North Texas Therapy Innovations, P.C.

Patient Information Adult Wellness

Patient Name _____ DOB_____ Age _____Gender_____
Address _____
City _____State _____ Zip Code _____
Phone #'s (H) _____ (Cell) _____ (W) _____
E-mail _____
Occupation _____ Employer _____

Spouse Information

Name _____ Emergency Contact _____
Phone _____ Alternate Phone _____
Employer _____ Occupation _____

Physician Information

Name _____
Phone _____ Fax _____
Diagnosis _____

Who may we thank for your referral? _____

Insurance Information Required

Insurance: Yes / No _____
Address: City/State/Zip _____
Benefit/Claims Phone # _____
Member ID # _____ Group # _____
Name of Insured_____
Insured DOB _____ Relationship to Patient _____

Authorized Person's Signature. I authorize payment of medical benefits to the undersigned provider for services rendered. I understand that NTTI files for the patient's primary insurance plan only as Out-Of-Network providers. I further recognize that Secondary Insurance policies claims must be filed by the policy holder.

[ ] FILE MY CLAIMS

_____

Signature Date

[ ] DO NOT FILE MY CLAIMS

___ **Your initials here allow NTTI to leave detailed medical information on your voice mail or email**

North Texas Therapy Innovations, P.C. Adult Wellness Clinic Policies

Please read and sign/initial the following.

Treatment Sessions
Half hour sessions of therapy are equal to 25 minutes of therapy; forty-five minute are equal to 35 minutes therapy; one hour sessions are equal to 50 minutes of therapy. _____ (initials)

Please dress in comfortable loose clothing for each session. No hard soled shoes or high heels are worn in the gym (tennis shoes are fine.) If gym equipment is used, patient will go barefoot to have grounded footing on the equipment. _____ (initials)

Payment And Billing
Payment of services is due on the day the service is provided. We accept cash, checks, Visa and Mastercard. Please make checks payable to North Texas Therapy Innovations (NTTI). A Credit Card on File form must be completed in order to charge treatment sessions to your credit card. If your credit card information changes, please notify us immediately and a new form must be completed. A copy of the patient's driver's license must accompany the form. There will be a **$40 charge for all returned checks and denied credit cards**. Your superbill at the time of service is your receipt. Patient detail reports are provided upon request only. _____ (initials)

No Shows And Late Cancellations
Our professional standard is to begin and end each session in a timely manner. Please be punctual so that we can optimize our appointment schedules. Patients arriving more than 10 minutes late may be rescheduled. Patients arriving more than 15 minutes late are considered NO SHOWS. In the case of an emergency or illness we can make exceptions to this policy. However, it is your responsibility to contact your therapist as soon as possible to eliminate extra fees. Please reschedule if you are ill with a fever, diarrhea, vomiting, the common cold or a rash.

Late Cancellations: Appointments not cancelled within 24 hours will be charged a fee of half of the scheduled session.
No Shows: Appointments not scheduled at all are considered a NO SHOW and are charged at the full rate of the scheduled therapy session.

Cancellations are to be made directly to your therapist. Emails and phone calls to the business office are not recognized. _____ (initials)

Patient Name _____

Patient Record Of Disclosures

In general, the HIPAA privacy rules give individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI be made by alternate means.

Please indicate the manner in which you would like to be contacted **(check all that apply)**

☐ **Home Phone Number:** _____

____ O.K. to leave message with detailed information
____ Leave message with call-back number only

☐ **Work/Cell Phone Contact:** _____

____ O.K. to leave message with detailed information
____ Leave message with call-back number only

☐ **Written Communication**

____ O.K. to mail my home address
____ O.K. to fax to this number: _____

Patient Record of Disclosures: _____ (initials)

Patient Release For Interns & Volunteer Staff

NTTI is a teaching clinic. On occasion we may have students from Texas Women's University and Washington University accompany your therapist, observe treatment and have sight of their notes. Students are background checked through each respective institution.

NTTI periodically allows volunteers to assist in the clinic. They are in place to learn and assist the therapist in the patient's treatment. Because they are not employees of NTTI they cannot assist you in scheduling, billing, medical or insurance information. Each volunteer has HIPAA Privacy instructions.

