INNOVATIVE PAIN *and* SPINE CENTER

www.innovativepainspine.com
Matthew Root, D.O.
4418 Vineland Ave Suite 218 North Hollywood CA 91602
P: (818) 621-0019 | F: (818) 671-5556

Welcome to our office! We are committed to providing the best care possible. We encourage you to ask questions and communicate openly with us. Please assist us by providing the following information. All information is confidential and will only be released with your consent.

PATIENT REGISTRATION FORM (WC)

General Information

Today's Date:_____ Appointment Time:_____

Name (Last, First, MI): _____ Sex:_____

Address (Street, City, State, Zip): _____

SSN:_____ Driver's Lic. #: _____ Date of Birth: _____ Age:_____

Best phone # to reach you: (*circle: home, work, cell)*_____

Alternate phone #: (*circle: home, work, cell)* _____

Email:_____

Social Information

Employer:_____ Occupation:_____

Employer Address:_____

Marital Status: *S M W D* Spouse's Full Name:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Accident Information

Affected Body Part(s):_____ Date of Accident:_____ Accepted Case: Y N

Approved Body Part(s):_____

Work Comp Insurer:_____ Claim #:_____

Adjuster Information:

Name:_____ Address:_____

Phone #:_____ Fax #:_____

I authorize payment of medical benefits be made directly to **MATTHEW ROOT, D.O.** for services rendered.
Date: _____ Signature:_____

I authorize any insurance company, employer, physician to release any information to this claim and the expenses reported.
Date:_____ Signature:_____

Have you seen other physicians for this issue?: ___ Yes ___ No

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If yes: Specialty:_____ Name:_____
Specialty:_____ Name:_____
Specialty:_____ Name:_____

Primary Care Physician Name:_____ Phone #:_____

Medications

Are you currently taking any of the following? *(write Yes or No)*:

Drug	Y/N	Specific Drug(s)	Dose	Reason
Blood thinners				
Aspirin				
NSAIDs (anti-inflammatories)				
Antibiotics/Antifungals				

Please list all **OTHER** medications, including: pain medication, vitamins, and/or herbal supplements you are taking:

Medication	Dosage (mg)	Frequency (1x/day, etc)

Have you stopped any previous pain medications? ___ Yes ___ No
Please list medications stopped and why? _____

ALLERGIES

Are you allergic to any of the following?:

Substance	Y/N
Steroids	
Penicillin or penicillin type antibiotics	
Sulfa drugs	
Iodine/ shellfish	
Latex	
Anesthetics	

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Medical History

Do you currently have or have had any of the following medical conditions?:

Condition(s)	Y/N	Specify
Bleeding problems *(e.g. hemophilia, clotting disorders)*		
Cancer *(e.g. prostate, breast, colon)*		
Heart disease *(e.g. hypertension, CAD, hyperlipidemia)*		
Respiratory problems *(e.g. asthma, COPD, sleep apnea)*		
Gastrointestinal disorders *(e.g. GERD, IBS, Crohn's)*		
Liver disease *(e.g. hepatitis, cirrhosis)*		
Kidney disorders *(e.g. CKD, ESRD, kidney stones)*		
Endocrine disorders *(diabetes, thyroid disorder)*		
Psychiatric *(e.g. anxiety, depression, bipolar, addiction)*		
Nerve disorders *(e.g. stroke, MS, neuropathy)*		
Infections *(e.g. frequent UTIs, HIV, sinusitis, common cold)*		
Rheumatologic disorders *(e.g. Lupus, RA)*		
Headache disorder *(e.g. migraines, cluster headaches)*		

Social History

Do you currently smoke? *(circle) Y N* — Have you ever smoked? *circle: Y N* Packs/day:_____

Do you currently use illicit drugs? *(circle) Y N* — Any history of drug abuse? *(circle) Y N* Time sober:_____

Do you currently use marijuana? *(circle) Y N* — Have you ever used marijuana? *(circle) Y N*

Do you drink alcohol? *(circle) Y N* — If yes, how many drinks per week?:_____

Any history of alcohol abuse? *(circle) Y N* — Time sober:_____

Are you currently working? *(circle) Y N* — Work status: *(circle) part-time full-time modified retired*

Family History

Are there any of the following illnesses in your family?:

