**HILO NATURAL HEALTH CLINIC***152 Puueo St, Hilo, HI 96720 808.933.4325, fax: 808-657-3926*

“Good Medicine Shouldn’t Be The Alternative”

**New Patient Intake Form**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_\_\_\_

Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M / F

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_ Home Ph: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Ph:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May I leave confidential voice-mail messages for you at any of the above numbers?**

(specify)  No  Yes (specify):  Home  Work  Cell

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*for healthcare use only!)*

Are you currently employed? Y N Occupation\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Can we thank them? Y N

Do you have insurance? (If yes, what type?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name (minors only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name (minors only): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact’s Phone: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home  Work  Cell

Primary Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Financial Terms:*** *I understand that I am responsible for all charges at the time of service. I understand that finance charges will begin accruing on accounts that are 60 days past due for payment at a rate of 1.5% per month. I further understand that excessively overdue accounts will be forwarded to an outside collection agency and I will be responsible for any fees generated as a result of collection efforts. I understand that any guarantor listed above is subject to the same financial terms as outlined in this paragraph and that my payment history, account balance and due dates may be disclosed to the guarantor for the purposes of securing payment. I understand that the guarantor, if someone other than myself, is not authorized to receive my medical information unless expressly authorized by me in writing.*

***Privacy Terms:*** *Records are kept of the healthcare services provided to you. Applicable state and federal laws protect the confidentiality of your medical information and grant you the right to see or obtain a copy of the records kept. Moreover, if you believe that information in your record is inaccurate, you may also request that it be corrected. Your medical information will not be disclosed to others unless you direct us to do so or applicable laws authorize or compel us to do so.* ***Privacy Policy is available upon request.***

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_/\_\_\_/20\_\_\_

**Main Reason for today’s visit** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Health Concerns

|  |
| --- |
|  |

**Present medications** (including contraceptives), nutritional supplements, herbs, etc.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of product | Brand | Dosage | Duration taken | Reason(s) | Did it help? |
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**Check any of the following that you currently use:**

\_\_laxatives \_\_ antibiotics \_\_sleep aids \_\_antacids \_\_allergy medications \_\_pain relievers

**List previous surgeries, hospitalizations, or special studies (MRI, etc):**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ year: \_\_\_\_\_

Top of Form

Bottom of Form

**HILO NATURAL HEALTH CLINIC**

**COLLABORATIVE CARE AUTHORIZATION**

*I give permission for the exchange of information between the following practitioners associated with Hilo Natural Health Clinic as is relevant to my condition. I understand that this is only to occur between practitioners with whom I have established care and is limited to discussions involving information that is relevant to diagnosis and treatment. This collaboration is to be done for the sole purpose of ensuring that I receive the best complementary care possible and to enhance communication amongst the practitioners. I understand that I have the right to revoke or alter this contract at any point in time for whatever reason I see fit.*

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

Signature Printed Name Date

**REVIEW OF SYMPTOMS**

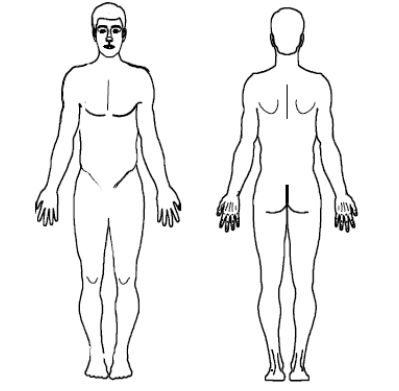
*Please take time to fill this out- it will help us maximize our time with you during your visit.*  *Answer questions about symptoms/ habits experienced in the past 6 months or those that greatly affect your daily life.*

**LIFESTYLE HABITS**

**Please shade in areas where you are experiencing** Interests and hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**pain on figures (if applicable).**  Exercise, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_Y \_\_ N Have a spiritual practice?

\_\_Y \_\_ N Average 6-8 hrs. of sleep?

\_\_Y \_\_ N Fall asleep easily?

\_\_Y \_\_ N Wake often in during sleep?

\_\_Y \_\_ N Have a supportive relationship?

\_\_Y \_\_ N History of abuse?

\_\_Y \_\_ N Major traumas?

\_\_Y \_\_ N Use recreational drugs?

\_\_Y \_\_ N Treated for drug dependence?

\_\_Y \_\_ N Consume caffeine? How much?\_\_\_\_\_

\_\_Y \_\_ N Add salt to your food?

\_\_Y \_\_ N Eat refined sugar?

\_\_Y \_\_ N Enjoy your work?

\_\_Y \_\_ N Take vacations?

\_\_Y \_\_ N Spend time outside, in nature?

\_\_Y \_\_ N Watch TV? How much? \_\_\_\_\_\_

\_\_Y \_\_ N Read? How often? \_\_\_\_\_\_\_\_\_\_

\_\_Y \_\_ N Consume alcohol? # per week \_\_\_\_\_

\_\_Y \_\_ N Use tobacco currently? # per day \_\_\_\_

\_\_Y \_\_ N Used tobacco in the past?

