Patient Last Name

Office Policies and Treatment Agreement

Welcome to Pelorus TMS. We specialize primarily in major depression treatment for those who have not responded to multiple anti-depressant medication trials. Our goal is to help you (or your loved one) feel better, while realizing that no honest person can predict the future or guarantee an outcome. In order to work together successfully, we thought it would be helpful to spell out some guidelines:

1. SCOPE OF PRACTICE/SERVICES:

Pelorus TMS is a group practice, with services provided by psychiatrists, nurse practitioners, physician assistants, and certified TMS coordinators. Dr. Deborah Ocasio is our psychiatrist coordinating TMS at our Cedar Knolls office, and Dr. Matthew Barnas is our psychiatrist coordinating TMS at our Raritan office.

For more information about our TMS program, please visit our website: https://pelorustms.com

2. CANCELLATION AND NO SHOW POLICY:

As a Medicare-accepting and uniquely specialized TMS practice, our services are in great demand. Therefore, we have limited time available for office consultations and TMS treatments. If you have scheduled an appointment, please try to keep it. If you must cancel your appointment, **we require at least 24 business hours notice** so we can assist someone else in need. If your appointment is on a Monday, we must be notified by the same hour on the preceding Friday.

If you do not give **at least 24 business hours** advance notice for a missed appointment, you (or your guardian) will be charged $250 for each missed appointment. We do occasionally make exceptions for extreme circumstances, however, if you were charged a fee for a missed appointment, we expect you to pay that fee in order to schedule a follow-up appointment. These types of fees are your responsibility, as insurance does not cover missed appointments.

3. COMMUNICATION:

Contacting the Office

You may contact our office during regular business hours, Monday through Friday, from 9:00 AM to 5:00 PM at 973-295-6335. We will be happy to help you with appointments, insurance questions, or clinical questions. Our clinicians make all reasonable efforts to respond to calls promptly. Please note that our office is **not** staffed on weekends or holidays.

We always prioritize "Safety First", therefore:

*****If you are having an emergency and are unable to reach your clinician: please do not hesitate to call 911, or call or go to your local hospital's emergency room for immediate help, such as Overlook Medical Center's Crisis Center (908-522-3586), Morristown Medical Center's Crisis Center (973-971-5402), or RWJ University Hospital Somerset's Crisis Center (800-300-0628). The ER staff will contact us, while you are safely under the hospital's care.*****

During business hours, if you are routed to our secure voicemail, it means our team is occupied assisting other patients, and you should kindly leave us a detailed message so we can follow up with you as efficiently as possible. Non-urgent calls are usually returned within the same day, but at the latest, by the following business day.

When leaving us a message, please select the **appropriate option** from our voicemail system as follows:

- Cedar Knolls TMS, press **6**
- Raritan TMS, press **5**

If you are calling because of an emergency, press "**4**" and leave your message there. This emergency line is monitored 24 hours/day, 7 days/week. Your message will go directly to our clinician that is on-duty covering *emergency* calls. **This option is not for appointments or other related questions**.

Emails

Be aware that email is not a confidential means of communication. We also cannot guarantee that email messages will be received or responded to in a timely fashion. As such, **email is not an appropriate way to communicate very urgent or confidential information.** Our medical providers do not email with patients or family, although our administrative team will email with patients for non-urgent issues like appointment scheduling.

Patient Outreach by our Practice

A member of our team, or one of our automated systems, may contact you, or a designated representative, via phone call, text message, and/or email in relation to any services received from us, or any services planned to be received from us. This includes any billing items or appointment reminders.

4. INSURANCE, BILLING, AND PAYMENTS:

This Agreement requires that you pay for each session you have at Pelorus TMS. If you have health insurance, your TMS treatment may be covered in whole or in part. Where applicable, we will bill the insurance company for you, but you are required to pay your co-payment and any deductibles involved. As a courtesy, we will check with your insurance carrier, and will make reasonable attempts to determine what you will need to pay at each session; however, we cannot guarantee that the information provided to us is correct, and you are ultimately responsible for determining your insurance coverage and paying for your treatments which are not covered by your insurance plan.

Some insurance policies may require a "Prior Authorization" OR an annual minimum "Deductible" payment before covering the costs of treatment. If your policy requires it, we will endeavor to obtain a "Prior Authorization" for your treatment. If you have any remaining "Deductible" on your policy at the time of our service, it will need to be paid for by you before your insurance policy will cover the cost of your treatment – exactly the same as an auto insurance policy "deductible".