Condition(s)	Y/N	Relationship
Neurologic disorders *(e.g. MS, etc)*		
Diabetes		
Depression		
Heart disease		
Stroke		
Rheumatologic disorders *(e.g. lupus, RA)*		
Thyroid disease		
Blood disorders *(e.g. anemia, etc)*		
Autoimmune disorders		
Addiction		

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Opioid Risk Assessment

The use of opioid medications can result in addiction or adverse effects. Due to the nature of these drugs, Innovative Pain and Spine Center **requires an initial Urine Drug Test** and additional urinalysis may be performed throughout the time of your treatment. Innovative Pain and Spine Center aims to provide the best quality of care for each patient. Your overall health is important to us and we ask that you **please answer the following questions honestly and to the best of your ability**.

NIDA *Quick Screen* Question: **In the past year, how often have you used the following?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
Alcohol • **For men, 5 or more drinks a day** • **For women, 4 or more drinks a day**					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

If you **HAVE** used "Prescription Drugs for Non-Medical Reasons" and/or "Illegal Drugs" in the past year, please answer the following:

Question 1 of 8, NIDA-Modified ASSIST **In your *LIFETIME*, which of the following substances have you ever used?** ***Note for Physicians: For prescription medications, please report nonmedical use only.***	**Yes**	**No**
a. **Cannabis** (marijuana, pot, grass, hash, etc.)		
b. **Cocaine** (coke, crack, etc.)		
c. **Prescription stimulants** (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. **Methamphetamine** (speed, crystal meth, ice, etc.)		
e. **Inhalants** (nitrous oxide, glue, gas, paint thinner, etc.)		
f. **Sedatives or sleeping pills** (Valium, Serepax, Ativan, Xanax, Librium,Rohypnol, GHB, etc.)		
g. **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. **Street opioids** (heroin, opium, etc.)		
i. **Prescription opioids** (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. **Other – specify:**		

(CONTINUED)

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IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE FILL OUT THE FOLLOWING QUESTION:

Question 2 of 8, NIDA-Modified ASSIST 2. In the past three months, how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

Please return form to office staff. THANK YOU.

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Patient Financial Agreement

This is an agreement between Innovative Pain and Spine Center and the Patient/Guarantor on this form. It is the policy of Innovative Pain and Spine Center that payment is due at the time of service unless other financial arrangements are made in advance.

This agreement confirms your knowledge and understanding of the items listed below:

1) **No-show policy:** There will be a $35 charge to your patient account for any appointment that is not cancelled within 24-hours of the time of appointment.

2) **Monthly Statement**: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

3) **Payment options if you DO NOT have insurance:** Payment for services rendered may be made in full OR a written payment plan may be coordinated with the physician and office staff. You may pay by cash, check, or credit card.

4) **Payment options if you HAVE insurance:** If you are covered by health insurance that is contracted with Innovative Pain and Spine Center, we will be happy to bill your insurance. Please provide your insurance information to the front office staff prior to the start of your appointment and we will verify your coverage as a courtesy. *Accepting your insurance does not place all financial responsibilities onto this practice, and you may be held accountable for any unpaid balances by your plan.* It is your responsibility to disclose all insurance information including primary and secondary insurance as well as any change of insurance information. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility benefits. If your insurance company is not contracted with our office, you agree to pay any portion of charges not covered by your insurance including but not limited to those charges above the usual and customary allowance. If your insurance pays you directly, you are responsible for payment and agree to forward payment to us immediately. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower or no payment from the insurance company, and the balance will be your responsibility. It is the policy of Innovative Pain and Spine Center that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-payment, co-insurance and any out-of-pocket portions at the time of service by cash, check, or credit card. If you choose to pay for all of your treatment in full at the time of service, we will issue a refund for any credit balance.

5) **Payments:** Unless we approve other arrangements in writing, the balance on your statement is due upon receipt. We may require personal financial information in order to make a determination regarding an extended payment arrangement. If payment is not received, we reserve the right to refuse future appointments on delinquent accounts.

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6) **Worker's Compensation:** If your claim is denied, you may be responsible for payment in full.

7) **Medicare:** We participate with Medicare. We agree to bill and accept contractual adjustments for programs and will not apply interest or finance charges to those accounts. There may be services and supplies rendered that are not covered by Medicare and therefore require an Advanced Beneficiary Notice (ABN) be signed by the patient/guarantor. By signing the ABN, you understand that you may be financially responsible for payment of those services and/or supplies.

