Fax/Email to Dr. Joseph Park

DATE: _____

TO: Mississauga Pain Clinic

FAX: 905-858-3527
EMAIL: jppainclinic@yahoo.ca

RE: _____

# of Pages including the cover sheet: _____

Notes/Comments:

From (Patient name): _____

Initial Patient Assessment Form
To be filled out by patient

Joseph Park, M.D., F.R.C.P.(C) Anesthesiology & Pain Management

Suite 220, 6855 Meadowvale Town Centre Circle, Mississauga, ON L5N 2Y1
T: (905) 858-8512, F: (905) 858-3527, jppainclinic@yahoo.ca

DATE:_____

About yourself

Please complete the following questionnaire as accurately and honestly as possible so that we can determine what kind of treatment would serve you best.

Name: Address: Phone: Alternate: Health Card #: Version code: Date of Birth: Height: Weight:

Name: _____ _____
First Last

Health Card #: _____ Version code: _____

Date of Birth: _____
Year/Month/Day

Address: _____

Phone number: _____

Contact in case of emergency (state relationship):_____

Who referred you? _____

Gender: Male: ☐ Female: ☐

Do you have a family doctor? Yes: ☐ No: ☐
Name and address of your family doctor: _____
Is your doctor aware of your drug problem? Yes: ☐ No: ☐

Drug history

Drug	Amount Used	How long	Route Taken	First Used	Last Used	Misc	
Heroin							
Other Narcotics							
Cocaine							
Barbiturates (Fiorinal)							
Benzodiazepines (Valium, Ativan)							
Amphetamines							
Marijuana (Cannabis, Pot, Hash)							
Alcohol							
Cigarettes (pack per day)							
Others							

Prescription medications:

(Any medications you regularly take or are prescribed, amount and frequency: None: ☐
or, give details: _____

_____

_____

Are you now or have you ever been prescribed narcotics (e.g. Tylenol #3, Percocet, Percodan, Dilaudid, Talwin, Morphine etc.) for extended period of time (e.g. for more than four weeks?)
Yes: ☐ Narcotic name: _____ No: ☐
Amount prescribed _____ For how long? _____
(per week/month) (weeks/months/years)
For what reason was it prescribed?

_____

_____

If it has been discontinued, when and why? _____

_____

Drug allergies:

None: ☐ if yes, give name of drugs and reactions

Name of drug	Reactions	misc

Any medications you can't take, and why not? _____
_____

Past medical history:

Hepatitis A: Yes: ☐ No: ☐ Never tested: ☐ Don't know: ☐
Hepatitis B: Yes: ☐ No: ☐ Never tested: ☐ Immune: ☐
Vaccinated: ☐ Carrier: ☐ Don't know: ☐
Hepatitis C: Yes: ☐ No: ☐ Never tested: ☐ Don't know: ☐
HIV: Yes: ☐ No: ☐ Never tested: ☐ Don't know: ☐
TB skin test: Yes: ☐ No: ☐ Never tested: ☐ Don't know: ☐

For the above questions, where was the test done, and where are the results now?
Year of first i.v. drug use: (_____) never: ☐
History of needle sharing (including cotton, spoons, filters, etc.): Yes: ☐ No: ☐
Overdoses: Yes: ☐ No: ☐

☐ Cardiac problem:_____
☐ Respiratory problem:_____
☐ Seizure ☐ Diabetes ☐ Liver disease
☐ Depression ☐ Anxiety disorder ☐ Migraines
☐ Peptic ulcer disease ☐ Kidney disease ☐ Bleeding disease
☐ Other: _____

Women only:

1. When was the first day of your last menstrual period? _____
2. Current method of contraception? The Pill: ☐ Condoms: ☐ Other: ☐
3. Is there any chance you might be pregnant? Yes: ☐ No: ☐

Emotional Health:

Have you ever been treat by a family doctor or psychiatrist for :
Anxiety? Yes: ☐ No: ☐ ☐
Depression? Yes: ☐ No: ☐
Have been admitted to a psychiatric facility? Yes: ☐ No: ☐
Received treatment for any other emotional problems? Yes: ☐ No: ☐
Were you abused? (mentally, sexually or physically) Yes: ☐ No: ☐
Have you ever attempted suicide? Yes: ☐ No: ☐
Are you currently depressed or suicidal? Yes: ☐ No: ☐

Family History:

(Any family history of medical problems like alcohol or drug abuse, depression, heart disease etc.)

