ChiroCare Fax Cover Sheet

ChiroCare of Wisconsin, Inc. rev 4/19/99

Date: _____

# of Pages: _____
(Including cover)

To: **ChiroCare**

Fax #: (414) 476-4517
Phone #: (800) 397-1541
(414) 476-4733

From: Provider's Name: _____

Contact's Name: _____

Fax #: _____

Phone #: _____

Instructions for Use

1. To insure the most rapid delivery to the intended recipient, please direct this fax to a specific department, and if applicable to a specific person.

2. If you need to send information to more than one department, please send a separate fax, with a separate cover sheet, to each department.

3. When sending requests for authorization, please indicate the patient name, the number of pages being submitted for the patient, and whether the patient information has been previously submitted and is being re-faxed.

4. If you are including instructions for processing a request for authorization they should be included with the actual forms, not on this page.

☐ **Utilization Review Department** *(Requests for authorization should be directed here.)*

Attention: _____

Patient Name	*# of Pages*	*Re-fax*	*Patient Name*	*# of Pages*	*Re-fax*
		☐			☐
		☐			☐
		☐			☐
		☐			☐
		☐			☐

☐ **Member/Provider Service Department** *(Questions regarding member/group eligibility, status of authorization requests or claims payment should be directed here.)*

Attention: _____

☐ **Other**

Attention: _____

Memo:

_____

_____

_____

_____

_____

Confidentiality Notice:

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Provider Report Form

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 5/18/99

Date Received

Effective Date

Authorization Number

Overlap With Authorization Number

Patient (Last, First, MI) ◯ Female ◯ Male

Date of Birth (mm-dd-yyyy)

Address

Patient's Insurance ID#

◯ Prim ◯ Sec

City State Zip

Health Plan

◯ Home ◯ Work

Patient Phone # ◯ Work ◯ Motor vehicle

Is condition related to

Group ID#

Name of Insured

Insured ID#

Insured's Employer

Provider Name

Phone #

Fax #

Address City State Zip

Attachment(s) *may be required

◯ CCWI Exam*/Narrative* ◯ Index Neck/Back
◯ PHQ* pg 1 - 2 ◯ SF-12
◯ PFQ ◯ PCP Referral*

Referral Information

◯ Yes ◯ No

Referred by PCP/Other Provider | Date Referral Issued | Referring Provider | Referral # | Condition referred for

Patient Type

① New to Your Office ***Pg 1&2 of PHQ req'd***
② Est'd, new to CCWI ***Pg 1&2 of PHQ req'd***
③ Est'd, new injury ***Pg 1 of PHQ req'd***
④ Est'd, new episode - PFQ rec'd
⑤ Est'd, continuing care - PFQ rec'd

Original Onset of This Condition

Most Recent Exacerbation

# of visits in last 30 days for all conditions

Current History/Complaint Description

Neck Index

Back Index

SF-12 PCS

SF-12 MCS

Nature of Condition

① Initial onset (within last 3 months)
② Recurrent (multiple episodes of <3 months)
③ Chronic (continuous duration >3 months)

Past History of Complaint and Response to Treatment

Nature of Complaint

① Localized
② Regional
③ Radiating

Cause of Current Episode

① Traumatic ③ Repetitive
② Unspecified ④ Post-surgical

Complicating Factors

Diagnosis

. . . .

Treatment Goals (focus on functional improvement and patient self-management)

Plan

If requesting any highlighted services you must submit the CCWI Exam Form

From

Through

E&M ◯ 99201 ◯ 99211
◯ 99202 ◯ 99212
◯ 99203 ◯ 99213
◯ ***99204*** ◯ ***99214***
◯ ***99205*** ◯ ***99215***

Xray ◯ 72040 ◯ 72020
◯ 72070 ◯
◯ 72100 ◯

40 41 42 43

# of CMT

# of Modalities (if > 1 per visit complete information to right)

# of Procedures (If requesting any procedures complete information to right)

Other (DME, lab, etc)

modality/procedure:
objective:

modality/procedure:
objective:

modality/procedure:
objective:

Anticipated status after this treatment plan

① MTB, no residuals, discharged
② MTB, residuals, discharged
③ MTB, residuals, PRN/supportive care
④ Not at MTB, update tx goals/plan
⑤ Referred/transferred

I declare that the above information is true and accurate to the best of my knowledge. It is my professional judgement that this treatment plan is not contraindicated for this patient.