8) **Returned Checks:** There is a fee of $30 on any checks returned by the bank, and we may choose to proceed with legal action, which may result in additional fees.

9) **Past Due Accounts:** Innovative Pain and Spine Center is willing to work with you on any outstanding balances; however, failure to correspond or work with our office in a reasonable manner may result in referral to a third party collecting agency.

10) **Finance Charges:** We compute the FINANCE CHARGE at a periodic rate of 1% per month, which is an ANNUAL PERCENT RATE of 12%. The finance charge is applied to the adjusted balance on your account. The adjusted balance is determined by taking the patient balance owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle.

11) **Personal Injury, Auto, and Third Party:** We bill your attorney for charges incurred associated with personal injury cases. We require a signed Lien for all personal injury cases.

12) **Effective Date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein.

Patient Name (Print):_____

Responsible Party (Print):_____ Relationship:_____

Signature:_____ Date:_____

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Patient Pain Management Agreement and Consent

I, _____ (patient name), and my physician, Matthew Root, D.O., agree to have a safe and controlled pain treatment plan. I understand that pain medications have a high potential for abuse, can be dangerous if used in the wrong way, and that there are risks that come from the use of pain medications. Patient Pain Management Agreement and Consent

NO-HARM AGREEMENT:

Due to the nature of the drugs prescribed and the harmful potential of these drugs if not monitored by a physician on an ongoing basis, it is essential that each patient be seen monthly to reduce any potential harm to our patients. It is also imperative that you see your primary care provider every three months or whenever you have a scheduled appointment and advise all of your physicians about the medications you're prescribed by Innovative Pain and Spine Center. Coordination of your care is critical to reducing risks to your health. Please feel free to discuss this policy with your treating physician, therapist, case manager, or use the links below:

http:/aapainmanage.org http://www.ampainsoc.org

We will NOT accommodate "walk-in" patients, including but not limited to writing refills on medication for the following reasons:

1. Failure to show up for your scheduled appointment
2. Late for your scheduled appointment
3. Failure to schedule a next month appointment during your visit

Partial refills will only be written IF your scheduled appointment was AFTER your regular fill date due to our office scheduling.

Patients that DO NOT attend their scheduled appointment may have their medication discontinued until an appointment has been attended. Multiple missed appointments will result in referral to the Pain Committee for further recommendations. These appointments include medical (monthly office visits, Surgery Center Procedures) behavioral health, physical therapy and acupuncture. We understand that illness and other unpredictable events occur; however, we expect that you will call to cancel and/or reschedule your appointment.

During the time as a patient under the care of Innovative Pain and Spine Center, I enter into this No-Harm agreement with the clinic and the providers of the clinic. I will not attempt to harm myself in any manner as this potential behavior is contraindicative to the treatment offered at Innovative Pain and Spine Center.

Patient Signature:_____ Date:_____

POLICY GUIDELINES: Initials

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To minimize the risks and problems with taking pain medications, **I agree to ALL of the following listed policy guidelines: (please initial at the bottom of every page to verify your agreement to all conditions)**

- I WILL:
  - Only get my pain medicine from this clinic during scheduled appointments.
  - Take my pain medicine the way that my healthcare provider has ordered.
  - Be honest with all of my healthcare providers if I am using street drugs.
  - Be honest about all of the medications that I use, including medications from stores and herbal remedies.
  - Be honest about my full health history.
  - Tell my physician and healthcare providers if I go to an Emergency Room for any reason.
    - If I receive any pain medications from the emergency room, I will inform my healthcare providers.
    - Will tell the Emergency Room staff that I have a pain medicine agreement.
  - Call the office if I am prescribed any medicine.
  - Call the office if I have a reaction to any medication.
  - Tell all other healthcare providers that I have a pain medication agreement.
  - Take drug tests and other tests when told to do so.
  - Go to physical therapy when I am told to do so.
  - Go to counseling when I am told to do so.
  - Follow directions for all treatments.
  - Show up ON TIME to all appointments.
  - Make an appointment for refills before I run out of my medications.
  - Tell my healthcare provider if I will be out of town so that I can get my refills.
  - Get past health records from other offices when needed.
    - I will deliver, pay for, and request these records by hand if needed within one month of being asked.
  - Give permission to the clinic to talk about my treatment plan with pharmacies, doctors, surgeons, nurses, healthcare providers, and others that are part of my care team.
  - Give permission to any healthcare provider to get information from this clinic about my health and pain treatment.
  - *(females only):*
    - Tell my physician or healthcare provider if I plan to become pregnant.
    - Tell my physician or healthcare provider if I am pregnant while I am taking pain medicine.
    - Tell my physician or healthcare provider if I am breastfeeding while I am taking pain medicine.
- If I undergo a procedure/surgery (or dental procedure) and am having severe pain or other symptoms, I will need to contact the physician (or dentist) that performed the procedure/surgery, as well as inform Innovative Pain and Spine Center.
- If I have a new injury (New Vehicle Accident, Slip and Fall, or battery) I may go to the Emergency Room for a diagnostic workup and will need to have the physician communicate with the pain management physician on changes of my pain regimen.
- Other medical problems outside of pain may be treated by the Emergency Room or Urgent Care, or another physician.

