐ **I currently do not have a psychiatrist**

Name: _____ license type:_____

Address:_____

Phone: _____ Email: _____

THERAPIST (Counsellor) - Leave blank if none ☐ **I currently do not have a Therapist/counsellor**

Name: _____ license type: _____

Address:_____

Phone: _____ Email: _____

How long have you been seeing this provider? _____

OTHERS – If any

Name: _____ license type: _____

Address:_____

Phone: _____ Email: _____

How did you hear about us? ☐ PCP ☐ Psychiatrist ☐ Therapist ☐ Other_____

Pharmacy Name and Address: _____Phone: _____ Fax: _____

I,_____, authorize Psych Associates of Maryland to release a summary of my visit and treatment plan to the following selected member(s) of my care team periodically and also as needed from time to time to keep them appraised of my behavioral health status and treatment plan which helps with coordination of my care. I understand that I can revoke this authorization at any time by giving a written request.

Please select all that apply ☐ PCP ☐ Psychiatrist ☐ Therapist ☐ Others

_____ _____

Patient signature

Signature of parent / guardian responsible for minor child or dependent adult

Date: ____/____/_____

NEW PATIENT INTAKE FORM

POLICIES

Missed Appointments

Please be advised that Psych Associates of Maryland has a missed appointment policy that is strictly enforced. The missed appointment charge is $100.

We require that you contact our offices 24 hours in advance during the business week to cancel your appointment if need be. If you are scheduled with a physician, you should call the receptionist, and if you are scheduled with a therapist you should contact them directly.

Prior to your next appointment, this fee must be paid

Medication Refill Requests

At the time of your appointment with the doctor, please schedule your follow-up visit according to the amount of medication your doctor has prescribed. We will try to remind you make an appointment. But It is your responsibility to be sure you schedule your next visit so that you see the doctor before you run out of medication.

We do not authorize refill requests via telephone nor via fax from your pharmacy. It is imperative that you keep your scheduled appointments.

Privacy in Our Offices

For the protection of our patients and staff, any activity that may be considered an invasion of privacy while in our offices will result in discharge of the offender from our practice. These activities include, but are not limited to, photography, recording of conversations, or similar behavior. Charges will be pressed against the offender to the fullest extent of the law.

I, _____, have read and understand the policies for Missed Appointments, Medication refills, and Privacy in our offices.

_____ _____

Patient signature

Signature of parent / guardian responsible for minor child or dependent adult

Date: ____/____/_____

NEW PATIENT INTAKE FORM

FINANCIAL POLICY

Full payment of your financial responsibility is due at the time of service. We accept cash, some credit cards and checks with a valid driver's license.

If your insurance policy requires preauthorization for a service and you do not have that authorization information, you will be responsible for payment of the full fee at the time of service. If your insurance denies a claim because there is no initial authorization, you are responsible for payment of the entire fee.

Because of our contracts with insurance companies, we are unable to provide service without charging you the portion for which you are responsible.

All overpayments are credited to your account. They will be held and applied as needed until all services have been paid in full. Remaining overpayments will be applied against future services, unless the overpayment is at least $20.00 and you request reimbursement.

I have read, understand and agree to this financial policy, including those sections in the "Patient Information Packet" which are pertinent.

_____ _____/_____/_____

Signature of person responsible for payment Date

NEW PATIENT INTAKE FORM

CONTROLLED SUBSTANCE USE AGREEMENT

I_____, understand that I/my dependent may be diagnosed with or treated for a medical condition that requires use of controlled substance medication(s) (benzodiazepines, stimulants, etc.) because this medical condition has not been adequately managed with non-controlled medications and my function is limited by this medical condition. I understand that the intent of this medication is to increase my/my dependent's ability to function, though the controlled substance medication is unlikely to eliminate my/ my dependent's condition.

I/my dependent will take the medication only as prescribed. I/my dependent will not take any additional sedatives, alcohol or other pain medications without the prior approval of my provider.

I/my dependent understand that the medication will be prescribed only according to the agreed upon schedule. Prescriptions will be provided only during regular business hours. Medications will not be called in to the pharmacy.