By initialing, I understand that my treatment, testing, evaluations, daily notes and superbills will be seen by student interns and by volunteer staff. I understand that the student interns and/or volunteers will be involved in my treatment. _____ (initials)

Patient Name _____

Fragrance Free Facility
Please note that NTTI is a perfume/cologne-free environment due to sensitivities of patients and staff and not allowed in the clinic. _____ (initials)

Financial Agreement
Aetna, BCBS, Cigna and UHC Patients: NTTI files claims as an out-of-network (OON) provider with the above listed insurance companies. Patients are billed for their annual OON deductible at the beginning of their plan's calendar year and after it has been satisfied the patient is responsible for the co-insurance amount set by the insurance carrier. Patients are billed for any remaining balance after payment has been received from the insurance company. Any non-covered services are the financial responsibility of the patient.

In the event that payment for a service performed is denied by the insurance carrier, it is the patient's responsibility to pursue action with their insurance carrier, as the policy is a legal contract between the patient and the insurance company. _____ (initials)

If a patient has insurance carriers other than those listed above or has no insurance coverage, they are responsible for all charges incurred at the time of service and payable at the time of service. _____ (initials)

I understand that payment is expected at the time of service. I must provide a photo copy of my insurance card annually and also at any time my insurance plan changes. It is my responsibility to notify NTTI of changes that affect the billing process. I understand that I am responsible for any amount not covered by my health plan without limitation of the out-of-network deductible, coinsurance and/or out-of-pocket maximum visits/amounts. _____ (initials)

Notice Of Privacy Practices
I acknowledge that I have received a copy of the Notice of Privacy Practice from NTTI. I have read this notice and am aware of my rights and obligations. _____ (initials)

Signing below validates your initials on each of the above clinic policies. Thank you for your time in completing these forms.

_____
Patient Name Printed

_____
Patient Signature Date

North Texas Therapy Innovations
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. *Please review this carefully.*

If you have any questions about this notice, please contact the Facility Privacy Officer by calling our office number.

Who Will Follow These Practices?

Protected Health Information (PHI) will be disclosed by NTTI and therapists.

These policies do not apply to information that NTTI and therapists receive while in a non-health care provider capacity.

These require NTTI, employees, and any third parties that participate to comply with the privacy rules while engaging in other activities.

NTTI employees providing services are required to protect each patient's PHI. This is information we have created or received relating to health conditions, all of the health care payments that identify you or provides basis to believe the information can identify you.

PHI does not include individually identifiable information contained in the Family Education Rights and Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA).

We provide you with this notice to explain how, when, and why we disclose your PHI. We will not disclose any more than is necessary.

We reserve the right to change the terms of this notice at any time that will apply to what we already have. We will make the change in this notice and post a new one at our location and on the website.

NTTI is required to notify affected individuals in the case of any breach of their unsecured PHI.

How We May Disclose and Use Your Protected Health Information

Certain uses and disclosures do not require your authorization for these reasons:

For Treatment-It may also be disclosed to educational facilities, your referring physician, and those participating in the delivery of health care.

For Payment-It may be disclosed so your services are billed and payment is collected properly. We may tell the clinic about treatment to be received to obtain prior approval and determine if your plan covers treatment. We may discuss PHI with a pharmacist as well to determine correct dosage and administration of medical information.

For Health Care Operations-It may be disclosed to review services to evaluate the performance of the staff and make sure all patients receive quality care. We may combine the PHI of several patients to determine if additional services need to be offered, which services are not needed, and if treatments are effective. Identifiable information may be removed for educational facilities to use.

When Disclosure Is Required By Law-Under HIPAA, we must make PHI disclosures to the Secretary of the Department of Health and Human Services if the law requires us to do so. It is for them to investigate our compliance with the requirements of the Privacy Rule with HIPAA.

For Public Health Activities-It may be disclosed if information is reported about births, deaths, various diseases, etc. to government officials collecting this information. Information will also be provided to necessary medical providers.

For Health Oversight Activities-It may be disclosed to a health oversight agency for activities authorized by the law. This is necessary to assist government conduction of investigation or inspection of a health care provider or organization.

For Research Purposes-It may be disclosed to approved researchers with reviewed and accepted protocols. This will include no unique identification of the subject of the information.

