Women's Medicine Collaborative
A program of The Miriam Hospital
Lifespan. Delivering health with care.™

146 West River Street
Providence, RI 02904
3rd Floor
(401) 793-7010
WomensMedicine.org

Dear _____ ,

Welcome to **Women's Primary Care.**

Your appointment is on _____ with _____.

Women's Primary Care is located on the Third (3rd) floor.

Please arrive at _____ am/pm.

Please bring the completed new patient packet (enclosed), along with your insurance cards, photo ID, and current medication list.
Please do not mail your packet back to us.

If you need to cancel or reschedule your appointment, we request that you do so at least 24 hours in advance.

Please Note: If you arrive later than 15 minutes for your appointment, you may have to reschedule your appointment.

Driving directions are enclosed. Park in the South parking lot. Parking is free.

For more information about the Women's Medicine Collaborative, please visit our website at *www.WomensMedicine.org.*

We look forward to seeing you.

Sincerely,
Women's Primary Care

"Helping women reach their greatest health potential in body, mind, and spirit."

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2nd Floor - Lifestyle Medicine Center, Bone Density Testing, Massage Therapy, Nutrition, Physical Therapy, Pulmonary Function Testing, Ultrasound, Yoga, Lifespan Laboratory

3rd Floor - Behavioral Medicine, Bone Health, High-Risk Breast Program, Cancer Survivorship, Colposcopy Clinic, Diabetes in Pregnancy, Gastrointestinal Medicine, Genetics, GYN Oncology, Menopause Consultation, Maternal-Fetal Medicine, Obstetric Medicine, Program for Pelvic Floor Disorders , Pelvic Pain Program, Primary Care, Pulmonary Medicine, Rheumatology, Urology, Urogynecology

Directions

From EAST of PROVIDENCE

- From Route 195, merge onto Route 95 North toward Providence
- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

From WEST of PROVIDENCE

- Follow Route 146 South to Providence
- Take the Admiral Street exit
- Turn left onto Admiral Street
- Turn right onto Charles Street / RI-246
- Turn left onto West River Street
- 146 West River Street is on the left (brick mill building)

Park in the South parking lot.

From NORTH of PROVIDENCE

- Follow Route 95 South toward Providence (crossing into Rhode Island)
- Take the Branch Avenue exit (Exit 24)
- Turn right onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- Turn right to stay on West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

From SOUTH of PROVIDENCE

- Follow Route 95 North to Providence
- Take the Branch Avenue exit (Exit 24)
- Turn left onto Branch Avenue
- Follow Branch Avenue to the first traffic light
- At the traffic light, turn left onto West River Street
- 146 West River Street is on the right (brick mill building)

Park in the South parking lot.

If you accidentally get on Route 146 North (instead of following Route 95 North) and take the Branch Avenue exit off of Route 146 North, you must turn right off of the exit.

BUS ROUTES

Best service to take is **Route# 51, 52 or 72** to Charles Street and West River Street. Route 51 runs every half hour. Route 52 and 72 both run every 45 minutes or so. Get off at bus stop in front of the Providence Post Office (across the street from the "Subway" sandwich shop). Walk to the corner of Charles Street and West River Street, take a right onto West River Street and walk straight down to our building. It is a brick mill building on the left. Enter into the South parking lot entrance. Contact RIPTA at (401) 781-9400 or online at www.ripta.com for schedules and additional information.

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146 West River Street
Providence, RI 02904

Tel 401 793-5700
Fax 401 793-7801

About Your Billing

To our patients:

This letter is to give you notice that the Women's Medicine Collaborative is an out-patient department of The Miriam Hospital. It is not a private doctor's office.

Because we are part of the hospital system, you may be responsible for two charges - a facility fee and a fee for physician or other licensed professional services.

You are responsible for all copayment, coinsurance, or deductible payments according to your insurance plan.

We cannot predict the total out-of-pocket expense you will have for your visit. You are strongly encouraged to contact your insurance company prior to your office visit or procedure to understand your responsibility for any copayment, coinsurance, and/or deductible. Your copayment is due at the time of the visit.

Please also ask your insurance company if a referral or prior authorization is necessary.

If you have any questions, please contact our office at (401) 793-5700.

Sincerely,
The Miriam Hospital
doing business as Women's Medicine Collaborative

Definitions

Facility fee: A facility fee is a legally mandated charge for services given in a hospital-based out-patient department. This is also called "provider-based billing", which is a service charge for the patient's use of the hospital's facility, equipment, and support services.

