Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Checklist for TPI, Inc. Clinical Business Files

The following needs to be filed in a business file for ALL clinical clients for TPI, Inc.

- Welcome letter
- Identifying intake information
- Identifying medical information
- Service Consent form
- Client Rights form
- Consent for electronic communication
- Advance Psychiatric directive form
- Consent for Telemental Health services (if applicable)
- Any ROI signed by client at Intake
- Crisis form- Clean sweep
- Insurance form – Therapist to fill out and sent to support staff and billing person
- Copy of the insurance card for file.
- Note: No treatment plans, reviews, testing, or case notes go into the business file
- Discharge summary 30 days after discharge from services to close out the business file
- Clinician's name: _____
- Client's name: _____
- Date:

CC: Client File/Business File

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Welcome to Therapy Place, Inc.! We are committed to providing you with excellent service. In order for our work together to be productive, it is important that expectations be clearly defined.

What you can expect from us:

1. The information you share with us will be kept confidential.
2. To notify you as soon as possible if your provider has to cancel your appointment and to make arrangements with you to reschedule.
3. To make every effort to be on time and to return your phone calls.
4. To work with you to set achievable goals and assist you in making progress towards these goals.

What we expect from you:

1. To be involved in setting your goals for therapy and to make progress.
2. To attend scheduled appointments or call 24 hours in advance to cancel.
3. To take financial responsibility by pre-authorizing treatment with your insurance company, paying co-payments / co-insurance at time of service and keeping your account current if applicable. Some exceptions may apply.

Fees:

Evaluations: Therapist--$250.00 Nurse Practitioner--$300.00
Therapy Sessions: 60minute - $200.00; 45minute – $150.00; Family with or without client - $175.00
Medication Checks: $150.00; Group- $50.00 an hour; Crisis Session- 200.00
No Show/Late Cancel Appointments for ALL insurance except Title 19: $25.00

Insurance:

If you are using health insurance, including Title 19, you will need to verify coverage prior to your first visit. If your insurance company covers our services, and if I am a provider for your insurance company, our office will bill your company after each visit. If your coverage is contracted with your HMO or PPO, you are only responsible for the required copayment and co-insurance. Co-payments/co-insurance is due before each session. If you do not have coverage, payment is expected on the day of your session in consultation with your therapist.

In case of an emergency: Please call your therapist and/or go to your nearest emergency room.

I understand that for two scheduled appointments with a no show/no call and/or canceling 3 scheduled appointments, I forfeit the right to remain a client of Therapy Place, Inc. depending on the circumstances and in consultation with your therapist.

I have read the above information and my signature indicates my acceptance of the terms of this agreement.

_____ _____

Provider for Therapy Place, Inc. Client or Parent/Guardian DatCC: Client File/Business File

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

DATE: _____ REFERRED by: _____

CLIENT INFORMATION
Name: _____Gender:_____
Address: _____
City, State, Zip: _____
Home Phone: _____Social Security #:_____
Cell Phone: _____Date of Birth: _____Age:_____
In Case of an Emergency, whom may we contact on your behalf? _____
Relationship to you: _____ Address: _____
Phone: _____ Alternative Phone: _____

EMPLOYMENT & EDUCATION
Employer: _____Occupation:_____
Employer Address: _____Work Phone: _____
Elementary/High School: _____Grade/Graduation Date: _____
College/Technical Program: _____Year/Graduation Date: _____
Military Branch: _____
Where do you prefer to receive calls? (Check) Home: _____ Work: _____Cell:_____
When is the best time to reach you? Time: _____ Days: _____
May we leave messages with you? (Check) Home: _____ Work: _____ Cell: _____

MARITAL STATUS
Single_____ Married_____ Separated_____ Divorced_____ Widowed____
Living with_____
Spouse or Domestic Partner's Name: _____
Employer: _____Occupation: _____Work Phone: _____
Education Level: _____

IF CLIENT IS A CHILD—COMPLETE THE FOLLOWING:
Child Lives With
Both Parents: _____ Mother: _____ Father: _____ Other (specify):_____