To Avoid Harm-It may be disclosed when we believe it will prevent a serious threat to the health and safety of a person or the public. We may provide PHI to law enforcement able to prevent or lessen harm.

For Specific Government Function-It may be disclosed for military personnel or veterans for intelligence, counter-intelligence, and national security purposes.

For Workers compensation Purposes-It may be disclosed to comply with these laws that benefit work-related injuries or illnesses.

Appointment Reminders and Health-Related Benefits-It may be disclosed for reminders and give information about treatment alternatives or services we offer.

Inmates-It may be disclosed about an inmate or the person having lawful custody. This is necessary to provide them with health care, protect their and others health and safety, and provide law enforcement on institution premises.

To You and Your Personal Representative-It may be disclosed to your representative if you are a minor. We will obtain documentation that supports your representation prior to disclosure. We do have the right not to accept this person if we have reason to believe they are a danger to you in some form.

Uses and Disclosures with Prior Written Authorization:

In situations not referenced above, we will ask for written authorization before using or disclosing your PHI. If you choose to authorize PHI disclosure, you can later revoke the authorization in writing to stop any further disclosure.

What Rights You Have Regarding Your PHI

To See and Get Copies of Your PHI-The request must be made in writing and we will respond to you within 30 days of receiving it. We may deny the request in writing in certain situations. We may charge a fee for copying, mailing or supply costs.

To Correct or Update Your PHI-If you think there may be a mistake or information is missing, you may submit a request in writing to change it and we will respond to it within 60 days. We may deny it if the PHI is complete and correct, not created by us, not allowed to be disclosed, or is not part of our records. If we approve it, we will make the change, tell you that we have, and make sure others know.

To Get a List of the Disclosures We Have Made-We will respond within 60 days of your written request. This list will include disclosures made in the last 6 years unless you request a shorter time. It includes the date of disclosure, to whom it was disclosed, description of the information, and the reason for disclosure.

To Request Limits on Uses and Disclosures of Your PHI-A written request must be submitted to NTTI. It must tell us the PHI you would like to limit, the reasons why, and to whom the limits apply. We will consider this request but are not legally required to accept it.

To Choose How We Send PHI to You-You can request that we send information to an alternate address or by alternate means. We must agree to this request as long as it is reasonable and can easily provide the requested information. It must be submitted in writing to NTTI.

To Get a Paper copy of This Privacy Notice-Request must be submitted or you may look on our website for a copy at www.sensorytherapydallas.com

How to Complain About Our Privacy Practices

If you think we may have violated your privacy rights or you disagree with a decision made about access to your PHI, you may file a complaint with the NTTI Privacy Officer. We will take no retaliatory action against you if you file a complaint about our Privacy Practices.

_____ _____

Signature of Patient or Personal Representative **Date**

North Texas Therapy Innovations
11886 Greenville Ave, Suite 110
Dallas, TX 75243

Communication Consent Form

I give permission to NTTI to contact me in the following methods regarding my private health information, evaluation, treatment, and appointments. I authorize NTTI to leave messages for me when I am not available.

☐ Home Phone (_____) _____

☐ Message with information ☐ Message with call-back number only

☐ Cell Phone (_____) _____

☐ Message with information ☐ Message with call-back number only

☐ Work Phone (_____) _____

☐ Message with information ☐ Message with call-back number only

☐ Text Messages (_____) _____

☐ Message with information ☐ Message with call-back number only

☐ Email _____

☐ Message with information ☐ Message with call-back number only

I authorize NTTI and therapists to discuss my health care information with the contacts listed below. I understand that by leaving these spaces blank, I am indicating that I do not want information released to anyone else.

Name	**Relationship to Patient**	**Phone Number**

By signing, I acknowledge that I have read and understand these communication guidelines. I Allow NTTI to contact me by these means and give permission to the people listed above to receive patient health care information.

_____ _____

Patient, Guardian, Legal Representative Signature Date

NORTH TEXAS THERAPY INNOVATIONS, P.C.

