Dear New Patient:

Welcome to the Pain and Headache Center

A few reminders to make your first visit a little easier:

- Please make sure to bring this completed new patient packet, your ID, and your insurance card to your visit.
    - If you are a Medicaid patient, you must have your Denali Card and $3 co-pay to be seen for every visit (no exceptions)
- We are trying very hard to stay on schedule. Your appointment time is the time when we hope to actually have you in the exam room, which means that you must arrive early to check in. We do not double-book patients, and so, if you are more than a very few minutes late, your time with our providers will be dramatically decreased or your appointment will be rescheduled.
- Please bring your records, Xrays, MRI's, or any other imaging (films or disc), and a list of ALL of your medications (or the bottles themselves)
    - Although we have made every effort to get records from your doctor, this is ultimately <u>your</u> responsibility to provide these records; without records, we may not be able to help you.
- If you are requesting pain medications, you will be required to provide a fresh sample of your urine during your visit. Please plan accordingly, because you will not receive a prescription without this urine for screening. If you cannot urinate or if the results of this urine screen are unexpected, we may decline to provide prescriptions at this visit.

- We try to treat our patients as responsible adults, and therefore we will not call to remind you of appointments. If you no-show for an appointment, you will be charged.

On behalf of our providers, welcome to the practice!

The Pain and Headache Center, LLC
Registration Form (please print)

PATIENT INFORMATION

Last name:_____ First name:_____ Middle initial:_____
Is this your legal name? YES NO if not, what is your legal name? _____
Previous name: _____ Marital status: Married Divorced Single Widowed Other
Race: _____ Language spoken: _____
Birth Date: _____ Age:_____ SSN: _____ Sex: Male Female
Mailing Address:_____ City:_____ St:___ Zip:_____
Physical Address: _____ City:_____ St:___ Zip:_____
Hm. Phone: _____ Cell #: _____ Work#: _____
Employer:_____ Occupation: _____
Employer Address:_____ City:_____ St:___ Zip:_____
Referring Provider: _____ PCP (if different): _____

INSURANCE INFORMATON

Primary INS: _____ Insurance phone #: _____
INS Address: _____ City:_____ St:_____ Zip:_____
Policy #:_____ Group#: _____
Subscriber's name: _____ Relationship to patient: _____
Birth Date: _____ Age:_____ SSN: _____ Sex: Male Female

Secondary INS: _____ Insurance phone #: _____
INS Address: _____ City:_____ St:_____ Zip:_____
Policy #:_____ Group#: _____
Subscriber's name: _____ Relationship to patient: _____
Birth Date: _____ Age:_____ SSN: _____ Sex: Male Female

Worker's Comp INS Co.: _____ W/C Phone#: _____
W/C Address: _____ City:_____ St:_____ Zip:_____
Claim #: _____ Date of Injury: _____ Site of Injury: _____
Name of Adjuster: _____ Adjuster Phone #: _____
Employer at the time of injury: _____

IN CASE OF EMERGENCY

Emergency Contact name:_____ Relationship:_____
Address: _____ City:_____ St:___ Zip:_____
Hm. Phone: _____ Cell #: _____ Work#: _____

CONSENT FOR TREATMENT: I hereby authorize *The Pain and Headache Center, LLC* providers to provide such medical treatments, examinations, and to perform such procedures deemed as medically necessary.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize *The Pain and Headache Center, LLC* or insurance company to release any information required to process my claim.

Patient/ Guardian printed name: _____ Date: _____

Patient/ Guardian signature: _____ Date: _____

The Pain and Headache Center, LLC

Financial Policy

Here at The Pain and Headache Center we are doing everything possible to hold down the cost of medical care. You can help a great deal by reducing the number of bills we send to you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE:
Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. The Pain and Headache Center, LLC accepts cash, personal checks, VISA, and MasterCard. There is a service charge of $35.00 on returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments. We realize that financial difficulty is a reality.