When did you quit? \_\_\_\_\_\_\_

**Check any of the following that are currently a chronic issue (NOT ACUTE) or have been a major health concern in the past.**

**SKIN HEAD / NECK IMMUNE**

\_\_\_Rashes\_\_\_Headache/migraine\_\_\_Chronic Fatigue Syndrome

\_\_\_Eczema, Hives\_\_\_Faintness\_\_\_Chronic infections

\_\_\_Acne, Boils\_\_\_Dizziness\_\_\_Chronically swollen glands

\_\_\_Itching\_\_\_Jaw Pain \_\_\_Slow wound healing

\_\_\_Fungal Infections \_\_\_Swollen Glands

\_\_\_Color change \_\_\_Goiter **MUSCLES / JOINTS/ BONES**

\_\_\_Hair Loss \_\_\_Pain or stiffness \_\_\_Joint pain

\_\_\_Dry skin / scalp \_\_\_TMJ \_\_\_Muscle pain

\_\_\_Lumps \_\_\_Muscle spasms / cramps

\_\_\_Night Sweats **RESPIRATORY** \_\_\_Restless leg Syndrome

\_\_\_Slow healing ulcerations\_\_\_Chest congestion \_\_\_Sciatica

\_\_\_Flushing or hot flashes \_\_\_Wheezing \_\_\_Osteoporosis

\_\_\_Asthma

**NOSE AND SINUSES** \_\_\_Bronchitis/Pneumonia **NEUROLOGIC**

\_\_\_Frequent colds\_\_\_Emphysema\_\_\_Seizures

\_\_\_Nose Bleeds \_\_\_Difficulty/Pain breathing\_\_\_Paralysis

\_\_\_Stuffiness\_\_\_Shortness of breath \_\_\_Muscle weakness

\_\_\_Hay fever\_\_\_Tuberculosis \_\_\_Numbness or tingling

\_\_\_Sinus problems\_\_\_Cough \_\_\_Wet or \_\_\_Dry \_\_\_Easily stressed

\_\_\_Loss of smell \_\_\_Coughing blood \_\_\_Vertigo or dizziness

\_\_\_Loss of balance

**EYES AND EARS CARDIOVASCULAR** \_\_\_Tics

\_\_\_Itchy eyes\_\_\_Heart disease

\_\_\_Watery eyes\_\_\_Angina/Chest pain **DIGESTION**

\_\_\_Dry eyes\_\_\_High/Low Blood Pressure\_\_\_Trouble swallowing

\_\_\_Swollen/painful eyes\_\_\_Murmurs\_\_\_Heartburn / Acid Reflux

\_\_\_Red Eyes\_\_\_Blood clots\_\_\_Change in thirst/appetite

\_\_\_Impaired vision/blurriness \_\_\_Irregular heart beat\_\_\_Ulcer

\_\_\_Floaters in vision \_\_\_Palpitations/Fluttering\_\_\_Nausea/Vomiting

\_\_\_Cataracts \_\_\_Swelling in ankles \_\_\_Gas/Bloating

\_\_\_Color blindness \_\_\_Belching or passing gas

\_\_\_Double Vision **CIRCULATION** \_\_\_Diarrhea

\_\_\_Glaucoma \_\_\_Easy bleeding or bruising \_\_\_Constipation

\_\_\_Hearing difficulty\_\_\_Anemia\_\_\_Pain or cramps

\_\_\_Ringing\_\_\_Deep leg pain\_\_\_Mucous in stools

\_\_\_Earaches/Infection\_\_\_Varicose veins\_\_\_Black / Bloody stool

\_\_\_Cold hands/feet\_\_\_Hemorrhoids

**MOUTH AND THROAT** \_\_\_Itchy / Burning Anus

\_\_\_Sore throat **ENDOCRINE** \_\_\_Rectal Pain

\_\_\_Copious saliva\_\_\_Hypothyroid\_\_\_Liver/Gall Bladder trouble

\_\_\_Teeth grinding\_\_\_Heat or cold intolerance\_\_\_Jaundice (yellow skin)

\_\_\_Sore tongue/lips\_\_\_HypoglycemiaBowel Movements:

\_\_\_Gum problems\_\_\_DiabetesIs this a change? How often?\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Hoarseness\_\_\_Excessive thirstStools? \_\_\_Hard \_\_\_Firm