CREDIT CARD AGREEMENT

North Texas Therapy Innovations, P.C. can process your payment via Master Card & Visa both Credit & Debit cards and personal checks. **SORRY, WE CANNOT ACCEPT DISCOVER & AMERICAN EXPRESS.**

We ask you to pay us promptly. Payment is due upon receipt of your invoice (Encounter Form) at the end of each week of treatment. It is your responsibility to keep a copy of your Encounter form for your records. You may choose to have us charge your credit card at the end of each week for services rendered. Once you authorize NTTI to charge your credit card for services rendered, your charges will automatically be processed each week according to the services rendered. **If you choose to discontinue Automatic Credit Card Services, it is your responsibility to notify the Main Business Office of NTTI in writing.**

We at NTTI are diligent to protect your privacy. Therefore, this document will remain at the Business Office in Dallas. Your therapists will not have access to this document so if you need to make changes, please contact the NTTI business office at 214-349-6178.

Thank you,
North Texas Therapy Innovations, P.C.

CREDIT CARD PAYER: **Patient:** _____

I **agree** to have North Texas Therapy Innovations, P.C. charge my credit card weekly for therapy services rendered. A $40.00 fee will be charged for inactive/declined credit cards.

_____ Name of Cardholder as it appears on the card

Card Type: ☐Master Card ☐Visa **SORRY, WE CANNOT ACCEPT DISCOVER & AMERICAN EXPRESS**

Credit Card #: Please print clearly!

Exp. Date: (ex: 04/10) Security #: (last 3 digits from back of the Card)

		/					

Credit Card Holder's Billing Address:

_____
Address

_____ _____ _____
City State Zip

_____
Cardholder / Responsible Party Signature Date

For Office Use Only:
Date Business Office Received forms: _____ Received by: _____

MEDICAL HISTORY FOR THERAPY EVALUATION

Patient: _____ DOB: _____ Today's Date: _____

Occupation: _____ Currently working? ☐ Yes ☐ No #Hrs/day____ # Days/wk _____
Physical requirements for work: _____
Current physical restrictions for work: _____
Native Language: _____ Language spoken most often: _____

CURRENT INJURY/PROBLEM

Date of injury/problem: _____ Work Related? ☐Yes ☐No
Chief complaint: _____
What caused your problem? _____
Previous Testing: ☐MRI ☐CAT ☐X-Ray ☐Other _____
Results of testing: _____
List any assistive or adaptive equipment/devices or supports you are currently using: _____
_____

Related Complaints of Pain:

			Constant	Intermittent	Improving	Unchanged	Worsening
Headaches			☐	☐	☐	☐	☐
Neck			☐	☐	☐	☐	☐
Mid Back			☐	☐	☐	☐	☐
Low Back			☐	☐	☐	☐	☐
Arms	R	L	☐	☐	☐	☐	☐
Legs	R	L	☐	☐	☐	☐	☐

1. Mark through the line below where you **pain** is **right now**

No Pain **Extreme Pain**

2. Mark through the line below where you **pain** is when **at its worse**:

No Pain **Extreme Pain**

3. Mark through the line below where you **pain** is when **at its best**:

No Pain **Extreme Pain**

List all medications you are currently using (prescription and over the counter):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

What makes/When is your pain better? (Check all that are appropriate)

☐ Bending	☐ Standing	☐ Walking	☐ Lying Down
☐ Stationary	☐ On the move	☐ Mornings	☐ Evenings
☐ Sitting	☐ Stand ➜ Sit	☐ Sit ➜ Stand	☐ As day progresses

What makes/When is your pain worse? (Check all that are appropriate)

☐ Bending	☐ Standing	☐ Walking	☐ Lying Down
☐ Stationary	☐ On the move	☐ Mornings	☐ Evenings
☐ Sitting	☐ Stand ➜ Sit	☐ Sit ➜ Stand	☐ As day progresses

Does the pain awake you at night? ☐Yes ☐ No If yes, how frequently? _____
Do you have pain 24 hours/day? ☐Yes ☐ No

Please give any other information you feel is important concerning your injury/problem:_____

_____

_____

GENERAL MEDICAL HISTORY

Please check yes or no to the following questions, and check whether it is related to your injury. This will help us understand your present and past medical history. This information will maximize the safety and effectiveness of your evaluation and/or treatment and is strictly confidential.