I/my dependent will not seek or accept any additional controlled substance medications (i.e. pain, anxiety or stimulants) other than those prescribed by my provider. This includes prescriptions from other providers, medications borrowed or accepted from family or friends and any illicit or street drugs.

Medication refills will be provided as written prescriptions only. No refills will be given prior to 30 days. I understand that I must make appointments with my provider at least every (3) months or sooner if my provider recommends. No refills will be given if I do not keep these appointments. Two (2) no show appointments will constitute grounds for immediate dismissal from the practice.

I understand that my provider is under no obligation to provide these medications to me, and that he/she reserves the right to discontinue these medications at any time. If I refuse, I understand the medications will be stopped.

I understand that lost or stolen medications will not be refilled under any circumstances. It is my responsibility to protect and secure my medications. This includes keeping the medication out of reach of children. A copy of a police report will be required for any lost or stolen controlled substance prescriptions.

I understand that my provider may request specialist evaluation of my treatment and I agree to keep appointments. My provider will send a copy of my medical record and care to the referred physician.

I understand that my provider by law is required to report all controlled substances dispensed to me to the state monitored prescription monitoring program.

_____ _____

Patient signature

Signature of parent / guardian responsible for minor child or dependent adult

Date: ____/____/_____

NEW PATIENT INTAKE FORM

In addition to the above agreements, I accept the right of my provider's staff to terminate this agreement for any of the following reasons:

a) I seek or obtain any pain medication from a source other than my provider.
b) I in any way attempt to forge or alter a prescription.
c) I distribute my prescribed medication(s) to any other person.
d) My medical condition declines to the point at which, in the judgment of my provider, continued therapy with this medication presents danger to my wellbeing or safety.
e) There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my provider determines that I am no longer a good candidate to continue the medication.

I understand that by signing this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and immediate dismissal from my provider and the practice.

I understand that if I default from this agreement and I am having a medical condition I should call 911 or go to the nearest emergency room.

_____ _____

Patient signature

Signature of parent / guardian responsible for minor child or dependent adult

Date: ____/____/_____

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

CONSENT FOR TREATMENT OF MINORS

I, we _____, do hereby authorize that my child,
(parent/legal guardian name)

_____, may receive medical and mental health treatment
(child's name)

provided by Psych Associates of Maryland, its employees and independent contractors. I am aware that all custodial parents and legal guardians must give consent before treatment begins. If the biological or legally adopted parents are currently separated or divorced, both parents would be required to sign a Consent for Mental Health Treatment Form before the child can be treated. If one of the parents has full legal custody, a copy of the divorce agreement/Custody arrangement would need to be received by us prior to beginning treatment for your child.

_____ _____
Patient signature

Signature of parent / guardian responsible for minor child or dependent adult

_____
Signature of parent / guardian responsible for minor child or dependent adult

Date: ____/____/_____

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐VISA ☐ Discover □Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (MM/YY): _____CVV _____
Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize Psych Associates of Maryland_to charge my credit card above for all outstanding balances and copays. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

FAMILY HISTORY

1) FATHER:

Age: _____ ☐ living ☐ deceased. If deceased, Cause_____ Age at death_____

Psychiatric problems if any: _____

Medical Problems if any: _____

2) MOTHER:

Age: _____ ☐ living ☐ deceased. If deceased, Cause_____ Age at death_____

Psychiatric problems if any: _____

Medical Problems if any: _____

3) SIBLINGS:

Age(s): _____ ☐ living ☐ deceased. If deceased, Cause_____ Age at death_____

Psychiatric problems if any: _____

Medical Problems if any: _____

4) CHILDREN:

Age(s): _____ ☐ living ☐ deceased. If deceased, Cause_____ Age at death_____

Psychiatric problems if any: _____

Medical Problems if any: _____

5) EXTENDED FAMILY:

Age(s): _____ ☐ living ☐ deceased. If deceased, Cause_____ Age at death_____

Psychiatric problems if any: _____

Medical Problems if any: _____

6) Relation: _____

Age(s): _____ ☐ living ☐ deceased. If deceased, Cause_____ Age at death_____

Psychiatric problems if any: _____

Medical Problems if any: _____

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

PSYCHIATRIC/MENTAL HEALTH HISTORY

Please list all Psychiatric Hospitalizations if any:

Reason	Hospital (location)	From	To	Comments

Have you ever had Psychotherapy? ☐ No ☐ Yes If yes, reason: _____ Outcome: _____

Technique/Modality_____ Frequency_____ From _____ To_____

Have you ever had TMS therapy? ☐ No ☐ Yes If yes, reason: _____ Outcome: _____

Have you ever had ECT? ☐ No ☐ Yes If yes, reason: _____ Outcome: _____

MEDICAL HISTORY

Please list all Non- Psychiatric Hospitalizations if any:

Reason	Hospital (location)	From	To	Comments

Please list all surgical history if any:

Reason	Hospital (location)	From	To	Comments

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

Do you now or ever had the following conditions? Please select all that apply.

☐Anemia	☐ Angina	☐ Asthma
☐ Cancer	☐ Cataracts	☐ Colitis
☐ Crohn's Disease	☐ Diabetes	☐ Embolism
☐ Emphysema	☐ Epilepsy(seizures)	☐ Fever
☐ Goiter	☐ Heart murmur	☐ Heart Problems
☐ Hepatitis	☐ High Blood Pressure	☐ High Cholesterol
☐ HIV/AIDS	☐ Hypothyroidism	☐ Jaundice
☐ Kidney	☐ Kidney Disease	☐ Leukemia
☐ Pneumonia	☐ Pressure	☐ Psoriasis
☐ Pulmonary	☐ Rheumatic	☐ Stomach or Peptic Ulcer
☐ Stones	☐ Stroke	☐ Tuberculosis

Other Medical Conditions:

_____

_____

Please list the medications/substances that you are allergic to if any:

Substance / Medication	Reaction	Age allergy developed/discovered	Comments

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

MEDICATIONS

Please list all of your past and current Psychiatric Medication if any and also include your current non psychiatric medications if relevant

Medication Name	Dosage (include strength and pills per day)	From Date	To Date	Side effects/effectiveness or reason for discontinuation

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

SUBSTANCE USE

Please also list the illicit substances you have used if any:

Illicit substance Name	Age when you first started	How much and how often did you use this	How many years did you use this?	When did you last use this?	Do you Currently use this?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

SEXUAL HISTORY ☐ Not Applicable

Are you sexually Active? ☐ Yes ☐ No

How many partners? _____

Who do you prefer? ☐ Men ☐ Women ☐ Both ☐ None

Do you participate in risky sexual behavior? ☐ No ☐ Yes

FOR WOMEN ONLY- REPRODUCTIVE HISTORY ☐ Not Applicable

Age of first period: _____

Number of pregnancies: _____ Number of miscarriages: _____ Number of abortions: _____

Have you reached menopause? ☐ Yes ☐ No

Do you have regular periods? ☐ Yes ☐ No

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

REVIEW OF SYSTEMS

In the past month, have you had any of the following problems?

NERVOUS SYSTEM

☐ Dizziness ☐ Fainting or loss of consciousness ☐ Headaches
☐ Memory loss ☐ Numbness or tingling

PSYCHIATRIC SYSTEM

☐ Anxiety ☐ Depression ☐ Difficulties with Sexual Arousal
☐ Difficulty Falling Asleep ☐ Difficulty Staying Asleep ☐ Excessive Worries
☐ Food Cravings ☐ Frequent Crying ☐ Guilty Thoughts
☐ Hallucinations ☐ Irritability ☐ Mood Swings
☐ Paranoia ☐ Poor Appetite ☐ Poor Concentration
☐ Racing Thoughts ☐ Rapid Speech ☐ Risky Behavior
☐ Sensitivity ☐ Stress ☐ Thoughts of Suicides/ Attempts
☐ Violence towards self ☐ Violence Towards Others ☐ Access to Gun