Copayment (Copay): A fixed amount ($20, for example) you pay for a health care service. Copayments can vary for different services within the same insurance plan, like medications, lab tests, and visits to specialists.

Deductible:
The amount you pay for health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of health care services yourself. After you pay your deductible in full, you usually pay only a copay or coinsurance for covered health care services. Your insurance company pays the rest.

Coinsurance: The percentage of the cost of a health care service that you must pay (20%, for example) after you've paid your deductible. For example, if you've paid your deductible in full, and the cost of the service is $100, you must pay 20% of $100, or $20. The insurance company pays the rest.

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GENERAL OFFICE POLICIES

Welcome to our practice! Thank you for choosing Women's Primary Care as your primary care office. We are committed to providing the finest personalized and professional care possible for our patients. We hope the following information will help answer some of your questions and help you understand how our office operates.

Office Hours

Monday	8:00 am - 5:00 pm
Tuesday	8:00 am - 6:30 pm
Wednesday	8:00 am - 5:00 pm
Thursday	8:00 am - 5:00 pm
Friday	7:30 am - 5:00 pm

NOTE: Our phones are answered by the office staff from 8:30am – 4:30pm Monday through Friday.

After Hours

An on-call physician is available after hours for any urgent medical questions/problems that arise. Prescription refills, appointment scheduling, and lab/test results should be handled during routine office hours only. If you have a life-threatening emergency, call 911 or go immediately to the nearest emergency room.

Patient Portal

MyLifespan is a secure, password protected site that allows you to see your test results and contact your provider. You can sign-up for the patient portal at your appointment or go to www.lifespan.org/mylifespan

Scheduling Appointments

Appointments can be scheduled by phone, via the patient portal, or in person at the office.
Patients arriving later than 15 minutes for their appointment may be rescheduled. Please contact the office as soon as possible if you cannot make your appointment time.

Sick/Urgent Visits

If you need to be seen for a sick visit we will try to accommodate you that same day. Please do not walk in for an appointment. Every effort will be made to have you seen by your assigned provider. If your provider is unavailable you will be scheduled to see another member of our practice. If you are experiencing a medical emergency please call 911.

Cancellation Policy

We realize patients may need to change their appointments. We kindly request 24-hour notification of cancellation for appointments so we may offer that time to another patient. A cancellation less than 24 hours before an appointment is considered a *no show* appointment. If you have 3 *no shows* you may be dismissed from the practice.

Medication Refills

You are generally prescribed enough medication to last until your next scheduled appointment. Medications (other than narcotics, stimulants, benzodiazepines, and sleep aides) will be approved for a refill if you are a current patient *actively in treatment* with a prescribing provider. *Actively in treatment* with a provider is defined as having had at least one (1) visit in the past twelve (12) months.

Check your prescription bottle or with your pharmacy to see if additional refills are already authorized. Your pharmacy will most often contact our office for routine refills. If additional refills are not authorized, please have your pharmacy send an electronic refill request to us directly. We ask that you provide us with at least 72 hours' notice for refill requests.

If you require a new medication, please contact our office via the patient portal or by telephone.

Controlled Substances

We are working hard to ensure that controlled substances are prescribed in the safest manner possible. For this reason, we do not prescribe controlled medications such as narcotics, stimulants, benzodiazepines, or sleep aides at your initial visit. We need to obtain prior medical and pharmacy information to prescribe these medications. Controlled substances will be refilled based on the below criteria:

a. Narcotics and Stimulants: the patient must attend an appointment every three (3) months unless otherwise agreed to by the patient and provider.
b. Benzodiazepines and Sleep Aides: the patient must attend an appointment every six (6) months unless otherwise agreed to by the patient and provider.

Antibiotics

It is our policy that we do not prescribe antibiotics over the phone. We feel it is important to include a physical exam in the decision to prescribe these medications. For this reason we will make every effort to fit patients in for sick visits quickly.

Test Results

All test results will be communicated through the patient portal, by mail, or telephone as appropriate.
To sign-up for the patient portal - called MyLifespan- go to: www.lifespan.org/mylifespan

Medical Forms

We do not charge a fee for completing health-related forms. However, please contact your provider in advance and allow 7 days for the completion of any forms. You may need an appointment to complete your form. If so, you are responsible for any co-pay.

Insurance

If you are planning on switching your medical insurance to a different carrier, please call us first to verify that we are participating with your new plan.

