

**CHERYL IVORY, M.A., LPC-Supervisor**

**Personal Information.**

Client's name: \_\_\_\_\_ Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Email Address: \_\_\_\_\_

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

Phone (Cell): \_\_\_\_\_ other \_\_\_\_\_

**Insurance Name** \_\_\_\_\_ **ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Relationship to Client:** \_\_\_\_\_

Billing Address, if different from home address: \_\_\_\_\_ **Primary**  
reason(s) for seeking services: Anger management \_\_\_\_\_ Anxiety \_\_\_\_\_ Coping \_\_\_\_\_ Depression \_\_\_\_\_ Sleep problems \_\_\_\_\_ Eating  
disorder \_\_\_\_\_ Fear/phobias \_\_\_\_\_ Mental confusion \_\_\_\_\_ Sexual Concerns \_\_\_\_\_ Addictive behaviors \_\_\_\_\_ Alcohol/drugs \_\_\_\_\_ Other  
mental health concerns (specify): \_\_\_\_\_

**Family Information**

	Name	Age
Self	_____	_____
Partner	_____	_____
Children	_____	_____
Other	_____	_____

**Marital Status** (Answer all that apply)

Single \_\_\_\_\_ Divorce in process \_\_\_\_\_ Unmarried, living together \_\_\_\_\_ -- Length of time \_\_\_\_\_

Legally married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Length of time \_\_\_\_\_

Widowed \_\_\_\_\_ Length of time \_\_\_\_\_ Annulment \_\_\_\_\_ Length of time: \_\_\_\_\_ Total number of marriages: \_\_\_\_\_ Assessment of current  
relationship (if applicable): Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

**Special circumstances** (e.g., raised by another person, information about spouse/children not living with you, etc.)  
\_\_\_\_\_

**Development**

Are there special, unusual, or traumatic circumstances that affected your development Yes \_\_\_ No \_\_\_ If yes, please describe:  
\_\_\_\_\_

Has there been history of child abuse? No \_\_\_ Yes \_\_\_ If yes, which type (s)? Sexual \_\_\_ Physical \_\_\_ Verbal \_\_\_ Neglect \_\_\_ If  
yes, the abuse was as a: Victim \_\_\_ Perpetrator \_\_\_

Other childhood issues: Inadequate nutrition \_\_\_ Other (specify): \_\_\_\_\_

**Social Relationships**

How do you generally get along with other people? (Check all that apply): Affectionate \_\_\_ Aggressive \_\_\_ Avoidant \_\_\_

Fight/argue often \_\_\_ Follower \_\_\_ Friendly \_\_\_ Leader \_\_\_ Outgoing \_\_\_ Shy/Withdrawn \_\_\_ Submissive \_\_\_ Other (specify):  
\_\_\_\_\_

Sexual orientation: \_\_\_\_\_

Comments: \_\_\_\_\_

Sexual dysfunctions? Yes \_\_\_ No \_\_\_ If yes, describe: \_\_\_\_\_

# Enlightened

15311 Vantage Parkway E. Suite 309 Houston, Texas 77032

# Psychotherapy

Tel: 832.329.8500

www.enlightenedpsychotherapy.com

## CHERYL IVORY, M.A., LPC-Supervisor

### Cultural/Ethnic

Are you experiencing any problems due to cultural or ethnic issues? Yes \_\_\_ No \_\_\_

To which cultural or ethnic group, if any, do you belong? \_\_\_\_\_

### Spiritual/Religious

Are you affiliated with spiritual or religious groups? Yes \_\_\_ Name \_\_\_\_\_ No \_\_\_

How important to you are spiritual matters? Not \_\_\_ Little \_\_\_ Moderate \_\_\_ Very \_\_\_

### Legal

Are you involved in any active cases (traffic, civil, criminal)? Yes \_\_\_ No \_\_\_

### Education

**Fill in all that apply:** Currently enrolled in school? Yes \_\_\_ No \_\_\_ HS Grad/GED Yes \_\_\_ No \_\_\_

College: Yes \_\_\_ No \_\_\_ Graduated: Yes \_\_\_ No \_\_\_ Major: \_\_\_\_\_ Vocational \_\_\_ Number of years \_\_\_\_\_

### Employment

Employer \_\_\_\_\_ Dates \_\_\_\_\_ Title \_\_\_\_\_ Reason left the job \_\_\_\_\_ How often miss work? \_\_\_\_\_