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- My doctor and my clinic will help with any investigation if I am suspected of prescription drug abuse or selling/trading drugs.
- I may be sent somewhere else for drug abuse or addiction help if I need it.
- Pain medicine can be addictive; this means that my body may need more and more pain medicine or that it may be hard for me to stop taking this medication.
- If I suddenly stop using this medicine, I can get withdrawal symptoms, which may include: low energy, irritability, anxiety, agitation, insomnia, runny nose, teary eyes, hot and cold sweats, goose bumps, yawning, muscle aches and pains, abdominal cramping, nausea, vomiting and diarrhea.
- If I use too much pain medicine, I can end up with health problems and complications including death.
- If I mix my pain medications with alcohol or drugs, I could also end up with health problems and complications including death.
- I understand that "overdose" is a risk of opioid therapy which can lead to death. I understand and recognize the signs and symptoms of overdose including respiratory depression.
- I understand that I may be prescribed or provided by my pharmacy naloxone because overdose is a risk of opioid therapy. I understand that naloxone is a drug that can reverse opioid overdose. I understand when and how to use naloxone.
    - I understand that it is strongly encouraged to share information about naloxone with my family and friends.
    - I understand that it is strongly encouraged to teach family and friends how to respond to an overdose.
- Here are some things that could go wrong if I use too much pain medication or mix pain medicine with other medications or alcohol:
    - Overdose, slower reflexes, problems with sex, addiction, nausea, dry mouth, constipation, difficulty with urination, depression, vomiting, confusion, trouble breathing, sleepiness, itching, and/or death.

LEGAL MATTERS:

If I am or ever will be on probation or involved in legal matters relating to drugs, I MUST notify my healthcare providers and physicians in order for them to comply with the rules of the court. I understand it is NOT a violation of HIPAA (Health Insurance Portability and Accountability Act) to disclose protected health information (PHI) to law enforcement without my consent under the following circumstances:

- To prevent or lessen a serious or imminent threat to the health or safety of an individual or the public
- To comply with a court order or court-ordered warrant, a subpoena or summons issued by a judicial officer, or a grand jury subpoena.
- To respond to a request for PHI for purposes of identifying or locating a suspect, fugitive, material witness or missing person; but the covered entity must limit disclosures of PHI to name and address, date and place of birth, social security number, ABO blood type and Rh factor, type of injury, date and time of treatment, date and time of death, and a description of distinguishing physical characteristics.
- To federal officials authorized to conduct intelligence, counter-intelligence, and other national security activities under the National Security Act (45 CFR 164.512(k)(2)) or to provide protective services to the President and others and conduct related investigations (45 CFR 164.512(k)(3)).