Parent (1) Name: _____	**Parent (2) Name:** _____
Address_____	Address_____
City, State, Zip_____	City, State, Zip_____
Occupation_____	Occupation_____
Employer_____	Employer_____
Employer Address_____	Employer Address_____
Employer Phone_____	Employer Phone_____
If deceased, cause of death_____	**If deceased,** cause of death_____

CC: Client File/Business File

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

NAME: _____ DATE: _____

AUTHORIZATION of Insurance Company Payment & Communication

I authorize the release of confidential information including professional opinions, reports of tests, exams, treatment summaries, diagnosis and prognosis rendered to me or my dependent during the period of such care, to third party payers. I authorize and request my insurance company to pay directly for all insurance benefits otherwise payable to me. I agree to be responsible for payment (charges which are considered usual and customary) of all services rendered on my behalf or on behalf of my dependents.

Signature of Client/Guardian of Client: _____Date_____

CONSENT to Communicate With Primary Care Physician

PRIMARY CARE PHYSICIAN:

Name of Doctor_____ Clinic Name_____

Address_____Phone_____

In order to coordinate your care, we may need to contact your Primary Physician:

I hereby give my consent to such communication with my Primary Care Physician.

Signature_____ Date_____

I do **not** give my consent.

Signature_____ Date_____

CC: Client File/Business File

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Medical Information

Name: _____ SSN #:_____Date:_____

The reason I am here today is: _____

Please check the items below which apply to you in the past six months:

____change in appetite
____loss of weight
____weight gain
____binge or purge
____worried about your weight
____trouble sleeping
____high energy
____low energy
____restless/difficulty sitting still
____anxious or nervous
____loss of interests
____feel like mind playing tricks
____worried about your appearance
____forgetfulness or memory problems
____anger
____verbal fighting
____physical fighting
____sexual problems
____difficulty concentrating
____racing thoughts
____sad or depressed
____crying spells
____thoughts of suicide
____self hurt/harm

Have you ever had counseling/therapy or medication for any of the above? _____Yes_____No
If "Yes," where_____when_____with whom_____

Have you been hospitalized for any of the above? ____No. If "Yes," reason_____
If "Yes," where_____when_____what Doctor_____

When did you last have a complete physical exam?_____

Who is your Primary Physician?_____

How do you rate your overall health?_____Excellent_____Good_____Fair_____Poor

What is your main concern about your health?_____

Any other medical problems? Please describe_____

Do you have any **Allergies or Drug Sensitivities?** If "Yes," describe: _____
_____

Please complete the following regarding your current medication:

Name of Medication/Herbs	Prescription Yes/No	When Prescribed / Who Prescribed	Amount Daily	Reason

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Name: _____ SSN #:_____Date:_____

Do you gamble: _____Yes _____No; how many times per month: _____

What percent of your monthly income do you spend per month on gambling: _____?

Do you use Tobacco? _____Yes_____No

Do you use Caffeine _____Yes_____No

Do you use other Substances: _____ Yes _____No What substances: _____

Prior Treatment History: _____

Do you abuse over the counter drugs or prescription drugs? _____

CC: Client File/Business File

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

SERVICES CONSENT FORM

We, the undersigned, agree to accept services for ourselves and/or family from Therapy Place, Inc., (Therapy Place) that provides therapeutic, support services, psychiatric evaluation, and medication management to families, couples, and individuals in the context of their families.

We understand that in the course of treatment or supportive services, many subjects will be discussed. Some of these subjects may be, but are not limited to: age, educational achievement, family background, prior treatment efforts, family relationships, marital issues, sexuality, violence, leisure activities, drug/alcohol usage, medical involvement, housekeeping, shopping/other habits, hygiene and past psychiatric treatment.

We understand that Therapy Place is a private service that endeavors to provide a safe place for people to converse about their concerns. You may be invited to construct new ways of understanding your present situation and you will be asked to think about how you might change that situation should you wish to do so.

No information identifying you or your family will be released or disclosed without written consent by a parent or your legally designated representative. You may be asked to sign specific releases of information to any other individuals or agencies which Therapy Place staff deem important to communicate with, in the best interests of your family. Therapy Place will not knowingly utilize any treatment or procedure which is experimental, controversial, or carries an intrinsic risk. You have the right to ask questions about any procedures used during therapy.