Additional Symptoms: Please check the below symptoms only if relevant:

GENERAL
☐ Fatigue
☐ Fever
☐ Night Sweats
☐ Recent Weight Gain
☐ Recent Weight Loss
☐ Weakness

MUSCLE/JOINTS/BONES
☐ Joint Pain
☐ Joint Swelling
☐ Muscle Weakness
☐ Numbness

EARS
☐ Ringing in ears
☐ Loss of Hearing

EYES
☐ Double or Blurred Vision
☐ Dryness
☐ Loss of Vision
☐ Pain
☐ Redness

THROAT
☐ Difficulty in Swallowing
☐ Frequent Sore Throats
☐ Hoarseness
☐ Pain in Jaw

HEART AND LUNGS
☐ Chest Pain
☐ Cough
☐ Fainting
☐ Palpitations
☐ Shortness of Breath
☐ Swollen legs or feet

STOMOCH AND INTESTINES
☐ Black Stools
☐ Blood in Stools
☐ Heartburn
☐ Increasing Constipation
☐ Nausea
☐ Persistent Diarrhea
☐ Stomach Pain
☐ Vomiting
☐ Yellow Jaundice

SKIN
☐ Color changes of Hands or Feet
☐ Hair Loss
☐ Nodules/Bumps
☐ Rash
☐ Redness

BLOOD
☐ Anemia
☐ Clots

KIDNEY/URINE/BLADDER
☐ Blood in Urine
☐ Frequent or painful urination

WOMEN ONLY
☐ Abnormal Pap Smear
☐ Bleeding between Periods
☐ Irregular periods
☐ PMS

OTHER
_____
_____

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

CURRENT VISIT SOCIAL HISTORY

How are your professional/workplace relationships? _____

How are you finances and career? _____

How are your grades if you are in school? _____

How are your personal relationships? _____

Any other relevant significant social issues that are impacting you? _____

In your own words describe why you are here today. Please include how you feel about your mental health condition and any other information that is relevant for this visit.

_____

_____

_____

_____

_____

_____

_____

_____

_____

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? Please circle

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**

PSYCH ASSOCIATES OF MARYLAND

Mood Disorder Questionnaire

Name: _____ Date: _____

Please answer each question as best you can.	Yes	No
1. Has there ever been a period of time when you were not your usual self and…		
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
…you were so irritable that you shouted at people or started fights or arguments?	◯	◯
…you felt much more self-confident than usual?	◯	◯
…you got much less sleep than usual and found you didn't really miss it?	◯	◯
…you were much more talkative or spoke faster than usual?	◯	◯
…thoughts raced through your head or you couldn't slow your mind down?	◯	◯
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
…you had much more energy than usual?	◯	◯
…you were much more active or did many more things than usual?	◯	◯
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
…you were much more interested in sex than usual?	◯	◯
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
…spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? Please check 1 response only.	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? Please check 1 response only. ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

PSYCH ASSOCIATES OF MARYLAND

NEW PATIENT INTAKE FORM

PERCEIVED STRESS SCALE

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

Name _____ Date _____

Age _____ Gender (*Circle*): **M** **F** Other _____

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often	
1. In the last month, how often have you been upset because of something that happened unexpectedly?	0 1 2 3 4
2. In the last month, how often have you felt that you were unable to control the important things in your life?	0 1 2 3 4
3. In the last month, how often have you felt nervous and "stressed"?	0 1 2 3 4
4. In the last month, how often have you felt confident about your ability to handle your personal problems?	0 1 2 3 4
5. In the last month, how often have you felt that things were going your way?	0 1 2 3 4
6. In the last month, how often have you found that you could not cope with all the things that you had to do?	0 1 2 3 4
7. In the last month, how often have you been able to control irritations in your life?	0 1 2 3 4
8. In the last month, how often have you felt that you were on top of things?	0 1 2 3 4
9. In the last month, how often have you been angered because of things that were outside of your control?	0 1 2 3 4
10.In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0 1 2 3 4