Newport Pain Management
Medical Corporation
phone 949 759-8400 fax 949 759-5566

DEMOGRAPHICS **DATE**

Name:_____ Spouses Name:_____
Date of Birth:_____/_____/_____ Spouse Soc.Sec.#: _____
Social Security #:_____ Marital Status:_____
Driver's License #:_____

Home address:_____ City:_____ Zip:_____
Home phone #:_____ Cell Number:_____
Employer:_____ E-Mail:_____
Work address: _____ City:_____Zip:_____
Work phone #:_____ Fax Number:_____

Primary Insurance Company: _____ Group ID#_____
Plan ID#_____ Authorization Phone #:_____
Insured's name:_____ Insured's date of birth: _____/_____/_____

Secondary Insurance Company: _____ Group ID#_____
Plan ID#_____ Authorization Phone #: _____

Person to contact in Emergency: _____ Relationship: _____
Phone #: _____ Pharmacy Name:_____ Phone #:_____

Primary Physician
Name:_____ Phone Number: _____
Address:_____

Referral Physician
Name:_____ Phone Number: _____
Address:_____

Other Physician
Name: _____ Phone Number: _____
Address:_____

How did you become aware of Dr. Scott? Location/ Phone Book/ Brochure/ Web/ News Article/ News Ad in _____ paper/ Referred by: Dr./ Family/ Other patient: _____

Who may we send copies of your medical records to: _____
_____

I hereby authorize Dr. Scott to furnish information to insurance carriers concerning this illness. I hereby irrevocably assign all benefits, including major medical benefits, for medical services rendered to be paid directly to the facility in accordance with California Insurance Code, Section 10133. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. Procedures may be performed at the Newport Center for Special Surgery, owned by Herbert Scott.

Patient signature: _____ Date: _____

NEWPORT CENTER FOR SPECIAL SURGERY

FINANCIAL POLICY

The doctor you are seeing has adopted the following Financial Policy so that we can keep our costs down and still provide high quality medical and/or outpatient surgical care to you, our patient.

- **Payment for Services**: Payment is due at the time of service. Cash, Check or Credit Card will be accepted for payment for services, deductibles, co-pays and co-insurances.

- **For Cash Patients**: Payment is based on the surgeon's *estimated time* for your procedure. If the procedure runs over the surgeon's estimated completion time, you will be charged for the additional time.

- **Surgical Services**: Payment of co-pay, deductibles and co-insurance will be collected pre-surgery. A written estimate of charges will be given to you along with the portion of the charge you are responsible for paying. We will file with third party payors for only the assigned insurance balance due for surgical services.

- **Co-Pays, Deductibles, and Co-Insurances**: These amounts will be calculated and collected at the time of service.

- **Secondary Insurances**: Secondary Insurance claims will be filed for Surgical Services.

- **Non-Payment of Accounts**: <u>If the insurance carrier does not pay the claim within 60 days, you will be responsible for payment</u>. Any personal balance will be billed to you for 60 days. Accounts with no payment activity will then be forwarded to a collection agency.

- **Questions**: If you have questions concerning our payment policy, our fees, or difficulty making payment, please talk with our Front Office Staff or our Business Office Manager.

My signature below certifies that I have read and understand the terms of the Financial Policy listed above.

Signature of Patient	Date	Print Name of Patient	
Signature of Doctor or Facility Representative	Date	Print Name of Doctor or Facility Representative	

Newport Pain Management
Medical Corporation
phone 949 759-8400 fax 949 759-5566

NEW PATIENT INSTRUCTIONS

Thank you for allowing H. Rand Scott, M.D. and Newport Pain Management Medical Corporation an opportunity to care for you or your loved one. It is our goal at Newport Pain Management to offer you the leading edge in technology and safety equipment for pain control. This is why our clinic has quickly gained an outstanding local reputation. In order to better serve you, we ask a few things of you.

- ❒ Please be on time to appointments. Dr. Scott does not double book or overlap your time slot, so he can spend the entire appointment focusing on your problem. Call at least 24 hours in advance to cancel an appointment. Failure to do so may endanger your ability to continue care with Dr. Scott. There will be a $35.00 charge for a missed appointment. If you do not show for the initial consultation, you will not be rescheduled.

- ❒ **Verification of eligibility** is the responsibility of the patient. All patients are responsible for knowing their benefits including deductibles, coverage of procedures and restrictions. Be prepared to pay your portion prior to services being rendered.