INSURANCE:
We must emphasize that as a medical care provider our relationship is with you, not your insurance company.
We file your insurance claim as courtesy to you, and all charges are ultimately your responsibility. Not every service is a covered benefit with your plan. Some insurance companies arbitrarily select certain services they will not cover. **It is important that you read and understand YOUR health insurance policy and its requirements for coverage, including preauthorization of services.** We currently send claims to numerous plans and are not responsible for knowing the requirements of your specific plan. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges and secondary insurance, “usual and customary” charges. If you choose to file an appeal to your insurance, it is your responsibility.
If you need assistance or have questions, please contact The Billing Coordinator between 8:30 a.m. and 5:00 p.m., Monday through Friday at 907-980-7507.

REFUNDS:
Patient/guarantor credits in amounts less than $20.00 will be retained on account to be credited toward future balances, unless a written request for refund is received. Amounts $20.00 and greater will automatically be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge$50.00 for missed or late-canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand The Pain and Headache Center, LLC Financial Policy. I agree to assign insurance benefits to The Pain and Headache Center, LLC whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

BY SIGNATURE BELOW I ACKNOWLEDGE THAT I HAVE READ, I UNDERSTAND AND I APPROVE ALL OF THE ABOVE

Signature of insured or authorized representative: _____ Date: _____
Printed name of insured or authorized representative: _____ Date: _____

The Pain and Headache Center, LLC

Consent for Involvement of Care

In order to comply with specific rules regarding HIPAA, we ask that our patients complete and sign this privacy and security of health information. Unless this form is complete, we are not authorized to speak to anyone but you.

Personal Health Information:

I _____ herby authorize The Pain and Headache Center, LLC to speak to the person(s) listed below regarding my personal health information.

Name:_____ Relationship: _____

Name:_____Relationship: _____

Billing and payment information:

I _____ herby authorize The Pain and Headache Center, LLC to speak to the person(s) listed below regarding my billing and payment information.

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Medication Information:

I _____ herby authorize The Pain and Headache Center, LLC to release my prescriptions that need to be picked up on my behalf to the person(s) listed below.

Name:_____ Relationship: _____

Name:_____ Relationship: _____

Telephone Messages:

I _____ herby authorize The Pain and Headache Center, LLC and staff to leave messages by the following methods:

		Please Circle one	
Home Phone: _____	YES	NO	N/A
Cell Phone: _____	YES	NO	N/A
Work Phone: _____	YES	NO	N/A

I understand and assume responsibility of notifying The Pain and Headache Center, LLC whenever the listed information changes. I understand this release excludes; insurance companies, attorneys, and other health care providers.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

RESEARCH PURPOSES

I also agree to have my telemedicine records and clinical data reviewed for the purposes of evaluation (data collection, analysis, and presentation in verbal or written format at scientific meetings or publications) or other educational purposes. I understand that any presentation will not identify me by name or other identifiable markers. AGREE_____ (initials of patient only if AGREEING).

The Pain and Headache Center, LLC
HIPAA Privacy Policy

I (name of patient) _____, acknowledge and agree to the HIPAA Privacy Policy. I understand that I may receive a copy upon request.

Patient Signature:_____ Date:_____
Printed Name:_____Date: _____

Name: _____
DOB: _____

The Pain and Headache Center
New Patient Intake

Please answer the following to the best of your ability and in its entirety so we can optimize your care.

<u>Location of pain</u>: Please check which area of pain you have and the associated locations. Shade the diagram in where your pain is and trace any patterns or radiation.