\_\_\_Gagging/choking\_\_\_Excessive hunger \_\_\_Soft \_\_\_Loose

\_\_\_Difficulty swallowing\_\_\_Fatigue

\_\_\_Seasonal depression

**URINARY FEMALE ONLY**

\_\_\_Pain on urination\_\_\_Irregular cycles

\_\_\_Increased frequency\_\_\_Bleeding between cycles

\_\_\_Frequency at night \_\_\_Pain during intercourse

\_\_\_Frequent infections\_\_\_Clotting

\_\_\_Inability to hold urine\_\_\_Heavy or excessive flow

\_\_\_Kidney stones\_\_\_PMS

\_\_\_Blood in urine\_\_\_Endometriosis

\_\_\_Difficulty conceiving

**MENTAL/ EMOTIONAL** \_\_\_Painful menses

\_\_\_Mood Swings\_\_\_Vaginal discharge? Color? \_\_\_\_\_\_

\_\_\_Anxiety or nervousness \_\_\_Vaginal Odor

\_\_\_Considered/Attempted suicide\_\_\_Ovarian cysts

\_\_\_Depression\_\_\_Menopausal symptoms

\_\_\_Poor concentration \_\_\_Abnormal PAP

\_\_\_Poor Memory \_\_\_Sexually transmitted disease

\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_Breast pain/tenderness

\_\_\_Nipple discharge

**GENERAL** \_\_\_Breast Lumps

\_\_\_Poor Sleep / Insomnia Age at which menses began \_\_\_\_\_\_

\_\_\_Dream disturbed Sleep Age of last menses (if menopausal)\_\_\_

\_\_\_Fatigue / Low Energy Length of Cycle (ex. 28 days)\_\_\_\_\_\_\_

\_\_\_General feel Hot Duration of Flow (ex 3-5 days) \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_General feel Cold Date of last period \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Chills Are you sexually active? Yes No

\_\_\_Fevers Gender of Partners: Male Female Both

\_\_\_Poor Appetite Birth control? Type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Constant Hunger Number of pregnancies \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Cravings \_\_\_\_\_\_\_\_\_\_\_ Number of live births \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Peculiar taste in mouth Number of miscarriages \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Low Libido Number of abortions \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Experience High Stress Difficult or premature births

Do you do breast self-exams? Yes No

**MALE ONLY** Date of last Pap smear \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Hernias Date of last mammogram \_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Testicular masses Could be pregnant now?

\_\_\_Testicular pain Any other female difficulties?

\_\_\_Prostate disease

\_\_\_Sexually transmitted disease  **OTHER SYMPTOMS/CONCERNS?**

\_\_\_Discharge or sores

\_\_\_Sexual dysfunction

Are you sexually active? Yes No

Gender of Partners: Male Female Both

Birth control? Type? \_\_\_\_\_\_\_\_\_\_

Any other male difficulties? \_\_\_\_\_\_\_\_\_

**SOCIAL INFORMATION:**

Relationship Status: Single Married In a relationship

Do you have children? Y/N If so, what are their ages? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in your household ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:** Have you or any blood relatives been diagnosed with the following?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Disorder | Yourself? | | Relative(s) | Disorder? | Yourself? | | Relative(s) |
| Past | Present | Past | Present |
| Alcoholism |  |  |  | Drug Addiction |  |  |  |
| ALS/Lou Gehrig’s |  |  |  | Emphysema |  |  |  |
| Alzheimer’s |  |  |  | Epilepsy/ Seizures |  |  |  |
| Arthritis |  |  |  | Fibromyalgia |  |  |  |
| Asthma |  |  |  | Gout |  |  |  |
| Attention Deficit |  |  |  | Headaches |  |  |  |
| Autism |  |  |  | Heart Disease |  |  |  |
| Bipolar Disorder |  |  |  | Learning Disability |  |  |  |
| Bleeding Disorders |  |  |  | Lupus (SLE) |  |  |  |
| ↑ Blood Pressure |  |  |  | Mental Illness |  |  |  |
| Cancer |  |  |  | Migraines |  |  |  |
| Chemical Sensitivity |  |  |  | Multiple Sclerosis |  |  |  |
| ↑ Cholesterol |  |  |  | Neural Tube Defect |  |  |  |
| Chronic Fatigue Syn |  |  |  | Parkinson’s Disease |  |  |  |
| Crohn’s Disease |  |  |  | Pernicious Anemia |  |  |  |
| Depression |  |  |  | Polycystic Ovaries |  |  |  |
| Diabetes |  |  |  | Skin Problems |  |  |  |
| Down’s Syndrome |  |  |  | Ulcerative Colitis |  |  |  |

Do any other significant medical conditions or symptoms run in your family?

**DIET: List typical foods you would eat for the following:**

Breakfast:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dessert: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beverages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any allergies?**  **No Known Allergies**

|  |  |  |
| --- | --- | --- |
| Allergen | Reaction Caused | Severity of Reaction |
|  |  |  |
|  |  |  |
|  |  |  |

**STANDARD VISIT INTAKE**

What is your MAIN concern/ reason for today’s visit?

|  |
| --- |
|  |

Any other concerns that need to be addressed immediately?

|  |
| --- |
|  |

Any changes in medications/ supplements since last visit? If so, what?

|  |
| --- |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the past 2 weeks how often have you been bothered by the following problems? (check the box that best fits) | Not at All | Several Days | More than Half the Days | Nearly or Every Day |
| *Feeling nervous, anxious, or on edge* |  |  |  |  |
| *Not being able to stop or control worrying* |  |  |  |  |
| *Little interest or pleasure in doing things* |  |  |  |  |
| *Feeling down, depressed, or hopeless* |  |  |  |  |