BLATMAN
HEALTH AND WELLNESS CENTER

New Patient Packet

Date: _____

Dear _____,

We are excited that you are a new patient, and your first visit is scheduled to be on _____ at _____ . We focus our expertise to three areas.

1. Making your pain go away. No matter what your diagnosis and no matter how long you have been in pain, there is a good chance most of it can go away. Even scoliosis in a child can be reversed if not too late.
2. Regenerative medicine -you can grow a new rotator cuff tendon; you can restore the cartilage in a worn out joint. You can grow new nerves and blood vessels in private organs, so they work better. Your pelvic floor can be restored to reduce stress incontinence. Even organs can be restored if it is not too late .... Brain from dementia, kidneys from failure, etc.
3. We also treat chronic illness where conventional medicine doesn't do well, such as fibromyalgia, chronic fatigue, Lyme, mold, dementia, kidney failure, irritable bowel, and cancer.

We will help teach you how to get out of your body's way so it can do the healing it knows how to do. And then we will help facilitate your body's work to make the changes and healing needed to accomplish your healing needs.

Whether you are a child, adult, elderly, or professional athlete, we have more than 30 years of experience that can help you where nothing else has worked.

Our tools include: Nutrition, body work, trigger point injections, prolotherapy, prolozone, compounding pharmacy, bio-identical hormones, platelet-rich plasma, stem cells, exosomes, peptides, ARPWave, darkfield microscopy for live blood and mouth analysis, IV therapies including vit C, ozone, ultraviolet blood irradiation, mistletoe, hydration, immune boosting and more, genetic analysis and lab analysis to optimize nutrition and care, and more.

Your work: take some time and complete the medical history form provided in your packet. For some this is quick, others can take a while. Please write or type this information and bring in your packet to the first office visit.

Also enclosed are our General Information and Financial Policy Information. These will explain how our office functions. We ask that you the "patient", contact your insurance company so you can be advised of your medical out of network benefits.

A map to our office and a checklist of things to bring with you is enclosed for your convenience.

WE HAVE RESERVED A CONSIDERABLE AMOUNT OF TIME FOR YOU. IF YOU NEED TO CANCEL THIS VISIT YOU MUST CALL AND GIVE US AT LEAST 72 HOURS NOTICE OR YOU WILL BE CHARGED. THE $100 DEPOSIT FOR THIS RESERVED TIME.

We look forward to meeting you. If you have any questions, please call.

Yours truly,

Hal S. Blatman

Hal S Blatman MD and Staff

BLATMAN HEALTH AND WELLNESS CENTER

10653 Techwoods Circle
Suite 101
Cincinnati, OH 45242
Phone: 513-956-3200 **Fax:** 513-956-3202
www.blatmanhealthandwellness.com

GENERAL INFORMATION

OFFICE HOURS

Our office hours are from 8:OO AM until 5:OO PM, Monday through Thursday. Our office is closed on Friday, Saturday and Sunday.

PHARMACY/PRESCRIPTION REFILLS

All patients are asked to phone their pharmacy for refills and fax a request for more efficient and timely service. We must have **48 hour's notice** for your prescription medication to be filled; no prescriptions will be filled otherwise. Prescriptions will not be refilled in the evening or on weekends. Please remember, we are not open on Fridays! When calling the office for refills, spell your first and last name and tell us what medications are needed and the pharmacy number.

PHONE CALLS/EMAILS

Calls of a medical nature are often handled by our staff. If your call requires the doctor's attention, it will usually be returned after office hours. Please leave a number where you can be reached at those times.

WORKER'S COMPENSATION

BWC or self-insured workers' compensation patients must first call their case manager and must have written documents faxed or mailed to our office stating that BWC will cover the first consultation appointment. New patient appointments can be scheduled after we receive this documentation. Our Worker's Compensation Coordinator will help ensure the paperwork is in order. Ohio BWC policy is that treatment is not provided during this initial office visit.

LITIGATION

Medical Charges for services and treatment rendered by our office are not contingent upon the outcome of a legal action against another party. We will file it with your insurance carrier, but

regardless of the final settlement, payment in fall will be expected for all charges and at the time of visit.

ATTORNEY/ACCIDENT CASES MEDICAL BILLS

Office charges must be kept current. Please contact our billing specialist at ext. 105 to review your situation. We do not participate in agreements to wait for your claim to be settled.

APPOINTMENTS

All patients must complete our patient information registration form. All paperwork sent to each new patient should be completed prior to arriving at our office. Failure to have paperwork completed may force us to reschedule your appointment.

We make every effort to stay on schedule. Emergencies and unpredictable situations sometimes arise and affect our schedule. We ask for your patience if you should have to wait.

CONFIDENTIALITY

Your medical records are strictly private and confidential. No information from your chart will be given to family members, your employer, your attorney or other doctors without your written permission. Worker's Compensation patients have signed a release for medical records to be seen by the Ohio BWC.

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Office Hours are 8:OOAM to 5:OOPM, Monday through Thursday
Our office is closed Friday, Saturday and Sunday

FINANCIAL POLICY

We welcome you to our office, and we are pleased to have this opportunity to help you as a patient. We are providing this information to help you understand how our business office operates, and to acquaint you with the policies of our practice.