CAUSE FOR DISMISSAL FROM THIS CLINIC: Initials

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Any deviations from the agreement will cause the agreement to become null and void. The patient's pain management and patient/physician relationship will be compromised. *Should you deviate from the Pain Medication Agreement, your pain medication may be tapered off (or discontinued immediately) by your physician.*

- I WILL:
  - Take responsibility if I overdose myself accidentally or on purpose.
  - Keep my medications away in a safe, locked box so that any children, other members of my household, or any intruders cannot access it.
  - Take responsibility if any other individual overdoses accidentally or on purpose on my medications.
- I WILL NOT:
  - Share, sell or trade any of my medicine. (*This is a Federal Offense)
  - Drink alcohol or take street drugs while I am taking pain medicine.
  - Request for any early refills or off-hour refill requests of my pain medications.
  - Go to the Emergency Room, Urgent Care, or other doctors for the purpose of obtaining more pain medications or refilling my prescribed pain medications.
  - Stand in high places or do anything to hurt others or myself after I have taken pain medicine.
  - Leave my medicine where it can be stolen or where others can take it.
  - Leave my medicine where children can find it.
  - Suddenly stop taking my medicine. I know that if I do this, I can have withdrawals.
  - Hold Innovative Pain and Spine Center liable for the adverse and potentially lethal consequences of NOT taking my prescribed pain medications as directed.

- I know that I cannot call the office to have my medicine refilled over the phone.
- I know that no prescriptions for pain medication will be written, nor called into a pharmacy during evening or weekend hours by the "on-call" doctor.
- I know that when I drive a car or operating machinery, I must be fully alert. Pain medications may alter my ability to remain alert When I am taking pain medications, I need to make sure that I am fully alert and that it is safe for me to drive a car or operate machinery.

WHEN USING A PHARMACY, I WILL:

- Use the same pharmacy for all of my medications. This is the pharmacy that I have chosen:

  _____
- If my chosen pharmacy does not have my medication, I will inform the office of the alternative pharmacy filling my medications.
- Not ask for early refills or more pain medications, even if I lose my medications.

I KNOW THAT:

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- Pain management may include other treatments. Some treatments for pain may not include medication.
- Pain medicine will probably not get rid of all of my pain. Pain medicine can reduce my pain so that I can do more and have a better life.
- Part of my treatment is to reduce my need for pain medicine.
- If the pain medicines work, I will continue to use them. If the pain medicines do not help me, I will inform my physician or healthcare provider, and I understand that they will be stopped.
- My medicines will NOT be replaced if any of the following occur:
  - Medicine or the prescriptions is lost or stolen.
  - Medicine gets wet.
  - Medicine is destroyed.
- If my medicine or prescription is stolen, I must first file a report from the police about the medicine or prescription being stolen. I understand that it is not guaranteed that I will be provided the same medication.
- Any of my physicians or healthcare providers can find out from the *California Prescription Drug Monitoring Program* about any other medications I get from another pharmacy in California. This is called a CURES report.
- My physician or healthcare provider may contact the Drug Enforcement Agency (DEA):
  - If I try to get other doctors to give me pain medicine.
  - If I am not honest about how I take my pain medicine.

I understand this is the policy of Innovative Pain and Spine Center (IPSC) that all patients prescribed potentially addictive medications must sign and agree following the conditions described in this *"Pain Medication Agreement and Consent"*

Your continued safety and effective pain management are our goals. If you have questions regarding this policy or any other terms in your pain contract, please ask any of your IPSC providers.

Patient Name:_____
Patient Signature:_____ Date:_____

Pain Physician:_____
Primary Care Physician:_____

Acknowledgement of Receipt of Notice of Privacy Practices	Initials

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Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Innovative Pain and Spine Center Privacy Act on the date indicated. If you have any questions regarding the information in Innovative Pain and Spine Center Notice of Privacy Practices, please do not hesitate to contact our office located at 4418 Vineland Ave., Suite 218, North Hollywood, CA 91602.

The following individuals may have access to my medical records (family/friend(s)/caregiver(s):

_____

*I understand that ONLY the above named individuals will have access to my medical information upon their request. I understand that I may update this information at any time that I am physically in your office.

Patient Name (Printed):

_____

If Patient Representative, Name (Printed):

_____

If Patient Representative, Relationship to Patient (Printed):

_____

Signature:

_____

Date Notice Received:

_____

Authorization for Release of Medical Record Information

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Patient Name:_____ D.O.B.:_____
Home/Cell Phone:_____ Work Phone:_____
Email:_____
Address:_____
PLEASE NOTE: COPY FEE MAY BE CHARGED FOR MEDICAL RECORDS

Above listed patient authorizes the following healthcare facility to send and receive record disclosures:
Facility Name:_____
Facility Address:_____
Facility Phone:_____ Facility Fax:_____