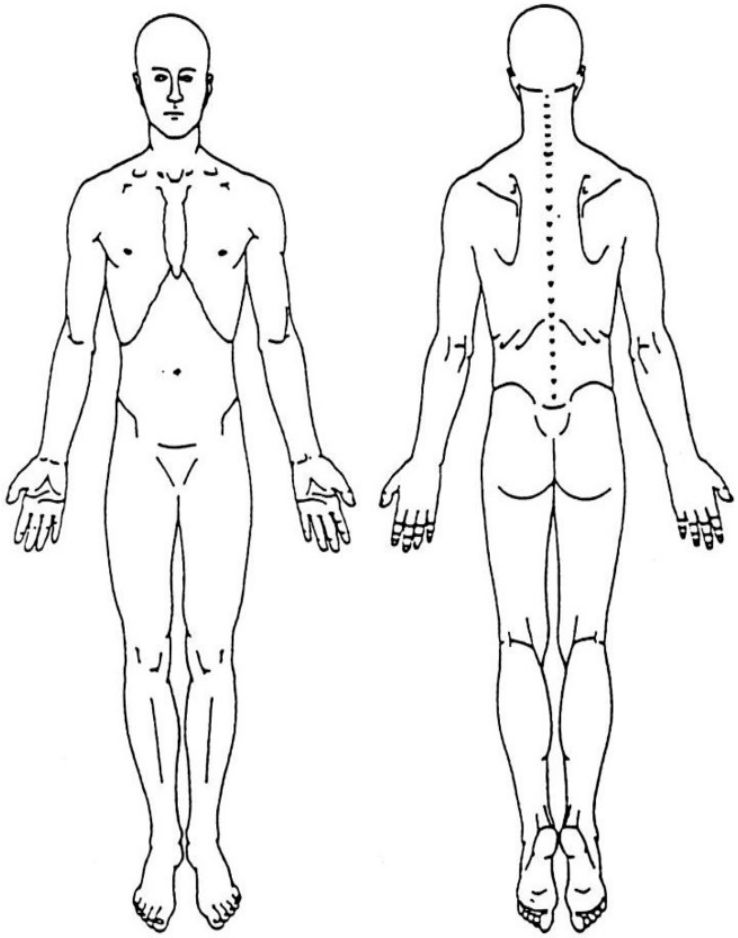
_____**Neck Pain**
- _____Pain causes headaches
  - _____Front of head
  - _____Temple, left
  - _____Temple, right
  - _____Back of head, left
  - _____Back of head, right
- _____Pain radiates into arms
  - _____Left
  - _____Right
- _____Pain radiates into hands
  - _____Left
  - _____Right

_____**Shoulder Pain**
- _____Left
- _____Right

_____**Upper Back**
- _____Pain radiates into ribs
  - _____Left
  - _____Right

_____**Lower Back**
- _____Pain radiates into hips
  - _____Left
  - _____Right
- _____Pain radiates into pelvis
  - _____Left
  - _____Right
- _____Pain radiates down the leg
  - _____Left
  - _____Right

_____**Other** (*Please explain)* _____



_____

_____

_____

How long have you had your pain?
- Years _____
- Months_____
- Weeks _____

What was the onset of your pain?
- Trauma (please explain): _____
- Unknown onset, sudden
- Unknown onset, gradual

Is this a work related injury? Yes No
Is worker's compensation involved? Yes No
If so, date of injury? _____

Please describe your pain at its….

Best	1…2…3…4…5…6…7…8…9…10
Worst	1…2…3…4…5…6…7…8…9…10
Average	1…2…3…4…5…6…7…8…9…10

Type of pain (*please circle)*

Aching	Burning	Dull	Constant	Episodic
Shooting	Tingling	Tight	Radiating	Intermittent
Cramping	Hot	Heavy	Annoying	Throbbing
Numb	Cold	Intense	Severe	Deep
Stinging	Sore	Knife-like	Sharp	_____

Does your pain wake you up at night? Yes No

When is your pain worse? Morning Afternoon Night

Assisted devices:

None	Cane	Walker
Corset	Brace	Wheelchair

Please mark if you have seen any of the following providers for your pain:

Orthopedic surgeon	Rheumatologist
Neurologist	Physical Therapist
Primary Care	_____
Emergency Room	_____

Have you been ever been discharged from a clinic? Yes No
If yes, please explain what happened and name of clinic:
_____
_____
_____

Have you done physical therapy? Yes No
1. Did it help with your pain? Yes No
2. When did you go? _____
3. For how long?_____

Aggravating Factors (please circle):

Sneezing	Lifting	_____
Coughing	Sitting	_____
Bowel Movements	Standing	_____
Bending	Walking	_____
Twisting	Lying down	_____

Relieving Factors (please circle):

Heat	Standing Up	_____
Ice	Rest	_____
Physical Therapy	Pain Meds	_____
Laying Down	Bending forward	