When patients with a policy "deductible" are seen early in the year (ie. January or February), they usually have yet to pay their deductible for the new year - therefore they will receive a higher-than-normal bill. The reason for the higher bill is because your policy's deductible has yet to be paid. Please call your insurance company to clarify if your policy requires a "prior authorization" or has a "deductible" remaining. **Every patient has a different policy with different details, so you must communicate directly with your insurer to understand the particulars related to your specific insurance policy.** You are responsible for payment if your insurance denies coverage for your treatment.

By signing this Agreement, you agree that you will pay any outstanding amounts due and owed to Pelorus TMS.

Any bills (for co-pays, co-insurance, deductibles, etc.) can be paid online through our payment portal using a credit or debit card at: https://www.pelorusmemory.com/payments/

5. **SECOND OPINION:**
If at any time you desire a second opinion (with an outside, non-Pelorus provider), please feel free to discuss this with us. We are eager to help you and will not be offended by such a request.

6. **TMS:**
TMS may be recommended to help improve the symptoms which led you (or your loved one) to seek a consultation. If it is agreed that TMS is indicated, your treating clinician will discuss options that are available to treat your current condition. Information will be presented to you in language that you can understand.

Treatment with TMS always involves potential risks and benefits. You will learn about the expected benefits of TMS, absolute and relative contraindications, possible side effects and risks, and its dosage and frequency.

By the end of the discussion, you will have all the information you need to make an informed decision as to whether treatment is right for you (or your loved one). If you decide that the benefits of treatment outweigh the risks, treatment will be prescribed and initiated. **If you have questions about TMS, your Pelorus medical provider will be happy to answer them.**

7. **CONFIDENTIALITY**:
Confidentiality is the cornerstone of mental health treatment and is protected by law. We can only release information about you to others with your written permission. Some basic information about diagnosis and treatment may be required as a condition of your insurance coverage.

There are exceptions to confidentiality where disclosure is required by law:

- If there is a threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization.
- If there is a threat to harm yourself, we are required to seek hospitalization for the patient, or to contact family members or others who can help provide protection.
- If there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency.
- If you are involved in judicial proceedings, you have the right to seek to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require our testimony.
- If due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, we may have to disclose information in order to access services that will provide for your basic needs.
- These situations have rarely arisen in our clinical practice, but should such a situation occur, we will make every effort to fully discuss it with you before taking any action.

8. TELEHEALTH:

Your provider may choose to conduct your appointment remotely using telecommunications technologies, such as video conferencing or telephone. The benefits of telehealth may include removing transportation and travel barriers, minimizing time constraints, and being able to access your appointment from the comfort of your own home. There are also risks associated with telehealth. These may include, but are not limited to, the possibility that transmission of your medical information could be disrupted or distorted by technical failures, the transmission of your medical information could be interrupted and/or accessed by unauthorized persons, and misunderstandings between you and your provider can more easily occur.

Telehealth-based services and care may not yield the same results or be as effective as face-to-face service for some individuals. If you or your provider believe that you would be better served by face-to-face service, you may be referred to an outside, non-Pelorus provider to receive such service.

All existing laws regarding your access to your medical information and copies of medical records apply. The laws that protect the confidentiality of your medical information also apply to telehealth.

You agree not to record or share the content of your telehealth visit. You agree to conduct the visit in a private space without any attendees present, or able to hear or see your visit, unless an alternative arrangement is agreed to by you and your provider. If someone comes into the room during your visit, please pause your video and restart only after they have left.

By signing this Agreement, you give your consent to conducting your appointments by telehealth and acknowledge the terms and conditions stated above.

9. TREATMENT CONSENT:

By signing below, you certify that you have read this document and understand the terms and conditions stated within. You understand that you have the right to choose between treatment vs. non-treatment, and that you can always inquire about the risks and benefits of treatment options. You understand that outcomes are not guaranteed. You agree that Pelorus TMS will bill you for any missed appointments that were not canceled in advance, per policy number 2 on page 1. You indicate that you understand the nature of our offered services, office and payment policies, insurance reimbursement, confidentiality requirements, telehealth, and communications policies, and that you agree to abide by the terms and conditions stated above during our professional relationship.