Provider Signature _____ **Date** _____

GENERAL EXAMINATION

Height Ft. Inches | Weight Lbs. | Blood Pressure / | L/R | Temp. | Pulse

Body Type
- Ectomorph
- Mesomorph
- Endomorph
- Obese

Systems Review (WNL / Deferred)
- EENT
- CV System
- Resp System
- GI/Abdominal
- GU

Significant Findings:

Vascular Tests
VBI [+ -] / Peripheral:

Observations

AP Curve	WNL	Decreased	Increased
Cervical			
Thoracic			
Lumbar			

Scoliosis

	Convex L	Convex R	Absent	Mild	Moderate	Marked
Cervical						
Thoracic						
Lumbar						
Other:						

Postural Symmetry

	Left	Right	Absent
Head Tilt			
High Shoulder			
Rib Hump			
High Iliac Crest			

	Left°	Right°	Anterior	Lumbar	Cervical
Antalgic Lean					

Subluxation:

Spinal Palpation (Tenderness) 1-4

Level	L	M	R

Level	L	M	R

Soft Tissue Evaluation
List Region/Muscle

	Hypertonicity L	Hypertonicity R	Atrophy 0	1	2	3	4	5	Tender 1	2	3	4	Trig Pts. A	A L	Strength 0	1	2	3	4	5	B

Additional Info:

CERVICAL ROM [ ] WNL

	Active°	Passive°	A	D	S	L	M	R	Level/Area
Flexion (50°)									
Extension (70°)									
Lt. Lat Flex (45°)									
Rt. Lat Flex (45°)									
Lt. Rotation (85°)									
Rt. Rotation (85°)									

THORACIC [ ] WNL

	Active°	A	D	S	L	M	R	Level/Area
Flex/Ext (60°)								
Lt. Trunk Rot. (45°)								
Rt. Trunk Rot. (45°)								

A = Absent D = Dull S = Sharp
L = Left M = Midline R = Right

LUMBOPELVIC [ ] WNL

	Active°	A	D	S	L	M	R	Level/Area
Flexion (90°)								
Extension (30°)								
Lt. Lat Flex (35°)								
Rt. Lat Flex (35°)								
Lt. Rotation (30°)								
Rt. Rotation (30°)								

ORTHOPEDIC/NEUROLOGICAL

CERVICAL

Stretch Tests	+	-	Dull	Sharp	Left	Midline	Right	Cervical	Shoulder	Arm/Hand	Thoracic
Lt. Shoulder Depression											
Rt. Shoulder Depression											
Soto Hall Test											

Compression Tests	+	-	D	S	L	M	R
Lt. Cervical Comp.							
Rt. Cervical Comp.							
Lt. Roos	+	-	Rt. Roos	+	-		

Distraction Tests

Cervical	+	-	Lt. Bakody's	+	-	Rt. Bakody's	+	-

Reflexes (0-5)

	L	R
Biceps		
Brachio		
Triceps		
Patellar		
Achilles		

LOW BACK

Stretch Tests	Degrees	+	-	Dull	Sharp	Left	Midline	Right	Lumbar	Gluteal	Above Knee	Below Knee
Lt. SLR												
Rt. SLR												
Lt. Braggard's												
Rt. Braggard's												
Lt. Bechterew's Test												
Rt. Bechterew's Test												

Compression Tests	+	-	D	S	L	M	R
Lt. Kemp's							
Rt. Kemp's							
Milgram's							
Valsalva Test							

Mechanical Tests	+	-		+	-		+	-
Lt. Gaenslen			Lt. Fabere			Lt.Yeoman		
Rt. Gaenslen			Rt. Fabere			Rt.Yeoman		

Sensory

	WNL	Left	Right	Description

Neurological Eval/Other Tests:

RADIOGRAPHIC EVALUATION

VIEWS TAKEN | DATE | WHERE IF NOT THIS CLINIC | ADDITIONAL VIEWS REQUESTED

Subluxation (level)

Scoliosis Location/ Apex

	L	R	Cobbs	+ Lovett -
/				
/				
/				

	⬇	⬆	R
AP Cervical Curve:			
Thoracic:			
AP Lumbar Curve:			

Sacral Base Angle
Lt. Short Leg (mm)
Rt. Short Leg (mm)

DDD	DJD	Level	Mild	Moderate	Marked
Osteoporosis:					

Other Findings/Recommendations:

Comments/Additional clinical information:

All the information provided above is a true, accurate and complete representation of:

PATIENT'S NAME | D.C. SIGNATURE | DATE

Patient Health Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 4/19/99

Patient Name _____ ***Date*** _____

1. When did your symptoms start: _____ ***Describe your symptoms and how they began:***

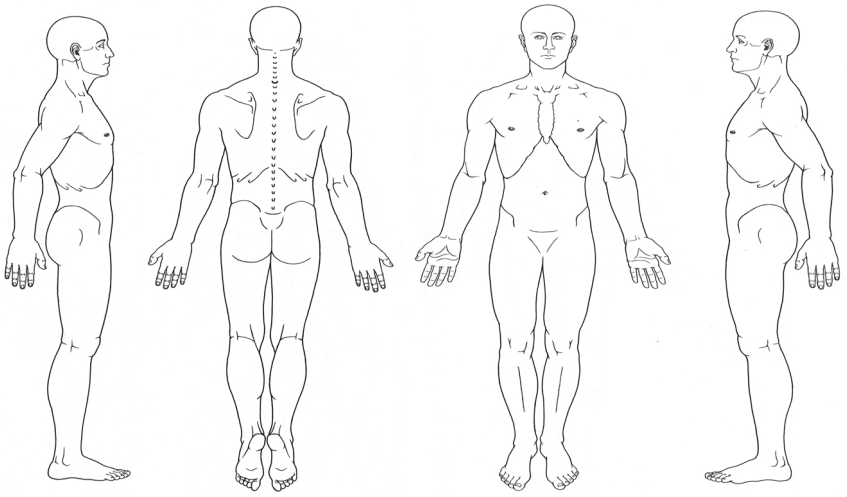
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

