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 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 five minutes late, your time with our providers will be dramatically decreased or your appointment will be rescheduled.
- Please bring your records, Xrays (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 your 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!

Initial:_____

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 907-563-1777.

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. I understand this release excludes; insurance companies, attorneys, and other health care providers.

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: _____

Appointment Reminders:

I _____ herby authorize The Pain and Headache Center, LLC and staff to leave appointment reminders 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 that I have received a copy of the HIPAA Privacy Policy.

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

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.

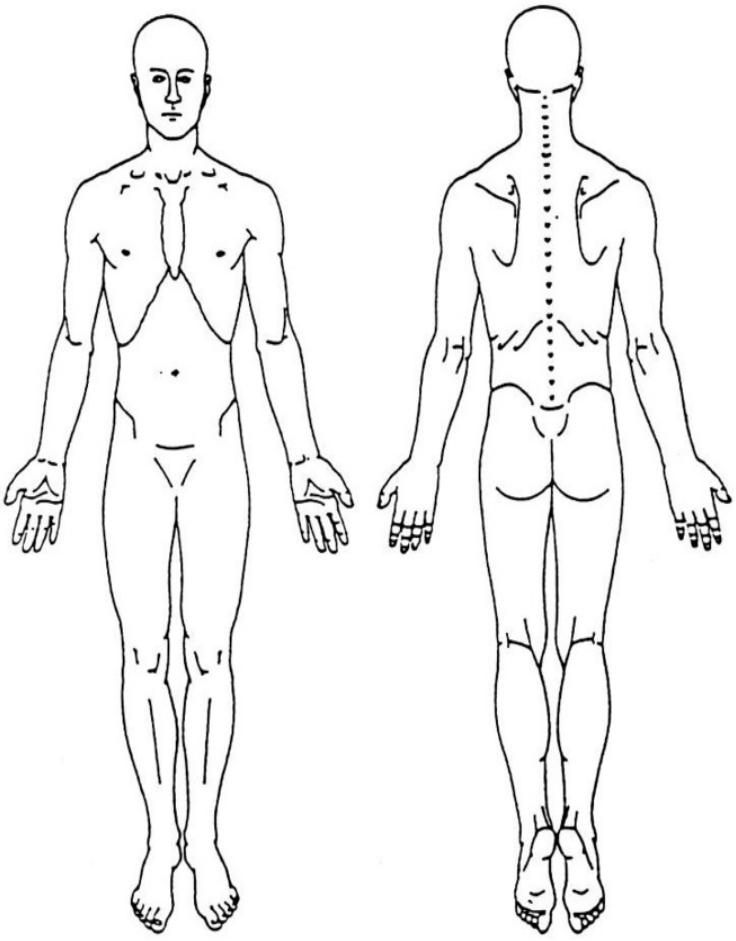
<u>Location of pain</u>: Please check which area of pain you have and the associated locations. Shade the diagram in where your pain is and trace any patterns or radiation.

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

Family History (please circle):

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

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

Have you ever been diagnosed with MRSA? if Yes when? 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

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 Anxicty 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

The Pain and Headache Center, LLC

Name: _____ **DOB:** _____

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 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 (0) 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 over weight?	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)	

Total: _____

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

Printed Name: _____

Signature: _____ Date: _____

The Pain and Headache Center, LLC

Name: _____ DOB: _____

BECK'S DEPRESSION INVENTORY

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad and unhappy that I can't stand it.
2	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel the future is hopeless and that things cannot improve.
3	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10	0	I don't cry any more than usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to
11	0	I am no more irritated by things than I ever was.
	1	I am slightly more irritated now than usual.
	2	I am quite annoyed or irritated a good deal of the time.
	3	I feel irritated all the time.
12	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people
13	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions more than I used to.
	3	I can't make decisions at all anymore.
14	0	I don't feel that I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel there are permanent changes in my appearance that make me look unattractive
	3	I believe that I look ugly.
15	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.

16	0 1 2 3	I can sleep as well as usual. I don't sleep as well as I used to. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep. I wake up several hours earlier than I used to and cannot get back to sleep.
17	0 1 2 3	I don't get more tired than usual. I get tired more easily than I used to. I get tired from doing almost anything. I am too tired to do anything.
18	0 1 2 3	My appetite is no worse than usual. My appetite is not as good as it used to be. My appetite is much worse now. I have no appetite at all anymore.
19	0 1	I haven't lost much weight, if any, lately. I have lost more than five pounds.
	2 3	I have lost more than ten pounds. I have lost more than fifteen pounds
20	0 1 2 3	I am no more worried about my health than usual. I am worried about physical problems like aches, pains, upset stomach, or constipation. I am very worried about physical problems and it's hard to think of much else. I am so worried about my physical problems that I cannot think of anything else.
21	0 1 2 3	I have not noticed any recent changes in my interest in sex. I am less interested in sex than I used to be. I have almost no interest in sex. I have lost interest in sex completely.

Total: _____

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the questions by counting the number to the right of each question you marked. The heist possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-on questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. You can evaluate your depression according to the Table below.