Mother: _____ Father: _____
Age Age
Brothers, sisters, others: _____

Drug treatment programs:

What kind of treatment did you have for addiction?
☐ Abstinence program ☐ Methadone program ☐ Suboxone program
(Including attempts at detox), program name, when, how long did you stay clean/why failed?

1. _____
2. _____
3. _____

Social history:

Are you married/single/separated/divorced/common-law/widowed
Children? _____ Whose custody are the children in? _____

Who live in your household? _____
Do they abuse alcohol? Yes: ☐ No: ☐ , drugs? Yes: ☐ No: ☐
Are the people close to you aware of your drug problem? Yes: ☐ No: ☐
Usual occupation: _____ Are you currently employed? Yes: ☐ No: ☐
Last job held: _____ from when_____ to _____
Highest level of education: _____
Are you receiving welfare: ☐ FBA: ☐ pension: ☐ UI: ☐ none: ☐ other: ☐
Do you drive a car? Yes: ☐ No: ☐

Legal Status:

1. Are you currently on probation or parole? Yes: ☐ No: ☐
   If yes, until when? _____
2. Is treatment a condition of your probation? Yes: ☐ No: ☐
   If yes, when? _____
3. Do you have any Court dates pending? Yes: ☐ No: ☐
   If yes, when? _____
4. Do you have previous convictions? Yes: ☐ No: ☐
   if yes, for what? _____
5. Have you been incarcerated? Yes: ☐ No: ☐
   if yes, for what? _____
6. How long have you been in jail for in total? _____
7. Have you been charged with impaired driving? Yes: ☐ No: ☐
8. Have you been charged with a crime that included a weapon or violence? Yes: ☐ No: ☐

About your addiction:

In the last 12 months:
Do you need more and more of the drug you are using to get the same effect? Yes: ☐ No: ☐
Describe what symptoms you experience if you suddenly stop taking the drug:

_____
_____

Do you frequently take more drugs than you planned, or use it for longer than you planned to?
Yes: ☐ No: ☐
Have you had many unsuccessful attempts to cut down on your drug use? Yes: ☐ No: ☐
Yes: ☐ No: ☐
Do you spend a lot of your day getting, using, and recovering from the effects of drugs?
Yes: ☐ No: ☐
Do you keep taking drugs, despite the harm and problems it is causing you?
Yes: ☐ No: ☐
Have you given up any activities because of your drug use?
Yes: ☐ No: ☐
Have you neglected your roles due to due to drug use?
Yes: ☐ No: ☐
Did you develop any physical or psychological problems related to drug use?
Yes: ☐ No: ☐
Did you develop any social or interpersonal problems elated to drug use?
Yes: ☐ No: ☐
Do you have any legal problems due to drug use
Yes: ☐ No: ☐
Why have you come for treatment at this time? _____
_____
What type of treatment do you feel that you need? _____
_____
What are your goals for treatment? _____
_____

EtOH
In the past have you ever:
Felt that you should cut down on your drinking? Yes: ☐ No: ☐
Have people annoyed you by criticizing your drinking? Yes: ☐ No: ☐
Have you ever felt bad or guilty about your drinking? Yes: ☐ No: ☐
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
Yes: ☐ No: ☐

OPIOID RISK TOOL

Risk factors	Score if you are female	Score if you are male
Family history of substance abuse of		
Alcohol	1	3
Illegal drugs	2	3
Prescription drugs	4	4
Personal history of substance abuse of		
Alcohol	3	3
Illegal drugs	4	4
Prescription drugs	5	5
Age	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
Attention deficit disorder, obsessive compulsive disorder, bipolar, schizophrenia	2	2
Depression	1	1
Total		

PQH for depression

Over the past few weeks have you been bothered by these problems?