Signed_____ Date_____

Patient
(or Power-of-Attorney)

Authorization to Release Health Information Pursuant to HIPAA

Patient Name_____ **Birth Date**_____

Authorization: By signing this form, I authorize:

- Any other providers involved in my medical care to release my records to Pelorus TMS.
- Pelorus TMS to release my records to the following people, without requiring a signed release from them:

Psychiatrist or Primary Care Provider: _____

Neurologist / Other Doctors: _____

Therapist:_____

Family / Other (POA, Spouse, Parent, Children, etc): _____

_____

I, or my authorized representative, request and authorize that health care information regarding my care and treatment be released as described below:

Complete medical record (unless otherwise noted here): _____

_____

I *specifically authorize* the release of the following types of highly confidential information: AIDS or HIV, Mental Health Information, Treatment Recommendations, Drug and Alcohol information, and Sexually Transmitted Diseases. (Unless otherwise noted immediately above)

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Pelorus TMS.

I understand that signing this authorization is voluntary and that Pelorus TMS, may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal or state privacy regulations.

I have received a copy of this authorization.

Purpose of Release: Records are being released for **continuity of my medical care**, and/or for the

reasons specified here: _____

Signature of Patient:_____
(or Authorized Representative, i.e. Power of Attorney)

Date:_____

Name of Authorized Representative (if applicable) _____

Authority of Representative (ie Power of Attorney):_____
(if applicable)

Signature of Witness:_____

Pelorus TMS

PATIENT DEMOGRAPHIC INFORMATION

Date:_____Referred by:_____

Patient:_____

Last Name First Name Middle Initial

☐ Cell Ph: _____ ☐ Home Ph: _____Email:_____

(indicate preferred method of phone contact)

Who will be communicating on behalf of the patient? ☐ Patient ☐ Designated Representative *(enter details on next page)*

Preferred language for automated reminders: ☐ English ☐ Spanish

Sex: ☐ M ☐ F Age:_____Date of Birth:_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Street Address:_____City:_____State:_____Zip:_____

Psychiatrist or Primary Care Provider:_____Doctor's Phone:_____

Doctor's Fax:_____Doctor's Address:_____

Neurologist:_____Neurologist's Phone:_____

Neurologist's Fax:_____Neurologist's Address:_____

☐ Retired ☐ Working ☐ Student ☐ On Disability Employer/School (if applies): _____

In case of emergency, who should be notified? _____ Phone #: _____

Emergency contact's relationship to patient: _____

Preferred Pharmacy: _____ Phone #: _____

Pharmacy Address: _____

Do you have Medical Insurance? ☐ Yes ☐ No If yes:

Name of **Primary** Insurance (i.e. Medicare, Cigna, etc.) _____

Name of **Secondary** Insurance (if any, i.e. AARP, etc.) _____

Name of person fiscally responsible for this account? _____

Relationship to patient: (ie Self, "Power of Attorney", etc.): _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with:

_____

Name of Insurance Company

And assign directly to Pelorus TMS all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured/Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pelorus TMS for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non- covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____ _____

Signature of Insured/Guardian **Date**

Designated Representative for Patient Communications

Who should we communicate with regarding the patient? (i.e. appointments, questions, etc.)
Please indicate your selection with a "X" below:

☐ Patient *(proceed to next page)* ☐ Designated Representative *(enter details below)*

Name of Representative: _____
(Please print)

Relation to Patient: _____
(Please print)

Representative Home Phone Number: _____

Representative Cell Phone Number: _____

Representative Email Address: _____

Preferred language for automated reminders: ☐ **English** ☐ **Spanish**

IMPORTANT: If a designated representative is appointed to communicate on the patient's behalf, then that person will need to be included on the HIPAA authorization form.

Pelorus TMS

NEW PATIENT INTAKE QUESTIONNAIRE

We appreciate your complete and accurate sharing of history and information, as it allows us to best understand your circumstances and individual needs.

Patient Name:_____ **Date:** _____

Patient Date of Birth: _____

Who referred you to Pelorus TMS, or how did you find out about this practice?

_____

Reason for seeking TMS treatment (i.e Diagnosis, Symptoms, Recent History)?

_____

_____

_____

_____

Stressors/Precipitants contributing to current situation/symptoms?

_____

_____

Psychiatric Medications

Antidepressant Medications (Including current and past medications)	Dose	Schedule	Start Date	Stopped Date	Reason for Discontinuing Medication
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

Past Psychiatric History?

Current psychiatrist(s)? _____

Current psychiatric diagnosis? _____

Current psychologist/therapist? _____

Type of Therapy? Individual ☐ CBT ☐ Group ☐ IOP ☐ Couple/Family ☐

Start Date?_____ Frequency? _____

Past hospitalizations (location, date)? _____

Any violent, self-injurious, or suicidal behaviors? _____

_____

Past treatment with TMS ("magnetic stimulation"), ECT ("Shock Treatments"), or Ketamine?