- 1-10 These ups and downs are considered normal
- 11-16 Mild mood disturbance
- 17-20 Border line clinical depression
- 21-30 Moderate depression
- 31-40 Severe depression
- 40+ Extreme depression

Printed Name:_____

Signature: _____ Date:_____

The Pain and Headache Center, LLC

Name: _____ DOB: _____

Opioid Risk Tool

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honesty as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
1. How often do you have mood swings?	0	1	2	3	4
2. How often have you felt a need for higher doses of medication to treat your pain?	0	1	2	3	4
3. How often have you felt impatient with your doctors?	0	1	2	3	4
4. How often have you felt that things are just too overwhelming that you can't handle them?	0	1	2	3	4
5. How often is there tension in the home?	0	1	2	3	4
6. How often have you counted pain pills to see how many are remaining?	0	1	2	3	4
7. How often have you been concerned that people will judge you for taking pain medications?	0	1	2	3	4
8. How often do you feel bored?	0	1	2	3	4
9. How often have you taken more pain medication than you were supposed to?	0	1	2	3	4
10. How often have you worried about being left alone?	0	1	2	3	4
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have others expressed concern over your use of medication?	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4

	Never	Seldom	Sometimes	Often	Very Often
14. How often have others told you that you had a bad temper?	0	1	2	3	4
15. How often have you felt consumed by the need to get pain medication?	0	1	2	3	4
16. How often have you run out of pain medication early?	0	1	2	3	4
17. How often have others kept you from getting what you deserve?	0	1	2	3	4
18. How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4
19. How often have you attended an AA or NA meeting?	0	1	2	3	4
20. How often have you been in an argument that was so out of control that someone got hurt?	0	1	2	3	4
21. How often have you been sexually abused?	0	1	2	3	4
22. How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
23. How often have you had to borrow pain medications from your family or friends?	0	1	2	3	4
24. How often have you been treated for an alcohol or drug problem?	0	1	2	3	4

Printed Name:_____

Signature: _____ Date:_____

Pain and Headache Center
12836 Old Glenn Hwy., Suite 2
Eagle River, AK 99577
907-622-3715

BLUEPRINT HEALTH

PATIENT: PLEASE RETURN THIS FORM TO THE FRONT DESK TO BE FAXED TO BLUEPRINT HEALTH.

1. COMPLETE THE SURVEY below so that we may determine whether some of the symptoms you are experiencing may be due to Hormone Deficiencies.

Make sure you have provided accurate contact information below, so one of our nurses can contact you to discuss next steps.

Provider you are seeing today: _____

2. PATIENT INFORMATION

First Name: _____ Last Name: _____ Email: _____

Phone (Best to Call): _____ Birthdate: _____

3. PATIENT SURVEY Please circle one

EVERYONE (please complete)

1. Do you have a decrease in muscle size, strength, or endurance overall? **Yes No**	2. Do you have decreased energy? Feeling tired or fatigued? **Yes No**	3. Do you have a decrease in libido (sex drive)? **Yes No**	4. Do you suffer from oily or acne prone skin? **Yes No**	5. Have you noticed a decreased enjoyment of life or activities? **Yes No**
6. Are you sad, depressed or anxious? **Yes No**	7. Do you eat when you are bored/ stressed? **Yes No**	8. Have you noticed any changes in mood? **Yes No**	9. Do you find yourself struggling to remember things? Foggy brain? **Yes No**	10. Have you experienced any weight gain in the past 6 months? **Yes No**

Thank you for taking the time to fill out the patient assessment form so that your Provider and Blueprint Health can better assist you. Please note that if your Provider deems necessary, you will be receiving a call from one of Blueprint Health's Patient Care Coordinators to set up lab work.

"A Blueprint to a Better, Healthier You!"

(844) 632-4325

Provider Signature: _____

Provider Notes: _____

_____

Complete requested information and fax to (844) 965-9871 or email to info@blueprint2health.com

BLUEPRINT HEALTH

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For more information please visit our website at
Blueprint2health.com

PATIENT INFORMATION

Dear Patient,

Based on your completed Symptom Assessment, your Provider, partnered with Blueprint Health, recommends ordering a highly-specialized lab panel to determine if your symptoms are related to a hormonal imbalance or deficiency.

The purpose of this panel is to review your body's critical hormones and include, but are not limited to measuring:

- Testosterone
- Estradiol
- Vitamin D3
- Thyroid
- DHEA
- B12
- Progesterone

If these hormone or vitamin levels are in abnormal ranges, there could be an easy fix to the symptoms you've been experiencing.

Your doctor has partnered with Blueprint Health to provide you with the best possible care throughout the entire process. Your Nurse will be contacting you shortly to arrange for your lab panel.

WHAT YOU NEED TO KNOW BEFORE GETTING YOUR LAB WORK

- Fasting Lab Draw (nothing to eat/drink except for water the 8 hours prior to your draw)

- Early morning is best time of day for draw (7am - 9:30am)

- No strenuous exercise 24-hours prior to labs

HOW LAB DRAWS WORK

Depending on your personal insurance coverage, you will be scheduled with a mobile phlebotomist who will come to you to perform the lab draw …

OR …

you will be scheduled to visit a local Quest or LabCorp collection center for your draw. Your Nurse will assist in determining the appropriate path for you.

LAB REVIEW

Once your labs are resulted, your Nurse will contact you to review your results and will also coordinate any recommended medication plan approved for you by your Provider.

MEDICATION PLAN

Patients in the Blueprint Health program are directly responsible for payment for services rendered. Your Nurse will explain our monthly program options to you.

BLUEPRINT HEALTH

A Blueprint Health staff member will contact you within 48 hours of receiving this form from your Provider to schedule your blood draw.

If you have questions, contact your Blueprint Heath Patient Care Coordinator at :

(844) 632-4325 ext. 1

OR VISIT:
blueprint2health.com/faqs/