Currently: FT \_\_\_ PT \_\_\_ Temp \_\_\_ Laid-off \_\_\_ Disabled \_\_\_ Retired \_\_\_

### Military

Military experience? \_\_\_ Yes \_\_\_ No; Combat experience? \_\_\_ Yes \_\_\_ No

### Health Questions:

Current/prescribed medications      Dose      Dates      Purpose      Side effects

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Last physical exam: \_\_\_\_\_ Last doctor's visit: \_\_\_\_\_

### General Questions

Please check any recent changes in the following: Sleep \_\_\_ Eating \_\_\_ Behavior \_\_\_ Energy level \_\_\_ Physical activity level \_\_\_ Weight

\_\_\_ Nervousness/tension \_\_\_ Reason(s) for use: Addicted \_\_\_ Build confidence \_\_\_ Escape \_\_\_

Self-medication \_\_\_ Socialization \_\_\_ Other (specify): \_\_\_\_\_

Have drugs/alcohol created a problem for your job? No \_\_\_ Yes \_\_\_ If yes, describe: \_\_\_\_\_

### Medical/Physical Health Please check boxes below if anything pertains to you:

<input type="checkbox"/>	AIDS	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Neurological disorders
<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	Abortion	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Eating problems	<input type="checkbox"/>	Sexual transmitted diseases
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Sleeping disorders
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Sore throat

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Arthritis	Frequent urination	Scarlet Fever
Asthma	Headaches	Sinusitis
Bronchitis	Hearing problems	Smallpox
Bed wetting	Hepatitis	Stroke
Cancer	High blood pressure	Sexual problems
Chest pain	Kidney problems	Tonsillitis
Chronic pain	Measles	Tuberculosis
Colds/Coughs	Mononucleosis	Toothache
Constipation	Mumps	Thyroid problems
Chicken pox	Menstrual pain	Vision problems
Dental Problem	Miscarriages	Vomiting
Diabetes	Nausea	Whooping cough
Diarrhea	Other (describe): Lupus	Other (describe): Glaucoma

### Chemical Use History Please check boxes below if anything pertains to you:

	Methods of use/amounts	Frequency of use	Age of first use	Age of last use	Used in 30 days	Use in 48 hours
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mescaline						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						

### Counseling/Prior Treatment History Information about client (past and present): please check all that apply

	Yes	No	When	Where	Overall Experiences
Counseling/Psychiatric					
Suicidal/Homicidal thoughts/attempts					
Drug/alcohol treatment					
Hospitalizations					
Self-help groups AA, SA, GA, NA					

### Client Services Agreement

## CHERYL IVORY, M.A., LPC-Supervisor

Welcome to Enlightened Psychotherapy (ENLIGHTENED). This agreement contains important information about our professional services and business policies. It also contains summary information about the (HIPAA), Health Insurance Portability and Accountability Act, a federal law that provides privacy protections and client rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on Enlightened unless we have taken action in reliance on this agreement or if you have not satisfied any financial obligations you have incurred. **I DO NOT FILL OUT DISABILITY PAPERWORK! I will not take you off of your job. Please see your doctor.**

### COUNSELING SERVICES

Your first appointment (or more, in some cases) will involve an assessment of your needs. By the end of the assessment your counselor will be able to offer you some first impressions of what your work may include and recommendations for getting help. One of the recommendations may be psychotherapy. If so, ENLIGHTENED may or may not be able to provide you with psychotherapy, depending on your overall needs. If psychotherapy or any other recommendations suggested by your counselor include things that ENLIGHTENED cannot provide, you will be given suggestions of where you might receive those services. Wherever you choose to obtain treatment, you should evaluate the information from your initial assessment along with your own opinions of what sort of treatment you are willing to do and whether you feel comfortable working with the treating clinician. Therapy involves a large commitment of **time, energy, and often money**, so you should be very careful about the therapist you select. If you have questions about the procedures used or conclusions made by your counselor at ENLIGHTENED, please discuss them whenever they arise. If your doubts persist, your counselor will be happy to help you set up a meeting with another mental health professional for a second opinion. Psychotherapy is not easily described in general statements. It varies depending on the particular problems you are experiencing, the therapeutic methods used by your counselor, and the personalities of the counselor and client. There are many different methods counselors may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, **you** will have to work on things that are discussed both during your sessions and on your own. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, shame, frustration, loneliness, and helplessness. The changes you make in therapy may also affect your relationships in unexpected ways. Psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

### MEETINGS

The initial assessment will last from one to two sessions. During this time, you and your counselor can both decide if she/he is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, your counselor will usually schedule one meeting per week at a time you each agree on. Once an appointment is scheduled, you will be expected to attend unless you provide advance notice of cancellation. If you need to cancel an appointment, it is your responsibility to contact us to cancel. Therapy may be provided by an Intern or student.