None *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩
b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ *No complaints* ① ② *Mild, forgotten with activity* ③ ④ *Moderate, interferes with activity* ⑤ ⑥ *Limiting, prevents full activity* ⑦ ⑧ *Intense, preoccupied with seeking relief* ⑨ ⑩ *Severe, no activity possible*

7. What activities make your symptoms worse: _____

8. What activities make your symptoms better: _____

9. Who have you seen for your symptoms?

① No One
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. When and what treatment? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

10. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Other Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

11. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

12. What do you hope to get from your visit/treatment *(select all that apply):*

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/20/99

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] *Feet Inches* Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

Patient Follow-up Questionnaire

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 5/10/99

Patient Name _____ ***Date*** _____

1. Describe your current symptoms _____

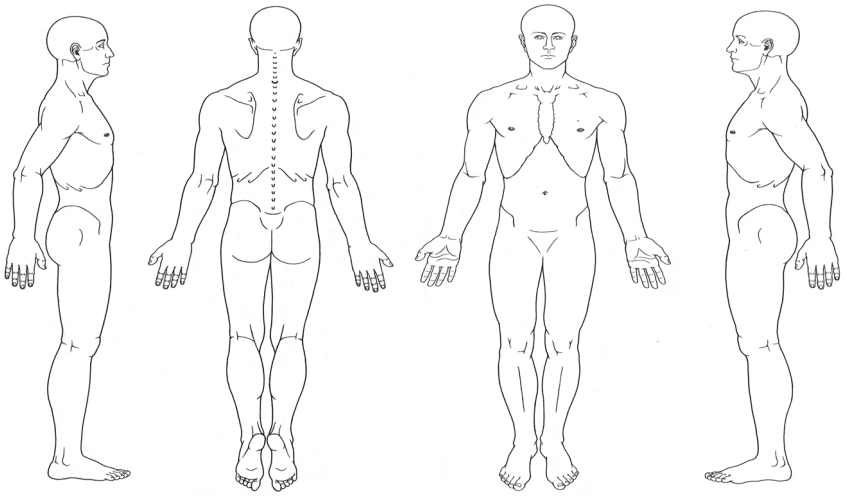
_____

_____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. How bad are your symptoms at their:

None *Unbearable*

a. worst: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

b. best: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩

6. How do your symptoms affect your ability to perform daily activities?

⓪ *No complaints*
① ② *Mild, forgotten with activity*
③ ④ *Moderate, interferes with activity*
⑤ ⑥ *Limiting, prevents full activity*
⑦ ⑧ *Intense, preoccupied with seeking relief*
⑨ ⑩ *Severe, no activity possible*

7. What do you hope to get from your visit/treatment *(select all that apply)**:***

① Reduce symptoms
② Resume/increase activity
③ Explanation of condition/treatment
④ Learn how to take care of this on my own
⑤ How to prevent this from occurring again
⑥

8. Additional comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature _____ ***Date*** _____

Back Index

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/15/99

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn't increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Back Index Score _____

Neck Index

ChiroCare of Wisconsin, Inc.

ChiroCare Use Only rev 1/15/99

Patient Name _____ ***Date*** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my care as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Neck Index Score

SF-12™ Health Survey

ChiroCare Use Only rev 1/29/99

Patient Name _____ ***Date*** _____

Please answer every question. Some questions may look like others, but each one is different. Please take the time to read and answer each question carefully by filling in the bubble that best represents your response.

1. In general, would you say your health is: ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

2. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. ***Moderate activites**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?*	①	②	③
b. *Climbing **several** flights of stairs?*	①	②	③

*3. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?*

	Yes	No
a. ***Accomplished less** than you would like*	①	②
b. *Were limited in the **kind** of work or other activities*	①	②

*4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?*

	Yes	No
a. ***Accomplished less** than you would like*	①	②
b. *Didn't do work or other activities as carefully as usual*	①	②

*5. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home, and housework)?*

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

*6. These questions are about how you feel and how things have been with you during the **past 4 weeks**. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the **past 4 weeks**....*

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. *Have you felt calm and peaceful?*	①	②	③	④	⑤	⑥
b. *Did you have a lot of energy?*	①	②	③	④	⑤	⑥
c. *Have you felt downhearted and blue?*	①	②	③	④	⑤	⑥

*7. During the **past 4 weeks**, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?*

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time