- ❒ Please have your old records, including old X-ray, MRI's or reports from them sent to our office prior to the day of your appointment. If sufficient records are not obtained prior to your appointment, you will need to be rescheduled. Please bring in all your medications as well. This helps us diagnose the problem, and communicate with your other Doctors.

- ❒ Please call in refill requests three days in advance of running out of medication.

- ❒ Please bring a driver if you are scheduled for an injection. No injections will be done without a driver.

- ❒ All blocks (injections) are performed in an Ambulatory Surgery Center, accredited by Medicare, the highest standard of accreditation. We do this for your safety and benefit. The surgicenter supplies and maintains defibrillators; heart, blood pressure, and oxygen monitors, and life support equipment. It also has emergency back-up power, and transfer agreements with Hoag Memorial Hospital. Importantly, the surgicenter performs quality assurance for such things as sterility of instruments and review of the Doctor's performance. Last, California law requires that a physician who administers medications that may cause loss of protective reflexes (unconsciousness) do so only in an accredited facility (a surgicenter or hospital). Accordingly, a separate surgicenter fee for these services will be charged for all blocks.

I have read and understand the above information: _____
Patient signature

newport
Center for Special Surgery

1401 Avocado Avenue, Suite 101
Newport Beach, CA 92660

Phone 949 644-8182
Fax 949 759-5566

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact **Herb Scott** at **949 644-8182 1401 Avocado Ave. #101 Newport Beach, CA 92660**

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed *Consent to* use and disclose health information for the following purposes:

For Treatment We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

For Health Care Operations We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

Appointment Reminders We may contact you as a reminder that you have an appointment for treatment or medical care at the office.

Treatment Alternatives We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders, or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

You may revoke your *Consent* at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time.

If you do revoke your *Consent*, we will not be permitted to use or disclose information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law We will disclose health information about you when required to do so by federal, state or local law.

Research We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.

Organ and Tissue Donation If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

Military, Veterans, National Security and Intelligence If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

Health Oversight Activities We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners, Medical Examiners and Funeral Directors We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

Information Not Personally Identifiable We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family and Friends We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization.* We must obtain your *Authorization* separate from any *Consent we* may have obtained from you. If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization,* in writing, at any time. If you revoke your *Authorization,* we will no longer use or disclose information about you for the reasons covered by your written *Authorization,* but we cannot take back any uses or disclosures already made with your permission.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization (different than the *Authorization* and *Consent* mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed *Consent* and a special written *Authorization* that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to **Herb Scott** in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

Right to Amend If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

To request an amendment, complete and submit a Medical Record Amendment/Correction Form to **Herb Scott**. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b) Is not part of the health information that we keep.

c) You would not be permitted to inspect and copy.

d) Is accurate and complete.

Right to an Accounting of Disclosures You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to **Herb Scott**. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are Not Required to Agree to Your Request If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you may complete and submit *the Request For Restriction On Use/Disclosure Of Medical* Information to **Herb Scott**.

Right to Request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the *Request For Restriction On Use/Disclosure Of Medical Information And/Or Confidential Communication* to **Herb Scott**. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact **Herb Scott**.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact **Herb Scott at 949 759-8400**. You will not be penalized for filing a complaint.

HOW MAY WE CONTACT YOU?

I hereby give approval for the physician(s) our employees, staff and other office personnel to contact me or leave messages for me via:

(Please initial each way we are allowed to contact you)

_____Home phone myself only
_____Home phone may leave message on answering machine and/or with person answering phone
_____Work phone myself only
_____Work phone may leave message on answering machine and/or with person answering phone
_____Cell phone and Cell Voice Mail
_____Fax Machine
_____Home address (or specify which address to use)_____
_____Email (supply address)_____

I have read, understand, and agree to the above.

Signature:_____Date:_____
Print Name:_____

PATIENT ASSESSMENT for: _____

Patient Name

Dear Patient,

Pain problems can be very complex, and it is essential that we learn as much about you as we can, and that we learn it directly from you. This questionnaire requests a great deal of personal information. PLEASE READ CAREFULLY AND ANSWER EACH AND EVERY QUESTION. Since this is your personal account of your problem, please do it entirely by yourself and not with the opinions of others. We will seek the opinions of others close to you at a later time.