### PROFESSIONAL FEES

## CHERYL IVORY, M.A., LPC-Supervisor

**Fees will be collected when services are rendered.** We will bill your insurance company for our services, but you are responsible for payment in case your insurance does not accept responsibility. In addition to therapy services fees may include assessment administration, scoring, and reporting; creating reports; creating copies of records on request; consulting with other professionals at the client's request. There will be an additional \$35 fee assessed for returned check.

### CANCELLATIONS

•Cancellations must be made between 8:30 AM and 5:00 PM Monday through Friday using our main number. We cannot accommodate cancellations made via email as we do not monitor email on a regular basis.

•**Cancellations with less than 24 hours' notice will result in a fee equal to the total amount of the missed session that will be collected at your next appointment, or, if payment information is on file, it will be debited from your credit card.**

•**After two no shows/late cancellations, client will prepay before services are rendered.**

•Clients who have pre-paid agree to have the entire fee deducted from their pre-payment in cases of no-shows and late cancellations.

### COURT TESTIMONY

•Court testimony costs begin at **\$250** per hour with a minimum charge of three hours. A retainer of **\$750** is due one week prior to the court date. Travel is billed at .50/mile. Failure to provide the specific fees as described constitutes a release from the requested court appearance.

•A minimum of 36 hours' notice be given if the testimony is not required, otherwise the entire retainer is forfeited. If proper notice is given, the retainer will be refunded.

•Additional services related to court preparation including all correspondence with attorneys or other service providers via phone, email, or letter, documentation review and/or documentation preparation are also billed at \$250 per hour, rounded to the nearest 15 minute increment. You (not your insurance company) are responsible for full payment of fees. You must pay your bill first, then contact your insurance company regarding reimbursement.

### CONTACTING US

We answer our main office number 8:00 am – 5:00 pm, Monday through Friday.

•Text messaging and email will be used for administrative tasks only.

•Therapists may not acknowledge or return emails or text messages that are not administrative. This includes emergency texts and emails.

•Skype, telephone, and web conferencing for counseling are allowed if you are within the state of Texas and there is completed intake paperwork on file.

### EMERGENCIES

\* If you have an emergency go to the emergency room nearest you or call 911.

If you have a non-emergency, contact the Enlightened main number it is not monitored regularly.

### FACEBOOK AND SOCIAL MEDIA

Social media, including but not limited to Facebook and Twitter, may be used by therapists as tools for marketing services and disseminating information.

•We do not provide therapy via social media. We do not accept client request on social media.

•You may use social media to reveal your own identity as a client of Enlightened Psychotherapy but you may not reveal the identity of another client. Doing so would be a breach of confidentiality and Enlightened

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Psychotherapy would take all available steps to protect the revealed client's rights, including blocking the offending client from accessing our social media and referring the offending client to another practice.

### **LIMITS OF CONFIDENTIALITY**

The law protects the privacy of all communications between a client and a counselor. In most situations, Enlightened can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA (included with this intake packet). There are situations that require you to provide written, advance consent which is provided by signing this document. This office uses the services of students, who are also bound by the same HIPAA laws. Your signature on this Agreement provides consent.

- You will have a file in our office to which all therapists and staff will have necessary access. Enlightened Psychotherapy counselors and staff consult with each other about our work. In most cases, we need to share protected information within Enlightened for both clinical and administrative purposes, such as scheduling, records management, and quality assurance. All of the mental health professionals and staff are bound by the same rules of confidentiality.
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, Enlightened cannot provide any information without a) your (or your legal representative's) written authorization, or b) a court order/subpoena. If you are involved in contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order Enlightened to disclose information.
- If a client files a complaint or lawsuit against Enlightened, we may disclose relevant information regarding that client in order to defend ourselves.
- If we have reasonable cause to suspect that a child or an elderly or disabled adult has been or may be subjected to abuse or neglect or observe a child being subjected to conditions or circumstances that would reasonably result in abuse or neglect, the law requires that Enlightened file a report with the Texas Department of Child Protective Services, and/or the Texas Department of Elder Protective Services. Once such a report is filed, we may be required to provide additional information.