Please list ALL of your current medications. List name, dosage, frequency and what they are used for:

Name Strength Frequency Usage

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please list ALL of the narcotics, pain patches, neuropathic medications etc. that you have taken in the past that DID NOT WORK:

Name Strength Why Stopped (side effects cost etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please indicate any diagnostic tests you have had. Approximate the date and location of where they were preformed:

	Had? Yes/No	**Body Part**	**Date**	**Facility**
XRAY				
EMG				
Myelogram				
MRI				
Other				

Allergies (please circle):

Shrimp	Adhesives	Seasonal Allergies	_____
Shellfish	Iodine	_____	_____
Latex	Penicillin	_____	_____

Social History

1. Do you use tobacco products? Yes No
   Please describe frequency and product consumed: _____
2. Do you consume alcoholic beverages? Yes No
   Please describe frequency: _____
3. Do you have a history of illegal drug abuse? Yes No
4. Is there any current illegal drug abuse? Yes No
5. How many caffeinated beverages do you consume daily? 0-1 2-3 3-4 5+
6. How many times do you exercise during the week? 1-2 3-4 5-6 Never
7. How often do you use your seatbelt? Always Sometimes Never
8. What is your occupation? _____

Past Medical History (please circle):

Alcoholism
Anemia
Anesthetic Complication
Anxiety
Arthritis
Asthma
Autoimmune Problems
Birth Defects
Bleeding Disease
Blood Clots
Blood Transfusion(s)
Bowel Disease
Breast Cancer
Cervical Cancer
Colon/Rectal Cancer
Depression
Diabetes I
Diabetes II
Growth/ Developmental Disorder
Heart Attack
Heart Disease
Heart Pain
Hepatitis A
Hepatitis B
Hepatitis C
High Blood Pressure
High Cholesterol
HIV
Kidney/Bladder Disease
Liver Cancer
Liver Disease
Lung/Respiratory Disease
Lung Cancer
Mental Illness
Migraines
Osteoporosis
Prostate Cancer
Reflux/ GERD
Seizures Convulsions
Severe Allergy/ Hives
STD
Skin Cancer
Stroke/ CVA of the Brain
Suicide Attempt
Thyroid Problems
Ulcers
Other Disease/ Cancer or Significant Medical Illness
_____
_____
_____

Family History (please circle):

Family history unknown
Alcoholism
Anemia
Anesthetic Problems
Arthritis
Asthma
Bleeding Disease
Breast Cancer
Colon/ Rectal Cancer
Depression
Diabetes
Other: _____
Heart Disease
High Blood Pressure
High Cholesterol
Kidney/ Bladder Disease
Lung/ Respiratory Disease
Migraines
Osteoporosis
Seizures/ Convulsions
Severe Allergy/ Hives
Stroke/ CVA of the Brain
Thyroid Problems
_____

Surgical History (please circle):

Cataract Surgery	L	R	Both	Mastectomy	L	R	Both
Deviated Nose Septum	L	R	Both	Breast Reconstruction	L	R	Both
Sinus Surgery				Breast Reduction	L	R	Both
Mastoidectomy	L	R	Both	Hysterectomy			
Tonsillectomy	L	R	Both	Ovary Removal	L	R	Both
Carotid Artery Surgery	L	R	Both	Tubal Ligation			
Thyroid Removal	L	R	Both	C-Section			
Breast Biopsy	L	R	Both	Carpal Tunnel Surgery	L	R	Both
Breast Lump Removal	L	R	Both	Rotator Cuff Repair	L	R	Both
Lung Surgery	L	R	Both	Shoulder Surgery	L	R	Both
Heart Bypass Surgery	L	R	Both	Hip Fracture & Surgery	L	R	Both
Heart Valve Replacement				Hip Replacement	L	R	Both
Appendectomy				Knee Replacement	L	R	Both
Gallbladder Surgery				Knee Surgery	L	R	Both
Kidney Removal	L	R	Both	Neck Surgery			
Inguinal Hernia Surgery				Low Back Surgery			
Colon Polyp Removal				Spinal Fusion			
Colon Removal				Spinal Decompression			
Anal Fissure Repair				Ulcer Surgery			
Leg Circulation Surgery	L	R	Both	_____			
Foot Surgery	L	R	Both	_____			