	Not at all	Several days	More days than not	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3

GAD for anxiety

Over the last 2 weeks how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3

Trouble relaxing	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3

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

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

COWS (Clinical Opiate Withdrawal Scale) assessment

Resting HR: 0: <80 1: 81-100 2: 101-120 4:>120	**Sweating** over the last ½ hr 0: no report of chills or flushing 1: subjective report of chills or flushing 2: beads of sweat on brow or face 4: sweat streaming off face	**Restlessness**: observed during assessment 0: able to sit still 1: reports difficulty sitting still, but is able to do so 3: frequent shifting or extraneous movements of legs/arms 5: unable to sit still for more than a few seconds	**Pupil Size**: 0: pupils pinned or normal for room light 1: pupils possibly larger than normal for room light 2: pupils moderately dilated 5: pupils so dilated that only the rim of the iris is visible	**Bone of joint aches**: If patient was having pain previously, only the additional component attributed to opiate withdrawal is scored 0: not present 1: mild diffuse discomfort 2: patient reports severe diffuse aching of joints/muscles 4: patient is rubbing joints or muscles and is unable to sit still because of discomfort
Runny Nose or Tearing: not accounted for by cold symptoms or allergies 0: not present 1: nasal stuffiness or unusually moist eyes 2: nose running or tearing 4: now constantly running or tears streaming down cheeks	**GI upset**: over last ½ hr 0: no GI symptoms 1: stomach cramps 2: nausea or loose stool 3: vomiting or diarrhea 5: multiple episodes of diarrhea or vomiting	**Tremor**: observation of outstretched hands 0: no tremor 1: tremor can be felt, but not observed 2: slight tremor observable 4: gross tremor or muscle twitching	**Yawning**: Observation during assessment 0: no yawning 1: yawning once or twice during assessment 2: yawning three or more times during assessment 4: yawning several times/minute	**Anxiety or irritability**: 0: none 1: patient reports increasing irritability or anxiousness 2: patient obviously irritable anxious 4: patient so irritable or anxious that participation in the assessment is difficult
Gooseflesh Skin: 0: skin is smooth 3: piloerection of skin can be felt or hairs standing up on arms 5: prominent piloerection	Total Score: _____/48 5-12: mild withdrawal 13-24: moderate withdrawal 25-36: moderately severe>36: severe withdrawal			

Do you have chronic pain?

☐ Yes ☐ No

Where is your pain?

☐ low back pain ☐ low back pain with leg pain
☐ neck pain neck ☐ pain with arm pain
☐ headache
☐ pain all over my body
☐ other type of pain:

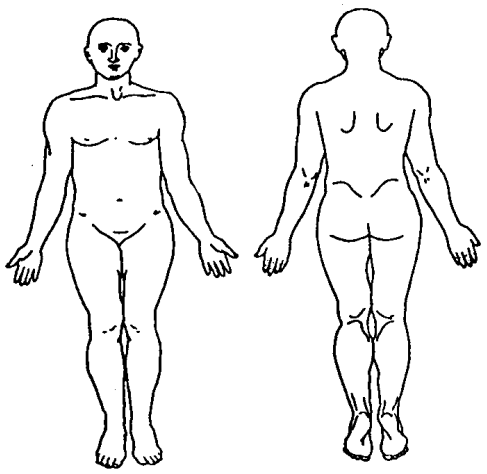
Specify:_____

How long have you had the above pain?