If you disclose past sexual abuse by a mental health provider we are obligated to report this to the proper authorities and licensing entities. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

### **COUNSELING VIA TECHNOLOGY**

Online methods of providing counseling services are evolving all the time. Enlightened Psychotherapy will utilize those means ethically and therapeutically. Be an established client with intake paperwork, payment information, and an emergency contact/face sheet on file with Enlightened Psychotherapy.

1. Have a release of information for an emergency contact for the location from which the client will be calling.
2. Assume responsibility for securing a location to speak with therapist that is confidential
3. Understand when communicating via technology, confidentiality cannot always be guaranteed. By engaging in counseling via technology client acknowledges that risk and holds Enlightened Psychotherapy harmless.

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4. Be domiciled (primary residence) in the state of Texas or be located on a US military base if out of the state of Texas to receive counseling services from Enlightened Psychotherapy. Therapists at Enlightened are licensed to practice in the State of Texas.
5. Agree to an alternate form of communication in case technology fails during the counseling session. If counseling cannot be resumed, client will still be charged for the session. If technology fails less than 30 minutes into a counseling session and communication cannot be reestablished, client can reschedule at no charge for the remainder of the missed session.

**PROFESSIONAL RECORDS.** The laws and standards of our profession require that Enlightened keep Protected Health Information about you in your clinical record. Your record includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, and any reports that have been sent to anyone. Except in the unusual circumstance where disclosure is reasonably likely to endanger you and/or others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm, you may examine and/or receive a copy of your record, if you request it in writing. These are professional records, they can be misinterpreted by and/or be upsetting to untrained readers.

Enlightened recommends that you initially review them in your counselor's presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, Enlightened is allowed to charge a copying fee of \$25 (and for certain other expenses). If Enlightened refuses your request for access to your records, you have a right of review, which a counselor will discuss with you upon request.

### **TERMINATION, DEATH, OR INCAPACITY OF THERAPIST/TERMINATION/CLOSURE**

In the event of your therapist's termination, death, or incapacity, all records created as a contract therapist with Enlightened Psychotherapy will be secured and archived with Enlightened Psychotherapy on an encrypted electronic server. In the event of the closure of Enlightened Psychotherapy or the death or incapacitation of its owner, records created by contracted therapists will be secured and archived on an encrypted electronic server. Access will be granted to Cindy Thornby, 281-755-3561

### **CLIENT RIGHTS REGARDING PRIVACY AND HIPAA**

If we are out of network, we will provide you with paperwork you may submit for insurance reimbursement. We will not file that paperwork for you. You should be aware that in the process of filing for a third party payment, your contract with your health insurance company requires that your counselor provide additional clinical information such as treatment plans or summaries, a diagnosis, or copies of your entire clinical record. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, counselors have no control over what it does with it once it is in their hands. In such situations, your counselor will make every effort to release only the minimum information about you that is necessary for the purpose requested. If you will be filing with your insurance for reimbursement of fees, please indicate your consent for us to release your PHI by signing below. For a copy of HIPAA policies, please ask. Enlightened may share my Private Health Information with my insurance company

### **MINORS & PARENTS**

Clients under 18, their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with

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teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child’s records. If they agree, during treatment, your counselor would provide them (if requested) only general information Enlightened the progress of your treatment, and your attendance at scheduled sessions. If requested, your counselor could also provide parents with a summary of your treatment when it is complete. Any other communication to your parents will require your Authorization, unless we feel that you are in danger or are a danger to someone else, in which case, we will notify the parents of our concern. If there is a minor child with divorced or separated parents, a certified copy of the temporary orders or divorce decree must be provided prior to the therapist beginning treatment.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO IT’S TERMS ALONG WITH PERMISSION TO BILL YOUR INSURANCE COMPANY AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE HIPAA PRIVACY NOTICE DESCRIBED ABOVE WAS MADE AVAILABLE TO YOU.