Medical Scribe

During your visit, your provider may be accompanied by a medical scribe. A scribe specializes in charting patient encounters, such as during medical examinations. A scribe is a trained assistant to the provider who performs documentation in the electronic medical record, which allows the provider more time for patient care. You will be asked if you agree to have a scribe in the room. You can always decline if you prefer.

We Are an Academic Practice

An academic practice means that our physicians are faculty at Brown University's Internal Medicine Residency program as well as The Warren Alpert Medical School and that our nurse practitioners are instructors at the University of Rhode Island and University of Massachusetts. We often have medical students, nurse practitioner students, and resident physicians working in our office. Resident physicians already have their medical degree but are completing their training in internal medicine. If a student or resident is working with your provider, you will be notified when scheduling your appointment. The student or resident physician will do the initial evaluation and then your provider will see you as well. The practice also sponsors research projects designed to advance outpatient medicine. Patients are welcome to participate if they are interested.

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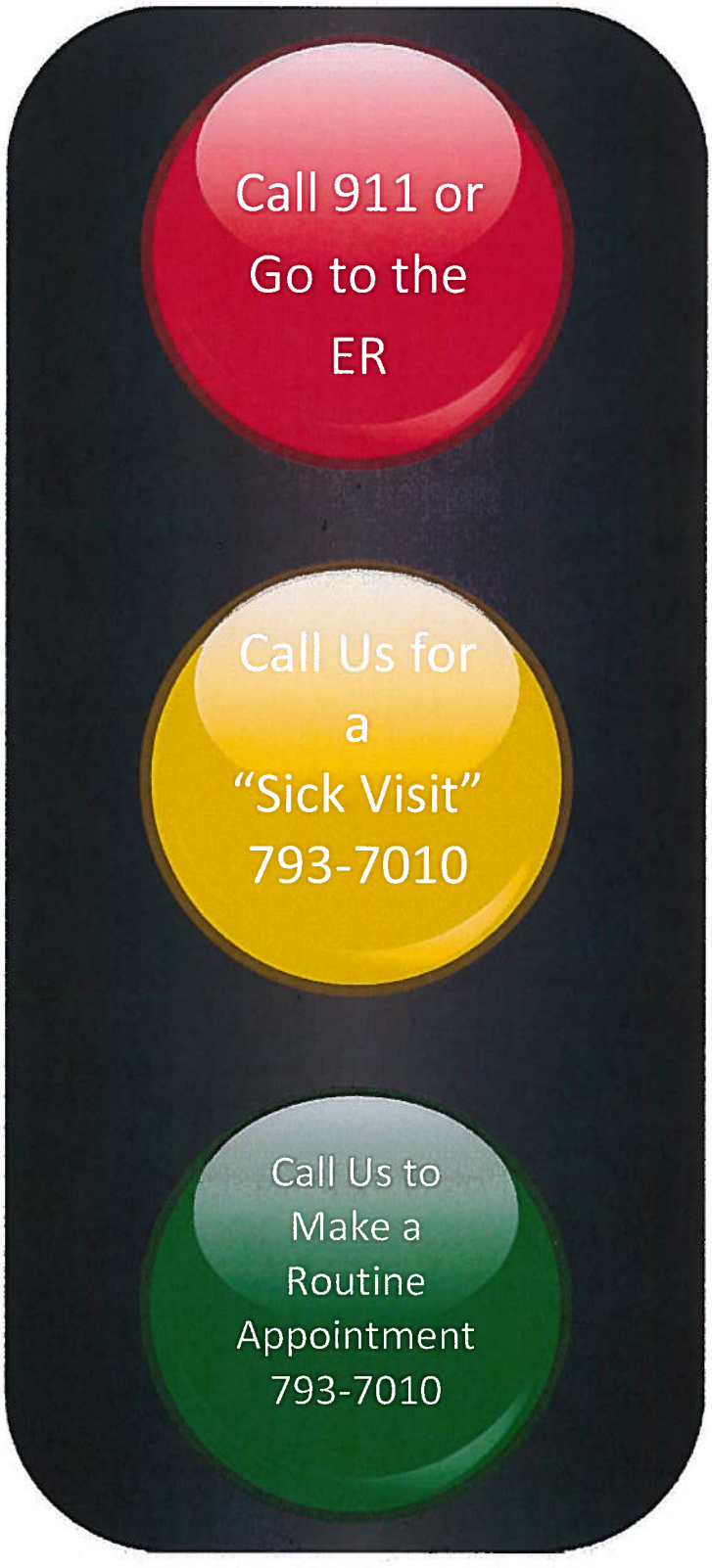
Deciding when to go to the Emergency Room

An on-call physician is available 24/7 to help guide your decision to go to the ER or not. Call 793-7010 and you will be directed to the Call Center.