1. Country of Birth: A. Yourself_____ B. Father_____ C. Mother_____

2. Highest level of school completed:_____

3. Do you (check all that apply)
   A. Live Alone ( )
   B. Live with Relatives ( ) Please name_____
   C. Live with Others (Roommate, Share apartment) ( )

4. Current Marital Status:
   A. Single ( )
   B. Married ( ) How many years? _____
   C. Separated( ) How long? _____
   D. Divorced ( ) How long? _____
   E. Widowed ( ) How long? _____

5. Number of Children: ____ List names and ages_____
   _____

6. Ages of children living at home:_____

7. If married, how would you describe your marital relationship?
   Very Good ( ) Good ( ) Tolerable ( ) Bad ( ) Very Bad ( )

8. Causes of your current problems and conflicts (check all applicable)
   Finances ( ) Children ( ) Relatives ( ) Work ( ) Marriage ( )
   Sexual Problems ( ) Housing ( ) Alcohol/Drugs ( ) Legal ( )

9. Current sources of income:
   Salary ( ) Self employed ( ) Investments ( ) Social Security ( )
   Welfare ( ) Disability ( ) Unemployment ( ) Workman's Comp ( )

Reviewed by: _____ Date: _____

10. At what age did you begin working full-time? _____

11. If married, what is your spouse's job? _____

12. Check your current job status:
    A. Working full time ( ) Employer name _____
       Job description _____
    B. Working Part time ( ) Employer name _____
       Job description _____
    C. Unemployed but looking for work ( )
    D. On sick leave, but expect to return soon ( )
    E. Unable to work now, but expect to return to previous job ( )
    F. Unable to work now, and cannot return to previous job ( )
    G. Unable to work now, but expect to return to new job ( )
    H. Unable to work now and disable from future employment ( )
    I. Other ( ) _____

13. If you are unemployed, is this due to your present pain condition?_____

14. How long have you been working at your present job? _____

15. If unemployed, disabled or retired, how long? _____

16. Which of the following are regular requirements of your job?
    A. Heavy lifting (over 30 lbs.) ( )
    B. Light lifting (less than 30 lbs.) ( )
    C. Frequent Stooping, bending or twisting ( )
    D. Standing for long periods of time ( )
    E. Sitting for long periods of time ( )
    F. Other- please describe_____
       _____

17. Check you current compensation or disability status:
    A. Receiving full compensation/disability ( )
    B. Receiving compensation/disability but full benefits that are due ( )
    C. Receiving compensation/disability but benefits will run out soon ( )
    D. Receiving compensation/disability but re-evaluation required ( )
    E. Was on compensation/disability but it has been stopped ( )
    F. I have filed for compensation/disability but have received none ( )

18. For each of the statements below, please indicate if you agree or disagree with what is being stated. Please circle the answer for each.

A. My job is dangerous	Yes No
B. My job makes my pain worse	Yes No
C. My pay is adequate for what I do	Yes No
D. I like the company of my fellow workers	Yes No
E. I would like to stay on my old job	Yes No
F. My job has enough challenge for me	Yes No
G. I will need a different job	Yes No
H. I will never be able to work again	Yes No

I have been treated fairly by:

A. Employer of boss (before injury)	Yes No
B. Employer or boss (after injury)	Yes No
C. My Doctors	Yes No
D. Insurance/Compensation people	Yes No
E. My family	Yes No

19. Have you ever had psychiatric/psychological treatment for any condition?_____ Give date of most recent treatment _____

For the next three questions, place a check mark in the blank which best describes your mood during the last month:

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

20. During the past month have you been tense or anxious?
1._____ 2._____ 3._____ 4._____ 5._____

21. During the past month have you been depressed or discouraged?
1._____ 2._____ 3._____ 4._____ 5._____

22. During the past month have you been irritable and short tempered?
1._____ 2._____ 3._____ 4._____ 5._____

23. Past or present sources of stress in my life include (check all that apply):

_____poor health	_____crime victim	_____war experience
_____divorce	_____money shortage	_____abuse
_____family problems	_____poor transportation	_____family illness

24. When did you first have the pain for which you are now seeking help?
Date:_____

25. In what parts of the body did the pain begin? _____
_____

26. How did the pain begin: _____
_____

27. Who do you think is at fault for your pain? Self ( ) Employer ( ) No one ( )
Other (explain) _____

28. Whenever the pain occurs, do you have problems or changes in other parts of the body? For example, if the pain is in the upper arm, does it cause a headache?, Etc. Please describe _____
_____