_____

_____

Substance Abuse History (i.e. Nicotine, alcohol, painkillers, illegal drugs, etc.)?

Do you smoke?_____If so, how many cigarettes per day? _____

Have you ever smoked?_____For how long?_____How many cigarettes per day? _____

Do you use, or have you used, any illegal drugs?_____If so, please describe: _____

_____

Have you misused, abused, or become addicted to any painkillers? _____

Do you consume alcohol?_____If so, please describe the type, frequency and amount:

_____

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Past Medical History:

	Yes	No		Yes	No
Vision Loss			Seizures with high fever as a child or baby		
Glaucoma			Head Trauma w/ Loss of Consciousness		
Loss of Hearing			Back pain		
Recurrent Vertigo			Hematological Disorder (Sickle Cell, Hemophilia)		
Hypertension (High Blood Pressure)			Bleeding Tendency		
Dyslipidemia (High Cholesterol)			Diabetes		
History of MI ("Heart Attack")			Thyroid Disease		
COPD/Emphysema			Immunological Disorder (Rheumatoid Arthritis, Lupus, etc.)		
Gastrointestinal Disease			Chronic Allergies/Hay Fever		
Liver Disease			Depression		
Chronic Skin Condition			Psychiatric illness other than depression		
Osteoarthritis/ Degenerative Joint Disease			Kidney Disease, Prostate, or other urological disorder		
Chronic Sleep Disorder			Tuberculosis		
Stroke (CVA)			HIV or AIDS		
Alzheimer's or Other Cognitive Disorder			Encephalitis or Meningitis		
Parkinson's or Other Movement Disorder			Polio		
Essential Tremor			Infections (Lyme, Tuberculosis…)		
Fainting or Blackouts			Gynecological problems		
Seizures/Epilepsy			Any history of cancer		

Please list any other medical illnesses not already described, or clarify any noted above:

_____

_____

_____

Other Current Medications (please list all medications, dose, and frequency/schedule for each):

_____
_____
_____
_____
_____
_____

Allergies (medication and food related):

❒No Known Drug Allergies _____

Personal/ Social History

Location born and raised? _____

Education/ Degree?_____

Occupation?_____

For how long?_____If unemployed or retired, how long?_____

Marital Status?_____Living situation? (alone, etc.)_____

Children? How many?_____

Any history of being the victim of abuse?_____

Any history of legal issues? (DUI, recent arrests, court proceedings, firearms offenses, etc.)

_____

_____

Any family history of neurological or psychiatric illness?

_____

_____

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Review of Systems:

(Please indicate any relevant symptoms below, or check "N/A" if no symptoms apply):

	Other:	N/A
CONSTITUTIONAL: ❒fever ❒fatigue ❒night sweats ❒weight loss		❒
EYES: ❒glasses ❒blindness ❒double vision ❒visual field deficit ❒drooping eyelid		❒
EAR NOSE THROAT: ❒hearing loss ❒tinnitus ❒infection ❒trouble swallowing ❒snoring		❒
CARDIOVASCULAR: ❒shortness of breath ❒chest pain ❒edema ❒palpitations ❒heart murmur		❒
PULMONARY: ❒cough ❒wheezing ❒shortness of breath ❒coughing up blood		❒
GASTROINTESTINAL: ❒constipation ❒vomiting ❒diarrhea ❒rectal bleeding ❒nausea ❒abdominal pain		❒
SKIN: ❒rash ❒itchiness ❒ulcers ❒lesions		❒
MUSCULOSKELETAL: ❒back pain ❒joint pain or stiffness ❒joint swelling ❒muscle cramps or weakness		❒
NEUROLOGICAL: ❒memory loss ❒headache ❒tremor ❒dizziness ❒paralysis or weakness (ie hemiplegia after a stroke)		❒
HEMATOLOGICAL/LYMPHATIC: ❒bleeding tendency ❒tendency to bruise easily ❒history of blood clots		❒
ENDOCRINE: ❒increased urination ❒increased appetite ❒intolerance to heat or cold ❒weight loss ❒weight gain		❒
ALLERGIC/IMMUNO: ❒swollen lymph nodes ❒reactions to food or medications		❒
PSYCHIATRIC: ❒depression ❒anxiety ❒panic attacks ❒insomnia ❒hallucinations ❒delusions		❒
UROLOGICAL: ❒incontinence ❒nocturnal frequency ❒burning on urination ❒dialysis ❒bloody urine		❒
INFECTIOUS DISEASE: ❒fever ❒night sweats ❒known disease		❒
OBGYN (women only): ❒pregnant ❒painful menses ❒abnormal menses ❒vaginal discharge ❒breast mass		❒