- Major injuries (broken bones)
- Uncontrolled bleeding
- Coughing or vomiting blood
- Sudden severe pain
- Poisoning
- Sudden facial drooping or weakness in an arm or leg
- Difficulty breathing
- Fainting
- Chest pain or pressure

- Flu symptoms
- Fever
- Earache
- Sore throat
- Non-life threatening illness or injury

- Check-up/Annual visit
- Vaccinations/Immunizations
- Discuss starting a new medication
- Discuss symptoms that don't seem to be going away

04.12.17

Women's Medicine Collaborative*

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146 West River Street, Providence, RI 02904

Patient Label

REGISTRATION FORM

PATIENT INFORMATION (PLEASE PRINT)

Last Name	First Name	Middle

Birth Date	Social Security #	Email

Street Address	Home Phone ( )

City	State	Zip Code	Mobile Phone ( )

Marital Status
❑ Single ❑ Married ❑ Divorced ❑ Legally Separated
❑ Widowed ❑ Significant Other ❑ Other:_____

Preferred Language
Spoken: _____ Written: _____
Interpreter Required? ❑ YES ❑ NO

Sex: ❑ Female ❑ Male

Religion: _____

Preferred Pharmacy: Name: Phone #:
Address:

Are you Employed? ❑ YES, Full Time ❑ YES, Part Time ❑ YES, Self-employed ❑ Student, Full Time
❑ NO, Not Employed ❑ NO, Disabled ❑ NO, Retired ❑ Student, Part Time

Employer	Occupation	Employer Phone ( )

Which provider you are here to see today?

How did you hear about us?

LAST Primary Care Provider (PCP) / Practice Name

LAST PCP Address	LAST PCP Phone ( )

INSURANCE INFORMATION - PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST

Person responsible for bill	Birth Date / /	Address (if different)	Home Phone ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Primary Insurance Plan Name

Group #	Policy #	Co-Pay Amount

Subscriber's Name	Subscriber's Birth Date / /	Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed

Subscriber's Employer

Name of secondary insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's relationship to subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Subscriber's Employment Status ❑ Full Time ❑ Part Time ❑ Unemployed

Subscriber's Employer

IN CASE OF EMERGENCY

Name of local friend or relative to contact	Relationship to patient	Home Phone ( )	Mobile Phone ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Miriam Hospital (Women's Medicine Collaborative) or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date

PATIENT PORTAL: Would you like access to the Women's Medicine Collaborative Patient Portal? ❑ Yes ❑ No

ADVANCED DIRECTIVES: Do you have a Living Will? (A written document instructing your attending physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition) ❑ Yes ❑ No Do you have a Durable Power of Attorney for Healthcare? (A written declaration by the patient designating another person to be the patient's agent) ❑ Yes ❑ No I would like the *Living Will and Durable Power of Attorney for Healthcare* booklet. ❑ Yes ❑ No

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Patient Label

ETHNICITY – PLEASE SELECT

We want to make sure that all our patients get the best care possible. Please tell us your country of origin and racial/ethnic background so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. Your answers are confidential and will have no effect on the care you receive.

❑ Hispanic or Latino ❑ Non-Hispanic/Latino ❑ Unknown ❑ Prefer not to answer

RACE - PLEASE SELECT

❑ Unknown

❑ Prefer not to answer

❑ American Indian or Alaska Native

❑ Asian (includes Chinese, Cambodian, Hmong, Indian, Filipino, Laotian, Other Asian)

❑ Black or African American (includes Black, African American, African, Ethiopian, Ghanaian; Haitian, Cape Verdean, West Indian, Nigerian, Other African)

❑ Native Hawaiian or other Pacific Islander (includes Native Hawaiian, Pacific Islander, Guamanian)

❑ White or Caucasian

❑ Other: _____

PHONE PRIVACY

In our efforts to protect your privacy, please let us know how you would like us to reach you regarding future appointments or information regarding your healthcare.