If you have had spinal surgery, please indicate date and facility: _____

Have you had any pain management procedures? Yes No

What procedure (Please circle):

Major joint injection
Epidural
Rhizotomy
Facet joint injection
Disectomy
Other: _____

1. Please indicate date and facility:

_____
_____
_____

2. Did you get any relief from these injections/procedures? Yes No
3. If so, for how long? _____

Have you ever had difficulty getting numb at the dentist office? Yes No

Review of Systems

Please circle the symptoms that are present at this time

General
Fever
Weight gain
Weight loss
Chills
Fatigue
Sweats
Loss of appetite
Anorexia
Malaise
Headaches

Eyes
Vision loss
Light sensitivity
Double vision
Blurring
Eye pain
Diplopia
Irritation
Discharge
Photophobia

Ears, Nose and Throat
Ringing in ears
Decreased hearing
Congestion
Hoarseness
Earache
Difficulty swallowing
Ear discharge
Nose bleeds
Sore Throat
Runny Nose

Cardiovascular
Difficulty breathing lying down
Leg cramps during exertion
Ankle swelling
Palpitations
Fainting spells
Chest pain

Respiratory
Shortness of breath at rest
Sputum Production
Shortness of breath with exertion
Cough

Respiratory Cont.
Chest pain
Snoring
Coughing up blood
Wheezing
Waking up gasping for breath

Gastrointestinal
Bloody or black stools
Abdominal pain
Nausea
Constipation
Vomiting
Diarrhea
Change in bowel habits

Genitourinary
Frequent urination at night
Difficulty starting urination
Blood in urine
Loss of bladder control
Urinary urgency/frequency
Vaginal discharge
Incontinence
Abnormal menstrual period
Pelvic pain

Musculoskeletal
Muscle weakness
Bone pain in last 3 months
Joint pain in last 3 months
Muscle cramps
Joint pain
Back pain
Joint swelling
Joint stiffness
Stiffness

Skin
Poor skin healing
Hair loss
Itching
Rash
Dryness
Suspicious lesions
Jaundice

Neurological
Memory loss
Tingling sensation
Tremors
Balance problems
Transient paralysis
Weakness
Unsteadiness
Speech problems
Numbness
Headaches
Seizures

Psychiatric
Suicidal thoughts
Hallucinations
Anxiety
Depression
Memory loss
Mental disturbance
Paranoia
Imsomnia

Endocrine
Increased appetite
Excessive urination
Cold intolerance
Increased thirst
Heat intolerance
Weight change

Heme/Lymphatic
Tendency towards bleeding
Abnormal bruising
Enlarged lymph glands

Allergic/Immunologic
Persistent infections
HIV exposures
Hives
Hay fever

Pain and Headache Center Screening Questionnaire

Patient name _____ Date _____

Nicotine Addiction	**Heavy Smoking Index**
How soon after waking do you smoke your first cigarette?	□ Within 5 minutes □ 6-30 minutes □ 31-60 minutes □ Longer that 60 minutes
How many cigarettes do you smoke per day?	□ 10 or less □ 11-20 □ 21-30 □ 31 or more
Alcohol dependence	**CAGE-Questionnaire**
Have you ever felt you needed to cut down drinking?	□ yes □ no
Have people annoyed you by criticizing your drinking?	□ yes □ no
Have you ever felt guilty about drinking?	□ yes □ no
Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or get rid of a hangover?	□ yes □ no
Psychiatric History	
Is there any history of psychiatric illness or addiction (such as alcohol or drugs) in your family (parents or siblings)?	□ yes □ no
Before the age of 14, have you experienced psychological strain and/or suffered from a cerebral lesion or disease that had negative influence on your development (resulting in difficulties at school, changes in behaviour or stuttering)?	□ yes □ no