I agree to allow Therapy Place staff to transport myself/child to and/or from therapy sessions, support services, or psychiatric services if applicable.

Any grievance concerning the quality of services provided by Therapy Place should be made in writing to the President of Therapy Place, Inc. A review of the grievance will take place within thirty days.

This agreement was entered into and signed on the _____ day of _____

on behalf of _____ by:

_____ (Client signature)

_____ (Signature of parent/guardian) (If client under age 18)

_____ (Date)

_____ (Relationship to client)

_____ (Witness to signature)

This agreement will remain in effect until one year after the family's/individual's involvement with Therapy Place, Inc. has been discharged. *Signature(s) indicate the form was read, understood, and agreed on by the client/parent/guardian.
CC: Client File/Business File

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

CLIENT RIGHTS

Your rights as a client are as follows:

1. You have the right to ask questions about any procedures used during therapy. If you wish, I will explain my usual approach and methods of therapy to you.

2. You have the right to decide not to receive therapeutic assistance from this agency. If you wish, I will provide you with the names of other qualified professionals in this area.

3. You have the right to end therapy any time without any moral, legal, or financial obligations other than those already incurred, unless ordered by the court.

4. As a client, you should know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. I am not required to inform you of my actions in this regard. These situations are as follows:

   A. If you threaten grave bodily harm or death to another person, I am required by law to inform the intended victim and the appropriate authorities.

   B. If a court of law issues a legitimate subpoena, I am required by law to provide the information specifically described in the subpoena.

   C. If you reveal information relative to child abuse or neglect, I am required by law to report this to the appropriate authorities.

   D. If you are in therapy as a result of a court order, I am required to report progress to the court.

_____ _____
(Client signature) (Signature of parent/guardian)
(If client under age 18)

_____ _____
(Date) (Relationship to client)

_____
(Witness signature)

PLEASE NOTE: NO ONE WILL BE REFUSED SERVICES DUE TO INABILITY TO PAY. WE WILL NOT DISCRIMINATE BASED ON RACE, COLOR, NATIONAL ORIGIN, DISABILITY, RELIGION OR SEXUAL ORIENTATION.

*Signature(s) indicate the form was read, understood, and agreed on by the client/parent/guardian.

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Consent to Use of Electronic Communication and Patient Rights

CONDITIONS FOR USE OF ELECTRONIC COMMUNICATION

Therapy Place, Inc will use reasonable means to maintain security and confidentiality of electronic communication information sent and received. Please acknowledge and consent to the following conditions:

1. Electronic communication may include, but is not limited to, email, text messaging, facsimile, social media, etc.

2. Therapy Place, Inc will work with you to avoid disadvantages (such as too much risk to your privacy or using electronic communication) when a face-to-face visit appears to be necessary. It is also important to understand that at times, email communication or cell phone communication including text message content between you and your therapist may be misinterpreted due to lack of eye contact, vocal tone, and attending to facial expressions between client and therapist. If you are unsure about the intent or content of an email or the intent of the therapist via cell message or conversation, you are encouraged to discuss concerns/questions and ask for clarification.

3. Electronic communication is not appropriate for urgent or emergency situations. We will do our best to respond within 3 days. If you have not received a response after 3 days, please call to speak directly with us at (712)254-9018. If you're experiencing an emergency, call 911 or your local emergency room.

4. Electronic communication should not be used for communication regarding sensitive or life-threatening subjects, such as suicidality, spouse or child abuse, chemical dependency, etc.

5. Electronic communication related to health consultation may be recorded in your medical record, just as telephone calls and sessions are.

6. If you frequently contact your therapist via email or phone outside of your normal session, it is important to understand that your therapist will bill you for a portion of his or her time, based on his or her regularly hourly rate as agreed upon. As the therapist sees numerous clients per week, the therapist may receive numerous emails and calls each week from many clients.

7. To protect your privacy, please understand that it is against Therapy Place, Inc, professional ethics to link with clients through any social media platform (ex. Facebook, Twitter, Instagram, etc).

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

RISKS OF USING ELECTRONIC COMMUNICATION

Transmitting information by electronic communication has risks to consider. These include, but are not limited to, the following:

1. Electronic communications can be altered, intercepted, forwarded or used without authorization or detection.
2. Electronic communications can be circulated, forwarded and stored in paper and electronic files.
3. Electronic communications senders can type in the wrong email address/phone number.
4. Electronic communications may be lost due to technical failure during composition, transmission and /or storage.