ALL PATIENTS:

Do you have indigestion or heart burn?	☐ Yes	☐ No	
Do you have any heart problems or disease?	☐ Yes	☐ No	
Do you have a pacemaker?	☐ Yes	☐ No	
Do you have a heart murmur/heart valve problem?	☐ Yes	☐ No	
Do you have frequent or easy bruising or bleeding?	☐ Yes	☐ No	
Do you have high blood pressure?	☐ Yes	☐ No	
Have you had a stroke?	☐ Yes	☐ No	
Do you have diabetes?	☐ Yes	☐ No	
Do you have scoliosis?	☐ Yes	☐ No	
Do you have swelling in your arms or legs?	☐ Yes	☐ No	☐ Injury Related
Do you have any fainting, dizziness, or light-headedness?	☐ Yes	☐ No	☐ Injury Related
Do you have any nausea or vomiting?	☐ Yes	☐ No	☐ Injury Related
Do you have any motion sickness?	☐ Yes	☐ No	☐ Injury Related
Do you have epilepsy, a history of seizures, or convulsions?	☐ Yes	☐ No	☐ Injury Related
Have you had changes in memory/orientation?	☐ Yes	☐ No	☐ Injury Related
Do you have ringing in your ears?	☐ Yes	☐ No	☐ Injury Related
Do you have any hearing problems/impairment?	☐ Yes	☐ No	☐ Injury Related
Do you have visual problems or impairment?	☐ Yes	☐ No	☐ Injury Related
Do you wear contacts, dentures, or hearing aids?	☐ Yes	☐ No	☐ Injury Related
Do you have any difficulty swallowing?	☐ Yes	☐ No	☐ Injury Related
Do you have any lung problems, breathing difficulty/disease?	☐ Yes	☐ No	☐ Injury Related
Do you have bronchitis, asthma, emphysema, or COPD?	☐ Yes	☐ No	☐ Injury Related
Are you awakened frequently at night?	☐ Yes	☐ No	☐ Injury Related
Have you had any changes in your sleeping pattern?	☐ Yes	☐ No	☐ Injury Related
Do you have unusual or frequent headaches?	☐ Yes	☐ No	☐ Injury Related
Do you have extreme fatigue or loss of energy?	☐ Yes	☐ No	☐ Injury Related
Have you had any increase in thirst or hunger?	☐ Yes	☐ No	☐ Injury Related
Have you had any recent weight loss or weight gain? How much? _____	☐ Yes	☐ No	☐ Injury Related
Have you ever had pain in your back?	☐ Yes	☐ No	☐ Injury Related

Have you ever had pain in your neck?	☐ Yes	☐ No	☐ Injury Related
Have you ever had pain in your pelvis?	☐ Yes	☐ No	☐ Injury Related
Have you had any fractured bones or joint dislocations?	☐ Yes	☐ No	☐ Injury Related
Do you have arthritis or joint problems?	☐ Yes	☐ No	☐ Injury Related
Do you have Fibromyalgia?	☐ Yes	☐ No	☐ Injury Related
Do you have osteoporosis?	☐ Yes	☐ No	☐ Injury Related
Do you have any metal implants?	☐ Yes	☐ No	☐ Injury Related
Have you had any pain with urination?	☐ Yes	☐ No	☐ Injury Related
Have you had any changes in urination or leaking of urine?	☐ Yes	☐ No	
Do you leak feces?	☐ Yes	☐ No	
Do you have pain with intercourse?	☐ Yes	☐ No	
Do you have irritable bowel syndrome?	☐ Yes	☐ No	
Do you have constipation?	☐ Yes	☐ No	
Have you had any changes in your bowel/bladder habits?	☐ Yes	☐ No	
Have you had any changes in stool color or rectal bleeding?	☐ Yes	☐ No	
Do you have a history of cancer or tumors?	☐ Yes	☐ No	
Have you ever had any blood disease?	☐ Yes	☐ No	
Do you have a fever or chills?	☐ Yes	☐ No	
Do you smoke? #pack/day____ # yrs____	☐ Yes	☐ No	
Do you have a latex allergy?	☐ Yes	☐ No	
Do you have a rubbing alcohol allergy?	☐ Yes	☐ No	
Do you have other allergies?	☐ Yes	☐ No	
Do you have any difficulty communicating? (Getting your point across?)	☐ Yes	☐ No	
Are there any activities/hobbies/selfcare/or work related duties that you are unable to perform?	☐ Yes	☐ No	