Dates and Type of Information to Disclose:
___ 2 years prior from last date seen
___ Dates Other:_____
___ Specific Information Requested:_____
_____

Purpose of Disclosure (check all that apply):
___ Change of Insurance of Physician
___ Continuation of Care
___ Referral
___ Other:_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:
Release to: Innovative Pain and Spine Center (Matthew Root, D.O.)
Address: 4418 Vineland Ave., Suite 218, North Hollywood, CA 91602

Phone: (818) 621-0019 **Fax: (818) 671-5556** Please (check): ___ Mail ___ Fax Records

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **This authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient or Authorized Representative Signature:_____ Date:_____
Patient or Authorized Representative Name (printed):_____
Relationship to Patient:_____
Address/Phone of Representative:_____

Brief Pain Inventory (Short Form)

Date: _____ Time: _____

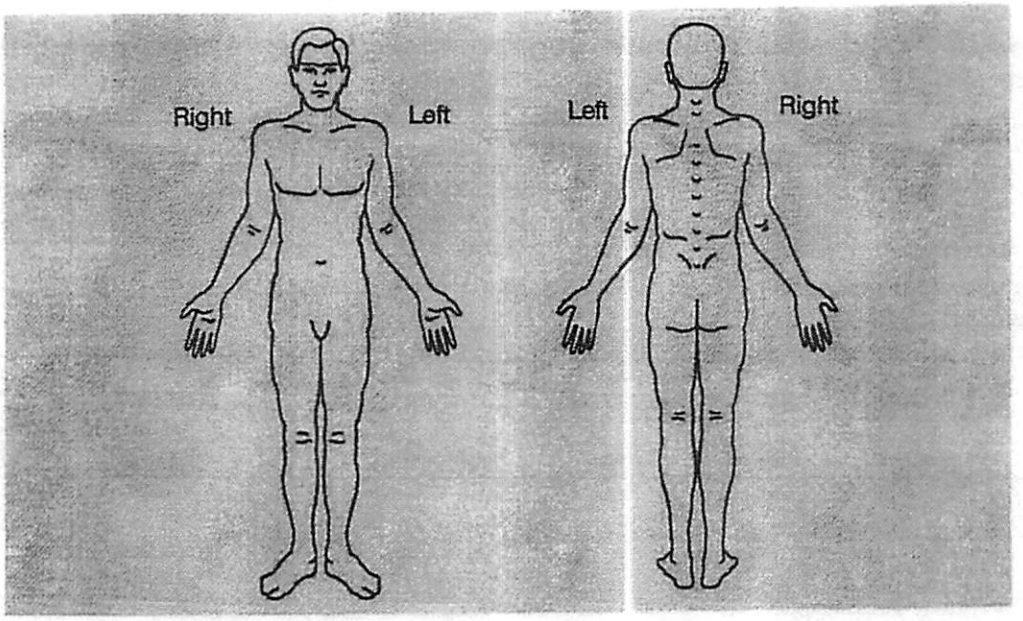
Name: _____

Last First Middle Initial

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have RIGHT NOW.

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that most shows how much RELIEF you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
No relief										Complete relief

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

A. General activity:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

B. Mood:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

C. Walking ability:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

D. Normal work (includes both work outside the home and housework):

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

E. Relations with other people:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

F. Sleep:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

G. Enjoyment of life:

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

Questionnaire

Name: _____ Date:_____

No.	Question	Answer	Score
1	Are you basically satisfied with your life?	Y / N	
2	Have you dropped many of your activities of interest?	Y / N	
3	Do you feel your life is empty?	Y / N	
4	Do you often get bored?	Y / N	
5	Are you in good spirits most of the time?	Y / N	
6	Are you afraid that something bad is going to happen to you?	Y / N	
7	Do you feel happy most of the time?	Y / N	
8	Do you often feel helpless?	Y / N	
9	Do you prefer to stay at home, rather than going out and doing new things?	Y / N	
10	Do you feel you have more problems with memory than most people?	Y / N	
11	Do you think it is wonderful to be alive?	Y / N	
12	Do you feel pretty worthless the way you are now?	Y / N	
13	Do you feel full of energy?	Y / N	
14	Do you feel that your situation is hopeless?	Y / N	
15	Do you think that most people are better off than you are?	Y / N	
	For office use	Total:	