☐ Months ☐ Years

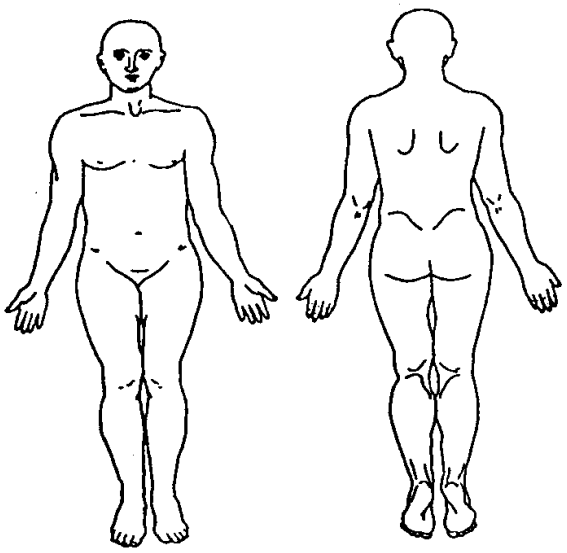
Where is your pain?

(please mark, on the drawings below, the areas where you feel the described sensations. Use the appropriate symbol. Include all affected areas.) Burning: xxxxxxx Stabbing: //////////



Do you have numbness or feel 'pins and needles' in your body?
(please mark, on the drawings below, the areas where you feel the described sensations. Use the appropriate symbol. Include all affected areas

Numbness:====== Pins and needles:°°°°°°



Which of the following best describes your pain? (Check more than one, if necessary):

☐ Hot ☐ Burning ☐ Lancinating
☐ Sharp ☐ Shooting ☐ Tingling
☐ Dull ache ☐ Throbbing ☐ Pulsating ☐ Gnawing ☐ Pulling
☐ Other:_____

Which word would you use to describe the pattern of your pain?

☐ Constant ☐ Intermittent ☐ Transient

How severe is your pain on 0 to 10 verbal rating scale (0: no pain, 10: worst pain)? _____/10

☐ Mild ☐ Moderate ☐ Severe

Check only those statements that describe you in relation to your pain

☐: I am totally incapacitated.
☐: I had to stop working.
☐: I am not able to do any type of house activities.

☐: I need to wear a back brace.
☐: I had to give up some sports such as: _____.
☐: I had to give up some activities such as: _____.
☐: I try to do as many house activities as possible.
☐: I can do most house activities but slowly and carefully.
☐: In spite of pain, I manage to function at work.
☐: I have difficulty going to sleep.
☐: My pain wakes me up at night frequently.
☐: I wake up in the morning feeling tired.
☐: I never feel rested.
☐: My back pain is worse in the morning.
☐: I try not to bend or kneel down.

Activities you have not been able to do because of pain:

_____
_____

Activities that you have difficulty doing:

☐ Self-care ☐ Making beds ☐ Cleaning ☐ Vacuuming ☐ Cooking
☐ Shopping ☐ Walk outside ☐ Exercise ☐ Work

Sleep:

☐ Little or no sleep ☐ fragmented ☐ uninterrupted

Mood:

☐ Depressed ☐ normal

Work:

☐ Unable to work ☐ more sick days than usual ☐ not affected

Household chores:

☐ Not possible ☐ light chores ☐ usual chores

Leisure activities:

☐ Not possible ☐ occasionally ☐ normal

How does the pain affect your:
Concentration: _____
Emotions: _____
Social relationships: _____

OSWESTRY DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement ***which most clearly describes your problem.***

Section 1: Pain Intensity
- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing,Dressing,etc.)
- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but can manage most of my personal care
- ☐ I need help every day in most aspects of self care
- ☐ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting
- ☐ I can lift heavy weights without extra pain
- ☐ I can lift heavy weights but it gives me extra pain
- ☐ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed e.g. on a table
- ☐ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- ☐ I can only lift very light weights
- ☐ I cannot lift or carry anything

Section 4: Walking
- ☐ Pain does not prevent me walking any distance
- ☐ Pain prevents me from walking more than 2 kilometres
- ☐ Pain prevents me from walking more than 1 kilometre
- ☐ Pain prevents me from walking more than 500 metres
- ☐ I can only walk using a stick or crutches
- ☐ I am in bed most of the time

Section 5: Sitting
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favourite chair as long as I like
- ☐ Pain prevents me sitting more than one hour
- ☐ Pain prevents me from sitting more than 30 minutes
- ☐ Pain prevents me from sitting more than 10 minutes
- ☐ Pain prevents me from sitting at all