Female Patients:

Are you currently Pregnant?	☐ Yes	☐ No
Do you have any pregnancy-related pain?	☐ Yes	☐ No
Do you have any problems with menstruation?	☐ Yes	☐ No
Do you have endometriosis?	☐ Yes	☐ No

If you answered "yes" to any of the above questions, please describe:_____

Surgical History: Check all that apply

☐ Back/neck surgery ☐ Bladder surgery ☐ Hysterectomy (abdominal__, vaginal__)
☐ Gall bladder surgery ☐ Appendectomy ☐ Hernias
☐ C-Section ☐ Ovaries removed ☐ Bowel/rectal surgery
☐ Hemorrhoidectomy
☐ Breast surgery (specify type) _____
☐ Other_____

Was your surgery injury related? ☐ Yes ☐ No
If you answered yes to the above list, please be specific with dates and outcomes.

_____
_____
_____
_____

Prior to your injury/problem did you exercise regularly? ☐ Yes ☐ No
Where?_____
How Often? _____
What exercises? _____

Are you currently exercising regularly? ☐ Yes ☐ No
Where? _____
How Often? _____
What exercises? _____

Have you ever had any falls (bike, skate board, ski, roller skating, etc.) or car accidents, list dates or age at time of injury and severity

_____
_____

DAILY FLUID INTAKE: (*enter number of 8 oz cups/glasses of fluid taken daily*)

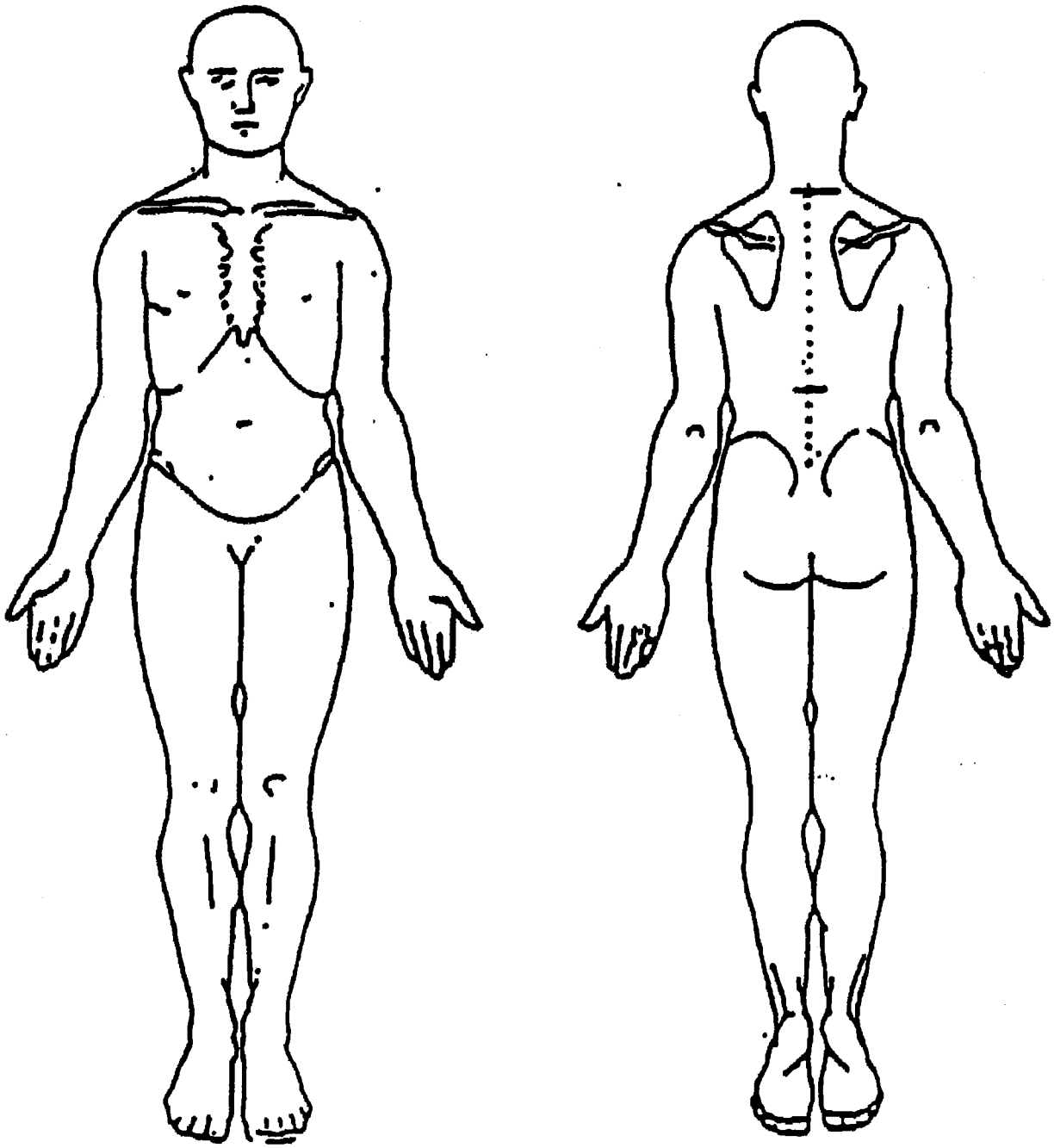
- ❑ Water ___
- ❑ Caffeinated drinks (coffee, tea, colas, chocolate) ___
- ❑ Decaffeinated drinks (coffee, tea, colas) ___
- ❑ Alcohol ___
- ❑ Juices ___
- ❑ Other ___