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

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

Signature of parent or guardian for clients less than 18 years old

Texas State Board of Examiners of Professional Counselors and Texas State Board of Examiners of Marriage and Family Therapists Complaint Process

An individual who wishes to file a complaint against a Licensed Professional Counselor may write to:

Complaints Management and Investigative Section

P.O. Box 141369

Austin, Texas 78714-1369 or call 1-800-942-5540

To request the appropriate form or obtain more information.

This number is for complaints only.

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## CHERYL IVORY, M.A., LPC-Supervisor

Please remit payment today for all services rendered according to the following schedule:

### Cheryl Ivory, MA, LPC-S

- Initial Consultation 90 minutes \$195
- Family Therapy 50 minutes \$130
- Couple Therapy 50 minutes \$130
- Individual Therapy 50 minutes \$130

### Interns

Individual Therapy, Family Therapy, Parenting, Couples Therapy 50 minutes \$80

**Printed reports, letters, consultations \$150/hour**

These rates will remain the same for the duration of your time with us.

**No-shows and late cancellations will be charged the amount of the missed session and payment will be collected at your next appointment, deducted from your credit card on file with us, or billed.**

We accept cash, personal check, American Express, Visa, Discover, Master Card, and PayPal.

### For your convenience, we allow recurring payment authorization:

I \_\_\_\_\_ authorize Enlightened Psychotherapy to debit my credit card for recurring payments for counseling services. I understand this information will be used to remit payment to Enlightened Psychotherapy for services rendered and outstanding balances including fees for no-shows and late (less than 24 hours notice) cancellations.

Visa/MasterCard/AMEX (circle one)

_____	_____	_____	\$ _____
Card number	Exp. Date	Security Code	Amount Due

_____	_____
Printed name on card	Signature

\_\_\_\_\_

Billing address with city, state and zip code

Phone number \_\_\_\_\_ Email Address \_\_\_\_\_

Thank you for trusting us with the care of you and your family.

**PRICES WILL INCREASE IN MAY 2019**

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Sliding Fee Application

It is the policy of Enlightened Psychotherapy (EP) to provide quality behavioral health services to all persons in need of care, regardless of income and/or the inability to pay. Please complete the following information so that EP will be able to determine your eligibility for discounted services. You will be reassessed for the sliding scale every six months and you will be required to provide updated proof of income.

Patient's Name: Preferred Name:

Date of Birth: Last four digits of Social Security Number:

Do you have commercial health insurance, Medicare, Medicaid, or any benefit that pays for health insurance?

Yes No Not Sure

HOUSEHOLD

A "household" includes legal children, a civil union partner or married spouse, and legal dependents. Please list the name of individuals in your household and relation to you. Please use the back of this form for additional space.

Table with 2 columns: Names of individual living in household (including yourself), Relation to you. Includes a row for TOTAL number of people in household.

ANNUAL HOUSEHOLD INCOME

Table with 5 columns: Source of Income, Self, Partner, Other, Total. Rows include Gross wages, salaries, tips, etc; Social Security (SSI or SSDI); Unemployment Benefits; Investment Income; Other; TOTAL INCOME.

PLEASE READ AND SIGN

I have reviewed this form and certify that the information I provided is true and correct to the best of my knowledge. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charged the full fee of my visit if I do not bring in documentation of income by my third visit or within 60 days of my first visit, whichever comes first. I understand that I am required to notify Enlightened Psychotherapy if my income level changes or if I become insured. If there are changes, I will be re-assessed for the sliding fee scale.

Print Name:

Signature {Guardian if applicable}: Date:

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## Depression Self-Rating Test

Nearly 20 million Americans experience depression,<sup>1</sup> but many will never seek treatment. The Depression Self-Rating Test is a simple 16-question quiz that can help identify common symptoms of depression and their severity. Remember—depression is more than just feeling down—it is a real medical condition that can be effectively treated.

**Please complete the following questionnaire and return it to your healthcare provider.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Instructions:** Please **circle** the one response to each item that best describes you for the past seven days.

**1. Falling asleep:**

- 0 I never take longer than 30 minutes to fall asleep.
- 1 I take at least 30 minutes to fall asleep, less than half the time.
- 2 I take at least 30 minutes to fall asleep, more than half the time.
- 3 I take more than 60 minutes to fall asleep, more than half the time.

**2. Sleep during the night:**

- 0 I do not wake up at night.
- 1 I have a restless, light sleep with a few brief awakenings each night.
- 2 I wake up at least once a night, but I go back to sleep easily.
- 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

**3. Waking up too early:**

- 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
- 1 More than half the time, I awaken more than 30 minutes before I need to get up.
- 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
- 3 I awaken at least one hour before I need to, and can't go back to sleep.