Are you or have you ever been suffering from a Depressive Disorder or Anxiety Disorders?	□ yes □ no
Evidence of former or current Abuse of or Addiction to illicit drugs?	□ yes □ no
Expected Effect of Pain Medication	
Do you think that a drug can make you happier, more content or more self-secure?	□ yes □ no
Do you think that a drug can help you unwind and/or reduce stress?	□ yes □ no
Origin of Pain	
In your opinion, is your pain mainly due to organ damage or could psychologic factors or psychosocial stress lead to your pain? Please assign your estimation with a horizontal line on the line between the two poles:	My pain is caused by physical reasons only 100%  100% My pain is caused by psychologic reasons only

Name: _____ DOB:_____

DO YOU SNORE?

SLEEP APNEA RISK ASSESSMENT

Sleep Apnea has been shown to increase the risk for heart disease, heart attack and stroke. It is also associated with numerous conditions that are known to increase the risk for cardiac disease, such as diabetes mellitus and hypertension. To find out if you may be at risk for sleep apnea, fill out the survey below.

Do you snore? Yes (2) No (0) _____

Can your snoring be heard through a door or a wall? Yes (2) No (0) _____

Has anyone ever told you that you stop breathing at night? Yes (2) No (0) _____

What is your collar size?

Male: Less than 17 inches (D) More than 17 inches (2) Female: _____

Less than 16 inches (0) More than 16 inches (2) _____

Do you occasionally fall asleep during the day when:

You are not busy or are inactive? Yes (2) No (0) _____

You are driving or stopped at a light? Yes (2) No (0) _____

Are you overweight? Yes (2) No (0) _____

Do you have high blood pressure? Yes (2) No (0) _____

Are you often tired during the day? Yes (2) No (0) _____

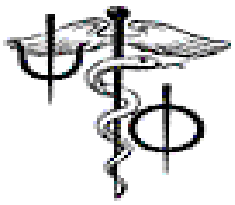
9 POINTS OR MORE	6-8 POINTS	5 POINTS OR LESS
SEVERE risk for Sleep Apnea	MODERATE Risk for Sleep Apnea	LOW Risk for Sleep Apnea

The snorts, whistles, and gasps you make while sleeping may do more than rob you of a good night's sleep. This "snorechestra" may be a sign of sleep apnea, which can lead to heart trouble and shorten life, reports the November 2008 issue of the *Harvard Heart Letter.*

People afflicted with sleep apnea temporarily stop breathing many times a night. In those with the most common kind, obstructive sleep apnea, the soft tissue of the palate or pharynx completely closes off the airway. The brain, sensing a drop in oxygen, sends an emergency "Breathe now!" signal that briefly wakens the sleeper and makes him or her gasp for air. This signal fires up the same stress hormones that go into overdrive when you are angry or frightened. They make the heart beat faster and boost blood pressure. They stoke inflammation, a key player in heart disease. They can damage blood vessels and
increase the blood's tendency to clot, a root cause of heart attack and stroke.

TELE-BEHAVIORAL MEDICINE ASSOCIATES
Herbert A. Schwager, Ph.D., DAABM, DIABM, FABMP, DABDA
E-mail: telebehmed@gmail.com Website: www.telebehavioralmedicine.com

- **Behavioral Medicine**
- **Pain Management**
- **Telemedicine Consultation and Programs Development**
- **Clinical Psychopharmacology**



203 N. Manzanita Dr. Suite B Payson, AZ 85541
928-474-6617, ext 101 – Fax: 928-474-7059

P.O. Box 522, Willow, Alaska 99688
907-715-7391, cell – Fax: 907-495-1283

PATIENTS WITH PAIN BENEFIT FROM A BEHAVIORAL ADVOCATE

Research and common sense tells us that individuals suffering ***CHRONIC PAIN*** benefit from having an advocate to assist them in coping with the behavioral, emotional, financial and family stressors common to ***CHRONIC PAIN***.

The ***PAIN AND HEADACHE CENTER*** is sensitive to this potentially devastating complication of those suffering ***CHRONIC PAIN*** and has made available the consultative services of **TELE-BEHAVIORAL MEDICINE ASSOCIATES (TBMA)**, directed by Dr. Herbert A. Schwager. Dr. Schwager is available to redirect and assist individuals to resolve many of these potentially serious quality of life complications. The results compliment the pain management treatment and quality of life issues.