BOWEL HABITS:

How often do you have a bowel movement? _____

Do you strain having a bowel movement?	❑ Yes	❑ No	
Do you experience abdominal cramping?	❑ Yes	❑ No	
Do you leak/stain feces?	❑ Yes	❑ No	If yes, how often?_____
Do you experience diarrhea?	❑ Yes	❑ No	If yes, How often?_____
Do you use laxatives?	❑ Yes	❑ No	If yes, how often/week?_____
Do you use enemas?	❑ Yes	❑ No	If yes, how often/week?_____
Do you include fiber in your diet daily?	❑ Yes	❑ No	If yes, how much?_____

Please draw in where you are affected by your injury/problem.



There are many words that describe pain. The following is a list of words used to describe pain. Look at each work group and place a check (✔) by the **one** word in the section which best describes your present pain. Only indicate the words that describes your pain. You do not have to choose a word in every group. If none of the words in a particular group describe your pain, go to the next word group.

1.
☐ Flickering
☐ Quivering
☐ Pulsing
☐ Throbbing
☐ Beating
☐ Pounding

2
☐ Jumping
☐ Flashing
☐ Shooting

3.
☐ Pricking
☐ Boring
☐ Drilling
☐ Stabbing

4.
☐ Sharp
☐ Cutting
☐ Lacerating

5.
☐ Pinching
☐ Pressing
☐ Gnawing
☐ Cramping
☐ Crushing

6.
☐ Tugging
☐ Pulling
☐ Wrenching

7.
☐ Hot
☐ Burning
☐ Scalding
☐ Searing

8.
☐ Tingling
☐ Itchy
☐ Smarting
☐ Stinging

9.
☐ Dull
☐ Sore
☐ Hurting
☐ Aching
☐ Heavy

10.
☐ Tender
☐ Taut
☐ Rasping
☐ Splitting

11.
☐ Tiring
☐ Exhausting

12.
☐ Sickening
☐ Suffocating

13.
☐ Fearful
☐ Frightful
☐ Terrifying

14.
☐ Punishing
☐ Grueling
☐ Cruel
☐ Vicious
☐ Killing

15.
☐ Wretched
☐ Blinding

16.
☐ Annoying
☐ Troublesome
☐ Miserable
☐ Intense
☐ Unbearable

17.
☐ Spreading
☐ Radiating
☐ Penetrating
☐ Piercing

18.
☐ Tight
☐ Numb
☐ Drawing
☐ Squeezing
☐ Tearing

19.
☐ Cool
☐ Cold
☐ Freezing

20.
☐ Nagging
☐ Nauseating
☐ Agonizing
☐ Dreadful
☐ Torturing

PRI (R) = _____ NWC = _____