Section 6: Standing
- ☐ I can stand as long as I want without extra pain
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me from standing for more than 1 hour
- ☐ Pain prevents me from standing for more than 30 minutes
- ☐ Pain prevents me from standing for more than 10 minutes
- ☐ Pain prevents me from standing at all

Section 7: Sleeping
- ☐ My sleep is never disturbed by pain
- ☐ My sleep is occasionally disturbed by pain
- ☐ Because of pain I have less than 6 hours sleep
- ☐ Because of pain I have less than 4 hours sleep
- ☐ Because of pain I have less than 2 hours sleep
- ☐ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)
- ☐ My sex life is normal and causes no extra pain
- ☐ My sex life is normal but causes some extra pain
- ☐ My sex life is nearly normal but is very painful
- ☐ My sex life is severely restricted by pain
- ☐ My sex life is nearly absent because of pain
- ☐ Pain prevents any sex life at all

Section 9: Social Life
- ☐ My social life is normal and gives me no extra pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- ☐ Pain has restricted my social life and I do not go out as often
- ☐ Pain has restricted my social life to my home
- ☐ I have no social life because of pain

Section 10: Travelling
- ☐ I can travel anywhere without pain
- ☐ I can travel anywhere but it gives me extra pain
- ☐ Pain is bad but I manage journeys over two hours
- ☐ Pain restricts me to journeys of less than one hour
- ☐ Pain restricts me to short necessary journeys under 30 minutes
- ☐ Pain prevents me from travelling except to receive treatment

NECK DISABILITY QUESTIONNAIRE

This questionnaire has been designed to provide information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section, and mark in each section only the ONE sentence which applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the sentence which most closely describes your problem.

Section 1 – Pain Intensity
- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

Section 2 – Personal Care (Washing, Dressing, etc.)
- ☐ I can look after myself normally without extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Reading
- ☐ I can read as much as I want to with no pain in my neck.
- ☐ I can read as much as I want to with slight pain in my neck.
- ☐ I can read as much as I want to with moderate pain in my neck.
- ☐ I can't read as much as I want because of moderate pain in my neck.
- ☐ I can hardly read at all because of severe pain in my neck.
- ☐ I cannot read at all.

Section 5 – Headaches
- ☐ I have no headaches at all.
- ☐ I have slight headaches which come infrequently.
- ☐ I have moderate headaches which come infrequently.
- ☐ I have moderate headaches which come frequently.
- ☐ I have severe headaches which come frequently.
- ☐ I have headaches almost all the time.

Section 6 – Concentration
- ☐ I can concentrate fully when I want to with no difficulty.
- ☐ I can concentrate fully when I want to with slight difficulty.
- ☐ I have a fair degree of difficulty in concentrating when I want to.
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty concentrating when I want to.
- ☐ I cannot concentrate at all.

Section 7 – Work
- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I can't do any work at all.

Section 8 – Driving
- ☐ I can drive my car without any neck pain.
- ☐ I can drive my car as long as I want with slight pain in my neck.
- ☐ I can drive my car as long as I want with moderate pain in my neck.
- ☐ I can't drive my car as long as I want because of moderate pain in my neck.
- ☐ I can hardly drive at all because of severe pain in my neck.
- ☐ I can't drive my car at all.

Section 9 – Sleeping
- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless).
- ☐ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ☐ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ☐ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ☐ My sleep is completely disturbed (5-7 hrs. sleepless).

Section 10 – Recreation
- ☐ I am able to engage in all my recreational activities with no neck pain at all.
- ☐ I am able to engage in all my recreational activities with some pain in my neck.
- ☐ I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
- ☐ I am able to engage in a few of my usual recreational activities because of pain in my neck.
- ☐ I can hardly do any recreational activities because of pain in my neck.
- ☐ I can't do any recreational activities at all.

Beck Depression Index

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describe the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you don't choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11. Agitation

0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than I used to.
3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1–2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of the things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.