HOME telephone # (_____) _____

MOBILE telephone # (_____) _____

WORK telephone # (_____) _____

BEST number to reach you: ❑ Home ❑ Mobile ❑ Work

May we leave a general message about appointments? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

May we leave a detailed message? HOME: ❑ Yes ❑ No
MOBILE: ❑ Yes ❑ No
WORK: ❑ Yes ❑ No

The Miriam Hospital
Lifespan. Delivering health with care.™

The Miriam Hospital
Health Information Management
164 Summit Avenue
Providence, RI 02906
Ph) 401-793-2222 Fax) 401-793-2247

Authorization to Use or Disclose Protected Health Information

(This form must be completed in full before signing)

Patient Name_____ DOB_____ Phone _____

Address _____
Street City State ZIP

1. I hereby authorize The Lifespan Hospital /Women's Medicine Collaborative to: ☐ Release to and/or ☐ Obtain from

2. _____ _____
Person /Place/Institution Phone Number

_____ _____
Street City State ZIP Fax Number

3. Dates of treatment or time period: _____

4. Purpose for which disclosure is to be made: ☐ Coordination of Care ☐ Patient Request ☐ Legal

☐ Other (please specify): _____

5. Record Format-please check one: ☐ paper ☐ data storage device

6. Information to be disclosed (check all applicable): *There may be a fee associated with this request.*

☐ Emergency Dept. Record ☐ Operative/Path Report ☐ Lab/X-ray Reports ☐ Other Diagnostic Testing

☐ Clinic/Office Visit ☐ Consultation/Evaluation ☐ After Visit Summary

☐ Abstract* ☐ Discharge Summary ☐ Other_____

*Abstract includes: Facesheet, ED Record, H & P, D/C Summary, Consult, Operative report, Pathology report, test results, PT/OT/ST

For Behavioral Health Affiliates: ☐ Assessment ☐ Treatment Plan ☐ Psychiatric Evaluation ☐ Medications

7. I do not want the following information disclosed: ☐ mental health ☐ alcohol/drug use/test

☐ sexual abuse ☐ sexually transmitted infections ☐ AIDS/HIV test results

8. I understand that my records are protected under the federal privacy laws and regulations and under the General Laws of Rhode Island, and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that certain health records containing alcohol or drug abuse information may be subject to further protection under Federal Regulation 42 CFR Part 2. Confidentiality of Alcohol and Drug Abuse.

9. I understand that if the person(s) or entity (ies) that receive(s) this information is not a health care provider or health plan covered by federal regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Lifespan, its employees and my physicians from all liability arising from this disclosure of my health information.

10. It is my understanding that this authorization is for information we have at the time of your request, only for the information requested above and will expire 1 year from the date signed below. I understand that I may revoke this authorization by notifying Lifespan in writing. I understand that any previously disclosed information would not be subject to my revocation request.

11. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits, unless otherwise described in the space provided here:

_____ _____ _____
Signature of Patient*, Legal Guardian, or Representative Date Time

_____ _____ _____
Print name of Patient, Legal Guardian or Representative Date Time

*Note Concerning Minors: For disclosures to persons/entities other than medical providers, the signature of a patient under 18 years who gave legal consent for testing, examination or treatment for reportable communicable disease (including HIV & venereal disease) or for alcohol and/or drug abuse treatment is required.

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Women's Primary Care
146 West River St., Providence, RI 02904
3rd Floor ~ Suite 11D
(401) 793-7010

Patient Label

PLEASE FILL OUT ALL FORMS AND BRING TO APPOINTMENT

Confidential Record: Information contained here will not be released except when you have authorized us to do so.

Last Name: _____ First: _____ DOB: _____

Other Physicians

Obstetrician/Gynecologist _____ Endocrinologist _____
Gastroenterologist _____ Other _____
Dermatologist _____ _____

Screening and Prevention

Last Physical Exam: Date _____ Physician/NP: _____
Last Cholesterol test Date_____ Testing facility _____ □ Normal □ Abnormal
Last Colonoscopy Date_____ Testing facility _____ □ Normal □ Abnormal
Last Mammogram Date_____ Testing facility _____ □ Normal □ Abnormal
Last Pap Smear Date_____ Testing facility _____ □ Normal □ Abnormal
Last Bone density test Date_____ Testing facility _____ □ Normal □ Abnormal
Last Stress Test Date_____ Testing facility _____ □ Normal □ Abnormal

VACCINES:

Measles/Mumps/Rubella Date_____ Testing facility _____
Hepatitis B Date_____ Testing facility _____
Tetanus Date_____ Testing facility _____
PPD test Date_____ Testing facility _____
Flu Date_____ Testing facility _____
Pneumonia Date_____ Testing facility _____

HIV screening is now recommended for all individuals. Have you ever been tested for HIV? □ Yes □ No