29. What activities bring on the pain or make it worse? _____
_____

30. Does the pain leave if you stop these activities? _____

31. If I were there when you are in pain, what would I see and hear? How do people around you know when you are in pain? _____
_____

Circle the number in each column that best describes your pain the past month

32. Intensity
Excruciating
Intolerable
Very Intense
Extremely Strong
Severe
Very Strong
Intense
Uncomfortable
moderate
Mild
Weak
Just Noticeable
None

33. Reaction
Agonizing
Intolerable
unbearable
Awful
Miserable
Distressing
Unpleasant
Uncomfortable
Distracting
Tolerable
Bearable
None

34. Sensation
Piercing
Stabbing
Shooting
Burning
Grinding
Throbbing
Cramping
Aching
Stinging
Squeezing
Numbing
Itching
Tingling
None

35. If a zero (0) means "no pain" and a ten (10) means "the worst pain possible" on this scale of 0 to 10, What is you level of pain? Please circle

Today	0	1	2	3	4	5	6	7	8	9	10
On good days	0	1	2	3	4	5	6	7	8	9	10
On bad days	0	1	2	3	4	5	6	7	8	9	10
Average	0	1	2	3	4	5	6	7	8	9	10

36. During the past month, how much did pain interfere with the following activities? Circle the number that best applies to your situation

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

Going to work	1	2	3	4	5
Performing household chores	1	2	3	4	5
Shopping	1	2	3	4	5
Visiting with friends	1	2	3	4	5
Hobbies or recreation	1	2	3	4	5
Sexual relations	1	2	3	4	5
Exercise	1	2	3	4	5
Sleep	1	2	3	4	5
Personal hygiene	1	2	3	4	5

37. When you are in pain, how often is your spouse/family supportive?
A. Never ( ) B. Seldom ( ) C. Sometimes ( ) D. Frequently ( ) E. Always ( )

38. When you are in pain, how often is your spouse/family angry, or ignore you?
A. Never ( ) B. Seldom ( ) C. Sometimes ( ) D. Frequently ( ) E. Always ( )

39. When you are in pain, how often does your spouse/family encourage you to stay active despite the pain?
A. Never ( ) B. Seldom ( ) C. Sometimes ( ) D. Frequently ( ) E. Always ( )

40. Describe other ways that your spouse/family responds when you are in pain:

_____

41. Are you capable of performing any of the following unassisted?

	Yes	No	If Yes
Walk	( )	( )	How far?_____
Sit	( )	( )	How many minutes? _____
Stand	( )	( )	How many minutes? _____
Drive Car	( )	( )	
Dress self	( )	( )	

42. Was any member of your family disabled when you were growing up? _____

43. Is any member of your current family disabled? _____

44. Have you ever been operated on for this pain? Yes ( ) No ( )
If yes, please list procedure and date:_____
_____
_____

45. What was the longest period of relief following operations? _____

46. Have you ever had any of the following for your pain?

	Yes	No		
Nerve blocks	( )	( )	Date_____	How long did it work? _____
TENS unit	( )	( )	Date_____	How long did it work? _____
Hypnosis	( )	( )	Date_____	How long did it work? _____
Holistic therapy	( )	( )	Date_____	How long did it work? _____
Physical therapy	( )	( )	Date_____	How long did it work? _____
Chiropractor	( )	( )	Date_____	How long did it work? _____
Acupuncture	( )	( )	Date_____	How long did it work? _____
Massage	( )	( )	Date_____	How long did it work? _____
Spinal Stimulator	( )	( )	Date_____	How long did it work? _____

47. What medications are you now taking?

Name	Dose	Frequency	Date started

48. Do you take medicine to help fall asleep? Yes ( ) No ( )

49. What medications have you tried in the past but failed to take away your pain? _____
_____

50. What specifically, does the pain keep you from doing? _____
_____

Please read these instructions very carefully, we want you to indicate on the drawings on the next page *exactly* where your pain is, and how much pain you feel. Read all instructions *before* you do anything.

1. Mark on the drawing the exact spot where your pain is. Mark this with a solid dot (•). If the pain starts at that spot and travels to another part of your body, draw a line from the spot where it starts to where it ends.

2. Now lightly shade in with your pencil all the parts of your body that hurt.

3. After you have shown where the pain is, and where it travels to, we want to know how much pain you feel. Look at the list of words below, which most people agree describes intensity of pain. Each word has a number.