Clarify any positive answers above, or any health symptoms not already mentioned:

_____

_____

_____

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TMS ADULT SAFETY SCREEN (TASS) QUESTIONNAIRE

1. Have you ever had an adverse reaction to TMS?
   Yes☐ No☐
   Comment:_____
   _____
   _____

2. Have you ever had a seizure?
   Yes☐ No☐
   Comment:_____
   _____
   _____

3. Have you ever had a stroke?
   Yes☐ No☐
   Comment:_____
   _____
   _____

4. Have you ever had a head injury?
   Yes☐ No☐
   Comment:_____
   _____
   _____

5. Do you have any metal in your head (outside of your mouth), such as shrapnel, surgical clips, or fragments from welding or metalwork?
   Yes☐ No☐
   Comment:_____
   _____
   _____

6. Do you have any implanted devices such as cardiac pacemakers, medical pumps, or intracardiac lines?
   Yes☐ No☐
   Comment:_____
   _____
   _____

Pelorus TMS

7. Do you suffer from frequent or severe headaches?
   Yes___ No___
   Comment:_____
   _____
   _____

8. Have you ever had any other brain-related condition?
   Yes___ No___
   Comment:_____
   _____
   _____

9. Have you ever had any illness that caused brain injury?
   Yes___ No___
   Comment:_____
   _____
   _____

10. Are you taking medication?
    Yes___ No___
    Comment:_____
    _____
    _____

11. If you are a woman of childbearing age, are you sexually active, and if so, are you not using a reliable method of birth control?
    Yes___ No___
    Comment:_____
    _____
    _____

12. Does anyone in your family have epilepsy?
    Yes___ No___
    Comment:_____
    _____
    _____

Patient Signature_____**Date**_____

Pelorus TMS

TMS Patient Screening Form

This section is to be filled out by the PATIENT/or patient representative. *Please indicate if you have any of the following:*

Aneurysms clips or coils	☐	Yes	☐	No	Wearable cardioverter defibrillator	☐	Yes	☐	No
Cardiac pacemaker or wires	☐	Yes	☐	No	Implanted insulin pump	☐	Yes	☐	No
Internal cardioverter defibrillator (ICD)	☐	Yes	☐	No	Programmable shunt or valve	☐	Yes	☐	No
Carotid or cerebral stents	☐	Yes	☐	No	Hearing aid	☐	Yes	☐	No
Deep brain stimulator	☐	Yes	☐	No	Cervical fixation devices	☐	Yes	☐	No
Metallic devices implanted in your head	☐	Yes	☐	No	Surgical clips, staples, or sutures	☐	Yes	☐	No
Dental implants	☐	Yes	☐	No	VeriChip microtransponder	☐	Yes	☐	No
Cochlear implant/ear implant	☐	Yes	☐	No	Wearable monitor (e.g. heart monitor)	☐	Yes	☐	No
CSF (cerebrospinal fluid) shunt	☐	Yes	☐	No	Bone growth stimulator	☐	Yes	☐	No
Eye implants	☐	Yes	☐	No	Wearable infusion pump	☐	Yes	☐	No
Cardiac stents, filters, or metallic valves	☐	Yes	☐	No	Radioactive seeds	☐	Yes	☐	No
Tattoo	☐	Yes	☐	No	Portable glucose monitor	☐	Yes	☐	No
Vagus nerve stimulator (VNS)	☐	Yes	☐	No	Tracheostomy	☐	Yes	☐	No
Blood vessel coil	☐	Yes	☐	No	Medical patch/nicotine patch	☐	Yes	☐	No
Shrapnel, bullets, pellets, BBs, or other metal fragments	☐	Yes	☐	No	Other implanted metal or device If yes, please specify:	☐	Yes	☐	No

Age:_____ Weight (lbs):_____ Height:_____ Last Menstrual period:_____

Have you ever been a machinist, welder, or metal worker?	☐ Yes	☐ No
Have you ever had a facial injury from metal and/or metal removed from your eyes?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Have you ever had a complication from an MRI?	☐ Yes	☐ No

Signature of person completing this form:_____ Date: _____

Signature of TMS Coordinator:_____ Date:_____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name _____ Date _____

Provider _____ Patient ID # _____

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

add columns: _____ + _____ + _____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:** _____

10. 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** _____

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