These services are typically offered via **real-time-face-to-face SECURE VIDEO CONFERENCE or Tele-Medicine**. Patients who have a computer, web-cam and high-speed internet connection are seen in the privacy of their own homes, with very flexible scheduling. Those who do not have computer access can see Dr. Schwager by scheduling at the Pain and Headache Center where a Video Conference portal is in place.

Simply said; individuals suffering chronic pain are typically unhappy, sometimes feel helpless, and may even be depressed. **Behavioral Medicine** is NOT ***psychiatry, clinical psychotherapy or even counseling***. Rather, it is a specialized discipline that incorporates the behavioral sciences with medicine. It is designed to integrate treatment with the pain management specialist and render a more TOTAL person approach to treatment.

If you are interested in setting up a consultation with Dr. Schwager, simply check the YES box below. Most commercial and workers compensation insurances are accepted, so as to minimize or eliminate any financial hardship. Feel free to discuss this option with the staff at the ***PAIN AND HEADACHE CENTER***.

___ YES. Please provide me with contact and referral information to see Dr. Schwager
___ NO. Not at this time, but I will reserve the right to reconsider at a later date.

Patient name: _____ Date: _____

Patient Signature: _____

Patient # _____

Pain and Quality of life Questionnaire #1

Before you begin, we would like to ask you to answer a few general questions about yourself by circling the correct answer or by filling in the space provided.

What is your gender? Male Female

What is your date of birth? _____

What is your highest level of education? None Elementary High School College

What is your marital status? Single Married Living as Married
Separated Divorced Widowed

We would like to ask you a few questions about your life in the past two weeks.

For Example, thinking of the last two weeks, a question might ask:

	None	A little	Moderately	Mostly	Completely
Do you get suport from others that you need?	1	2	3	4	5

You should circle the number that best fits how much support you got from others *over the last two weeks*, so you would circle the number **4** if you got a great deal of support from others. Please read each question, assess your feelings and circle the number on the scale that gives the best answer for you for each question.

Please circle the number

	Very poor	Poor	Neither poor or good	Good	Very good
How would you rate your quality of life?	1	2	3	4	5
How satisfied are you with your pain control?	1	2	3	4	5

The following questions ask about **how much** you have experienced things in the last two weeks.

	Please circle a number				
	Not at all	Slightly	A moderate amount	Very much	Extremely
To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
How well are you able to concentrate?	1	2	3	4	5
How safe do you feel in your daily life?	1	2	3	4	5

The following questions ask how ***completely*** you experience or were able to do certain things in the past two weeks.

	Please circle the number				
	Not at all	A little	Moderately	Mostly	Completeley
Do you have enough energy for everyday life?	1	2	3	4	5
How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how **good** or **satisfied** you have felt about various aspects of your life over the last two weeks.

	Please circle a number				
	Very dissatisfied	Dissatisfied	Neither satisfied or dissatified	Satisfied	Very Satisfied
How satisfied are you with your sleep?	1	2	3	4	5
How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
How satisfied are you with yourself?	1	2	3	4	5
How satisfied are you with your personal relationships?	1	2	3	4	5
How satisfied are you with your sex life?	1	2	3	4	5
How satisfied are you with the support you get from your friends?	1	2	3	4	5
How satisfied are you with the condition of your living place?	1	2	3	4	5
How satisfied are you with your access to health services?	1	2	3	4	5
How satisfied are you with your mode of transportation	1	2	3	4	5

The following question refers to **how often** you have felt or experienced certain things in the last two weeks.

	Please circle the number				
	Never	Seldom	Quite often	Very often	Always
How often do you have negative feelings such as blue mood, despair, anxiety or depression	1	2	3	4	5

In the last 2 weeks, what has been your overall impression of change in your pain condition? Please circle the best description of the change.

Much worse a little worse no change a little better a lot better almost gone

If improved, can you give us a percent improvement? _____ %

Did someone help you fill this form out? Yes No