CLIENT ACKNOWLEDGEMENT AND AGREEMENT

I have read and fully understand the information in this authorization form. Consent to the Electronic communication conditions and agree to abide by the guidelines listed above, as well as understand and accept the risks associated with the use of unsecured Electronic communications. I further understand that, as with all means of Electronic communications, there may be instances beyond the control of the health care provider where information may be lost and inadvertently exposed, such as during technical failures. By signing below, I acknowledge the privacy risks associated with using electronic communications and authorize Therapy Place, Inc to communicate with me or any minor dependent/ward for purpose of mental health and/or substance use advice, education, and treatment.

Signature of Client:_____Date:_____

Signature of Parent/Guardian
(If required):_____Date:_____

Signature of Therapist:_____Date:_____

CONSENT FOR ELECTRONIC SESSION RECORDING

With the client's or parent/guardian's consent, it may be found beneficial for certain aspects of a therapy session to be tape recorded, videotaped, or photographed. The recordings will only be used for the following purposes: to retain important information in client files that can benefit the overall treatment plan in future sessions or to allow students who are coming into the mental health field to gain insight and further their education. The use of this technique is entirely up to the client or parent/guardian and can be amended at any time

Client or Guardian Signature:_____Date:_____

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Psychiatric Advance Directive – To be used on all MCO Clients

☐ I currently have a Psychiatric Advance Directive.

☐ I do not have a Psychiatric Advance Directive. I understand that I can follow-up on this option with the information provided below. If such a document is completed I will provide a copy to this agency.

Psychiatric advance directives are relatively new legal instruments that may be used to document a competent person's specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that someone may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness.

What can be included in a Psychiatric Advance Directive

- Crisis Symptoms
- Medication Choices
- Hospital Choices
- Emergency Contacts
- Relapse/Protective Factors
- Instructions to Staff
- Other Instructions

For More information on what you can include in a Psychiatric Advance Directive, log on to www.nrc-pad.org

It is advised that you seek legal counsel when completing this document. Iowa currently does not have a specific Psychiatric Advance Directive Form.

_____ _____

Signature Date

CC: Client File/Business File

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Date: _____

Clean Sweep: Crisis Safety Plan; Protecting Suicidal Clients

1. Warning Signs (Discuss and determine any changes that have occurred in behavior, speech, or thought content):
   _____
   _____
   _____
   _____
2. Coping Strategies (using the warning signs, identify coping strategies they have used in the past OR teach and discuss new coping strategies that can be implemented. Discuss reasons to live during this step as well):
   _____
   _____
   _____
   _____
3. Social Distractions (Identify people (not family) and social settings that will provide a distraction and increase the youth's social connection):
   _____
   _____
   _____
   _____
4. Social Support (Identify specific family/close friends that you can inform about the youth's moments of crisis. These people should be on board for being a point of contact):
   Name: Number: Notified:
   Name: Number: Notified:
   Name: Number: Notified:
5. Professional Support (Discuss personal, local, and national mental health support they can access during a crisis) During business hours the client will contact their individual therapist as they're in the best position to be helpful and coach them properly. A crisis session should occur if possible prior to ER. **Therapy Place Inc. 712-254-9018; Suicide hotline: 1-800-273-TALK**
   Name: Number:
   Name: Number:
   Name: Number:
6. Client will access the local hospital in an emergency. Client will go directly to the hospital or call 911.
7. Eliminating Means (SAFETY SWEEP) (Discuss and identify any access to lethal means):
   _____
   _____

   Steps will be taken in order, Level 1, Level 2, Level 3. Client will attempt those three levels before calling the identified therapist. If the client has tried all levels and still cannot manage the client will then follow through with Level 6 as specified above.
   Client Sign: _____ Practitioner Sign: _____
   Copies made for client, social support, guardians (if under 18), and practitioner

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the undersigned, authorize the Release the following information:

_____ Attendance Only
_____ Diagnosis
_____ Diagnostic assessment
_____ Evaluation/Testing results
_____ Mental health treatment
_____ Health/Medical Information including HIV
_____ Case Consultation