**4. Sleeping too much:**

- 0 I sleep no longer than 7–8 hours/night, without napping during the day.
- 1 I sleep no longer than 10 hours in a 24-hour period including naps.
- 2 I sleep no longer than 12 hours in a 24-hour period including naps.
- 3 I sleep longer than 12 hours in a 24-hour period including naps.

**5. Feeling sad:**

- 0 I do not feel sad.
- 1 I feel sad less than half the time.
- 2 I feel sad more than half the time.
- 3 I feel sad nearly all of the time.

**6. Decreased appetite:**

- 0 There is no change in my usual appetite.
- 1 I eat somewhat less often or lesser amounts of food than usual.
- 2 I eat much less than usual and only with personal effort.
- 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

**7. Increased appetite:**

- 0 There is no change from my usual appetite.
- 1 I feel a need to eat more frequently than usual.
- 2 I regularly eat more often and/or greater amounts of food than usual.
- 3 I feel driven to overeat both at mealtime and between meals.

**8. Decreased weight (within the last two weeks):**

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight loss.
- 2 I have lost 2 pounds or more.
- 3 I have lost 5 pounds or more.

**9. Increased weight (within the last two weeks):**

- 0 I have not had a change in my weight.
- 1 I feel as if I've had a slight weight gain.
- 2 I have gained 2 pounds or more.
- 3 I have gained 5 pounds or more.

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### 10. Concentration/Decision making:

- 0 There is no change in my usual capacity to concentrate or make decisions.
- 1 I occasionally feel indecisive or find that my attention wanders.
- 2 Most of the time, I struggle to focus my attention or to make decisions.
- 3 I cannot concentrate well enough to read or cannot make even minor decisions.

### 11. View of myself:

- 0 I see myself as equally worthwhile and deserving as other people.
- 1 I am more self-blaming than usual.
- 2 I largely believe that I cause problems for others.
- 3 I think almost constantly about major and minor defects in myself.

### 12. Thoughts of death or suicide:

- 0 I do not think of suicide or death.
- 1 I feel that life is empty or wonder if it's worth living.
- 2 I think of suicide or death several times a week for several minutes.
- 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

### 13. General interest:

- 0 There is no change from usual in how interested I am in other people or activities.
- 1 I notice that I am less interested in people or activities.

- 2 I find I have interest in only one or two of my formerly pursued activities.
- 3 I have virtually no interest in formerly pursued activities.

### 14. Energy level:

- 0 There is no change in my usual level of energy.
- 1 I get tired more easily than usual.
- 2 I have to make a big effort to start or finish my usual daily activities (for example: shopping, homework, cooking, or going to work).
- 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

### 15. Feeling slowed down:

- 0 I think, speak, and move at my usual rate of speed.
- 1 I find that my thinking is slowed down or my voice sounds dull or flat.
- 2 It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.
- 3 I am often unable to respond to questions without extreme effort.

### 16. Feeling restless:

- 0 I do not feel restless.
- 1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
- 2 I have impulses to move about and am quite restless.
- 3 At times, I am unable to stay seated and need to pace around.

### This section is to be completed by your doctor.

#### To Score:

- Enter the highest score on any 1 of the 4 sleep items (1-4) \_\_\_\_\_
- Item 5 \_\_\_\_\_
- Enter the highest score on any 1 appetite/weight item (6-9) \_\_\_\_\_
- Item 10 \_\_\_\_\_
- Item 11 \_\_\_\_\_
- Item 12 \_\_\_\_\_
- Item 13 \_\_\_\_\_
- Item 14 \_\_\_\_\_
- Enter the highest score on either of the 2 psychomotor items (15 and 16) \_\_\_\_\_

#### TOTAL SCORE (Range 0-27) \_\_\_\_\_

**Scoring Criteria:** Normal 0-5    Mild 6-10    Moderate 11-15    Severe 16-20    Very Severe 21+

NOTE: The above cutoff points are based largely on clinical judgment rather than on empirical data.

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References: I. National Institute of Mental Health website. Depression Research at the National Institute of Mental Health Fact Sheet. Available at: <http://www.nimh.nih.gov/publicat/depresfact.cfm>. Accessed November 28, 2002.