MILD - 1	MODERATE - 2	STRONG - 3	VERY STRONG - 4	SEVERE - 5

Which word best describes your pain as it usually is? Put the *number* of that word next to the point where your pain is, as marked on the drawing. If there is a difference in the pain intensity where the pain travels to, pick the word that best describes it from the list above, and put that number next to the right place on the drawing. If you shaded in an area, do the same thing for that area.

Before you begin to do anything to the drawings on the next page, look at the example and read the description of what it means so that you will understand perfectly what you are to do.

EXAMPLE

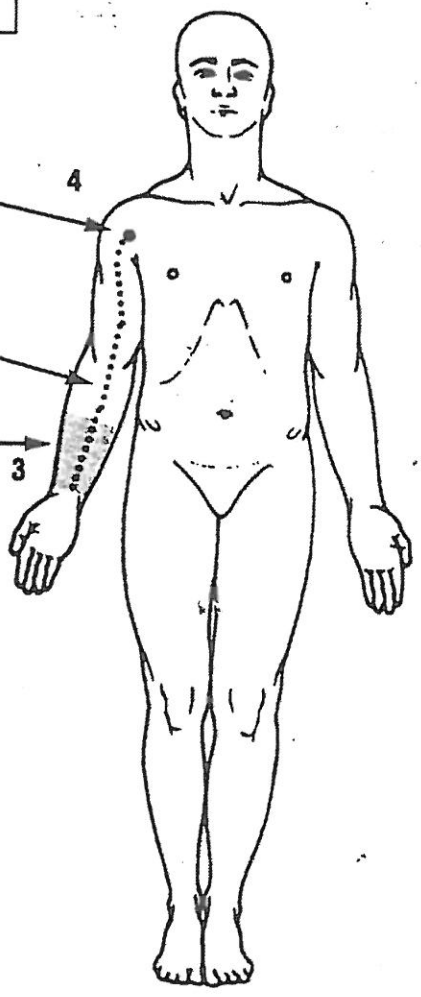
THIS PATIENT'S PAIN BEGINS IN THE SHOULDER JOINT (BLACK DOT).

THE PAIN RADIATES DOWN TO THE WRIST. (LINE FROM DOT TO WRIST).

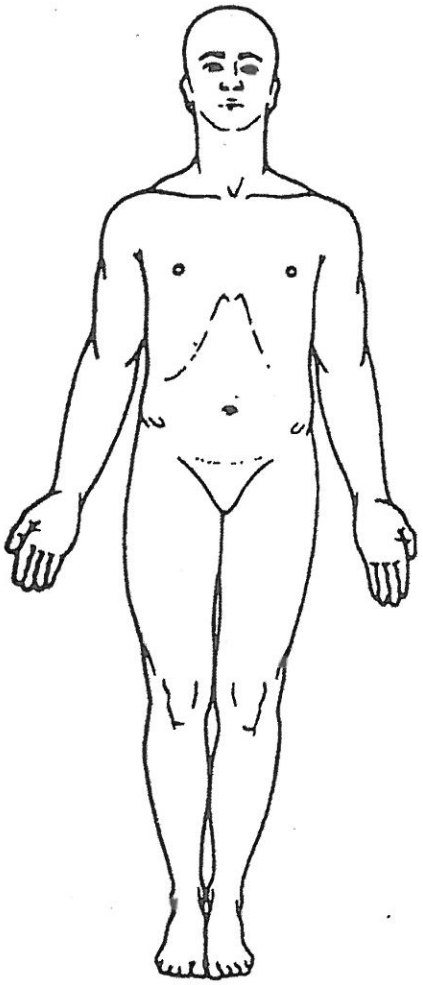
THE WHOLE LOWER ARM HURTS, NOT JUST A PARTICULAR PLACE (LOWER ARM SHADED).

THE SHOULDER JOINT PAIN, WITH THE NUMBER 4, SHOWS THAT FROM THE LIST OF WORDS ABOVE, THE PAIN IS VERY STRONG.

THE PAIN IN THE LOWER ARM IS NUMBER 3 — STRONG.



YOUR PAIN



1. **SHOW WHERE YOUR PAIN IS**
   (SEE #1 ON PREVIOUS PAGE)

2. **DOES THE PAIN TRAVEL (RADIATE)?**
   (SEE #2 ON PREVIOUS PAGE)

3. **HOW MUCH PAIN DO YOU FEEL?**
   (RATE FROM 1 TO 5)