____ Substance Use Disorder Diagnosis and Treatment
____ Substance Use Disorder Diagnosis and Treatment
____ Reports including Diagnosis, Attendance, Participation, Recommendations, Participation, Progress and Prognosis.
____ Termination/Discharge Summary
____ Other _____

Information to be released (**please circle**) _ TO: _ FROM: _ BOTH TO & FROM:

Name:		Phone:	
Company:		Fax:	

Regarding:

CLIENT/FAMILY NAME: _____
ADDRESS: _____
PHONE: _____

- The purpose for this disclosure is to facilitate effective treatment service coordination.
- A photocopy or exact reproduction of this form for release of information shall have the same effect as the original.
- This authorization will automatically expire one year from the date of signature unless a shorter period is specified (specific number of days/months): _____
- I understand that I may revoke this authorization at any time, except to the extent that information has already been released as authorized by giving written notice to Therapy Place, Inc., or their representative.
- I understand I have the right to review the disclosed information by contacting the office of Therapy Place, Inc. Once this authorization has expired or has been revoked, it can be renewed only by proper execution of another authorization.
- I acknowledge that information to be released may include material that is protected by state and/or federal law, including applicable mental health, alcohol/drug abuse, HIV/AIDS information, or all of these. My signature authorizes release of only the information specified above.
- I understand that information authorized by this consent cannot be released to anyone other than those listed above unless I give written permission. *Signature(s) indicates client/parent/guardian given a copy of the confidentiality/privacy policy for Therapy Place, Inc.

_____ (Client signature)

_____ (Signature of parent/guardian) (If client under age 18)

_____ (Date)

_____ (Relationship to client)

_____ Witness (Signature of Witness)

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

CONSENT TO PROVIDE TELEMENTAL HEALTH SERVICES:

I/We understand that telemental health is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent for providing health care services to me via telemental health by:(clinician's name)________.

I/We understand that the laws that protect privacy and the confidentiality of medical information also apply to telemental health. As always, your insurance carrier will have access to your medical records for quality review/audit.

I/We understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I/We understand that I have the right to withhold or withdraw my consent to the use of telemental health in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Therapy Place, Inc. at 712-254-9018. As long as this consent is in force, mental health services may be provided to me via telemental health without the need for me to sign another consent form.

No information identifying you or your family will be released or disclosed without written consent by you or a parent or your legally designated representative. You may be asked to sign specific releases of information to any other individuals or agencies which Therapy Place staff deem important to communicate with, in the best interests of you and/or your family. Therapy Place will not knowingly utilize any treatment or procedure which is experimental, controversial, or carries an intrinsic risk. You have the right to ask questions about any procedures used during therapy.

Any grievance concerning the quality of services provided by Therapy Place should be made in writing to the President of Therapy Place, Inc. A review of the grievance will take place within thirty days.

This agreement was entered into and signed on the _____ day of _____

on behalf of _____ by:

_____ _____
(Client signature or Parent if client under the age of 18) (Relationship to client)

_____ _____
(Date) (Client email address)

_____ _____
(Witness to signature) (Client phone number)

Email Address:_____

This agreement will remain in effect until one year after the family's/individual's involvement with Therapy Place, Inc. has been discharged. *Signature(s) indicate the form was read, understood, and agreed on by the client/parent/guardian. DS - 2-16-19-3-05-19-4/17/19

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date**_____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*. how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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
	☐	☐	☐	☐

Serving Southwest Iowa
Therapy, Groups, Assessments
PCIT, EMDR, Psychiatric Services
Team Meetings, Aftercare Program
www.therapyplaceinc.com

Email: office@therapyplaceinc.com
Mailing Address: P.O. Box #1
Panama Iowa, 51562
Offices In: Atlantic, Council Bluffs, and Waterloo

PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide

For physician use only

Scoring:
Count the number(#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all	(#) ___	x 0 = x
Several days	(#)	I = x 2
More than half the days	(#)	= x 3 =
Nearly every day	(#)	

Total score:

Interpreting PHQ-9 Scores		Score	Actions Based on PH9 Score Action
Minimal depression	0-4	<4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27	> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/