Past Medical History (please check all that apply)

□ High Blood Pressure □ Diabetes (including gestational)
□ Stroke □ High cholesterol □ Heart Attack □ Asthma □ Pneumonia
□ Emphysema □ Tuberculosis □ Kidney Disease □ Thyroid Disease □ Ulcers
□ Liver Disease □ Alcohol problems □ Depression □ Anxiety □ Migraine
□ Arthritis □ Osteoporosis □ Fractures □ Bleeding Tendency □ Anemia
□ Blood clot □ Seizure □ Frequent UTIs □ Sexually transmitted disease
□ Ovarian cysts □ Fibroids □ D.E.S. exposure
□ Cancer: type_____ □ Other _____

Prior Hospitalizations/Surgeries: _____

_____

_____

Have you ever received a blood transfusion? □ Yes □ No If yes, year _____
Have you had a hysterectomy? □ Yes □ No If yes, reason_____
Were your ovaries removed? □ No □ Yes (one) □ Yes (both)

List all ALLERGIES:	**Medication/Food**	**Reaction**

Patient Label

List all MEDICATIONS (please include non-prescription drugs)

Name	Dose	Frequency

Family History	AGE	Health Status	Age at Death	Cause
Father				
Mother				
Brothers/Sisters				
1.				
2.				
3.				

Do you know of any blood relative who has or had: □ Diabetes □ Heart Attack □ High Blood Pressure
□ Stroke or Blood Clot □ Tuberculosis □ Asthma □ Thyroid disease □ Kidney disease
□ Liver disease □ Cancer: Type_____ □ Depression □ Alcoholism □ Bleeding disorder

Lifestyle and Personal Habits

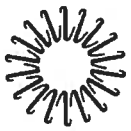
Who do you live with at home? _____ Your occupation_____
Do you/have you ever smoked? □ Yes □ No If yes, _____ packs/day for _____yrs Quit date _____
Do you drink alcohol? □ Yes □ No If yes, number of drinks/week _____
Do you use any recreational drugs? □ Yes □ No If yes, what type? _____
Do you exercise regularly? □ Yes □ No Activity: _____ hours/week_____
Do you follow a special diet? □ low fat □ low carb □ vegetarian □ other _____
How many meals/day do you have? _____ Servings of calcium per day? _____
Do you wear seatbelts? □ Yes □ No Do you feel safe at home at present? □ Yes □ No
Do you have smoke alarms at home? □ Yes □ No Has anyone ever physically hurt or threatened you? □ Yes □ No
Do you have guns in your home? □ Yes □ No Has anyone ever hit, kicked, or choked you? □ Yes □ No
Has anyone ever forced you to have sexual activity? □ Yes □ No

OB/GYN HISTORY: Number of Pregnancies: _____ Living: _____ Miscarriages: _____ Abortions: _____
Are you currently sexually active? □ Yes □ No Do you partner with □ Men □ Women □ Both
Do you use contraception? □ birth control pills □ contraceptive ring □ contraceptive patch □ condoms □ IUD
□ tubal ligation/vasectomy □ diaphragm □ other _____
Planning a pregnancy in the next year? □Yes □ No Last Menstrual Period :_____
Age at first period:_____ Occurs every ____ days Length of flow: ____ days Age at Menopause:_____
History of infections (please check all that apply): □ herpes □ gonorrhea □ chlamydia
□ syphilis □ PID □ warts □ yeast □ trichomonas □ gardnerella
Have you had an abnormal PAP in the past? □ Yes □ No

Please list any new concerns you have experienced in the past 2 weeks.

Please understand that we may need to have you schedule a follow-up visit.

Date _____ Signature_____



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Patient Label

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

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

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Patient Label

Name: _____ DOB: _____ Date:_____

CAGE-AID QUESTIONNAIRE

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

	In the past 12 months	**Yes**	**No**
1	Have you ever felt that you ought to cut down on your drinking or drug use?		
2	Have people annoyed you by criticizing your drinking or drug use?		
3	Have you ever felt bad or guilty about your drinking or drug use?		
4	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

	Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**Over half the days**	**Nearly every day**
1	Feeling nervous, anxious, or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it's hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3
	Add the score for each column				
	Total Score (add your column scores) =				

If you checked off any problems, how difficult have these 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	

Spitzer RL[1], Kroenke K, Williams JB, Löwe B: A brief measure for assessing generalized anxiety disorder: the GAD-7. Arch Intern Med. 2006 May 22;166(10):1092-7.