We are committed to providing you with the best possible care, and we are always willing to discuss our professional fees with you. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions about our fees, financial policies, or your financial responsibility, please call our financial coordinator.

PAYMENT METHODS

We accept cash, money orders, and Major Credit Cards.

INSURANCE

We are not a participant in any insurance plans. Most insurance company networks do not cover our treatment completely. It is your responsibility to contact your insurance company prior to your office visit. **Payment for services in full is due at the time services are rendered.** If you would like, we will file a claim with your insurance company. You must realize, however, that your insurance company is a contract between you, your employer and the insurance company. We are not a party to that contract. Again, we urge you to check with your company before your first visit regarding your out-of-network benefits.

We must emphasize that, as medical care providers, our relationship is with you, not your insurance company. **While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in managing your account.

APPOINTMENTS

We schedule 2 hours for a new patient visit. If you cancel your new patient office visit, you must let us know at least 72 hours (about 3 days) in advance of your appointment, or you will be charged $100.00. As an established patient, if you are unable to keep your scheduled appointment, please contact our office at least 24 hours in advance. This courtesy allows us to be of service to other patients. You will be charged a $65.00 no show fee if you cancel less than 24 hours prior to your scheduled time and this charge must be paid prior to your next office visit.

If your account falls behind and we are forced to send it to a collection agency, you will be charged a $50.00 fee and any other fees associated with collecting the money owed. These rates are all subject to change without notice.

CONFIDENTIALITY

Your medical records are strictly private and confidential. No information from your chart will be given to family members, your employer, your attorney or other doctors without your written permission. Worker's Compensation patients have signed a release for medical records to be seen by the Ohio BWC.

I have read the financial policy of the Blatman Health and Wellness Center and agree.

Patient Name _____ Date_____

HAL S. BLATMAN, M.D.
BLATMAN HEALTH AND WELLNESS CENTER
10653 Techwoods Circle, Suite 101
Cincinnati, Ohio 45242
Phone: 513-956-3200

DIRECTIONS TO OUR OFFICE

75 Southbound:
75 South to 275 East
Exit onto Reed Hartman Highway (3 exits) turn right
At the 5th or 6th light turn left onto Creek Road.
Make a right at the first driveway on the right, which is Techwoods Circle
Turn into the 4th driveway on the right
Take an immediate left and park in designated area.

75 Northbound:
75 North to 275 East
Exit onto Reed Hartman Highway (3 exits) ton right
At the 5th or 6th light turn left onto Creek Road.
Make a right at the first driveway on the right, which is Techwoods Circle
Turn into the 4th driveway on the right
Take an immediate left and park in designated area.

71 Southbound:
Exit Pfeiffer Road
Take a right at the light onto Pfeiffer Road
Turn right onto Kenwood Road
At light make a left onto Creek Road
Take a left onto Techwoods Circle
Turn Left into 3rd driveway
Take and immediate left and park in designated area.

71 Northbound:
Exit Pfeiffer Road
Take a left at the light onto Pfeiffer Road
Turn right onto Kenwood Road
At light make a left onto Creek Road
Take a left onto Techwoods Circle
Turn Left into 3rd driveway,
Take and immediate left and park in designated area.

CHECKLIST OF ITEMS TO BRING TO YOUR NEW PATIENT OFFICE VISIT

PLEASE FILL OUT ALL APPLICABLE SECTIONS OF PAPERWORK.

(Be aware some forms are two sided)

- ❑ Registration
- ❑ Who May We Speak to Regarding You
- ❑ Financial Policy
- ❑ Patient Consent Form
- ❑ Patient Information Record
- ❑ Privacy Policy
- ❑ Current Medical History
- ❑ Financial Policy
- ❑ Pharmaceutical Records from Past Six Months If Relevant
- ❑ (Ask Your Pharmacy to Fax These To 513-956-3206)
- ❑ List Of All Medicines Including Over-The-Counter Medications, Supplements & Vitamins Taken in the Past.
- ❑ LIST OF ALL MEDICAL ALLERGIES - List in Patient History
- ❑ Labs: Blood Work - Recent, Mri Reports, Ct Scan Reports, X-rays – Films and Reports If Relevant
- ❑ Insurance Card, Driver's License or State I.D.
- ❑ Payment (Checks Not Accepted for First Visit), Cash, Major Credit Cards

PLEASE DO NOT SMOKE IN VEHICLE BEFORE APPOINTMENT OR ON DRIVE TO OFFICE

PLEASE DO NOT WEAR ANY PERFUME OR COLOGNE THE DAY OF YOUR APPOINTMENT DUE TO PATIENT AND STAFF ALLERGIES AND CHEMICAL SENSITIVITIES.

ALSO A REMINDER:

If you need to cancel your appointment for any reason, we set aside 2 hours for your visit and we require at least a 72-hour notice or you will be charged a $100 fee for this reserved time.

PATIENT INFORMATION RECORD (PLEASE PRINT LEGIBLY)

DATE OF INJURY OR DATE SYMPTOMS STARTED: _____ **DATE TODAY:** _____

PATIENT FIRST NAME MI	LAST NAME	SINGLE / MARRIED	WIDOWED / DIVORCED
STREET ADDRESS	CITY, STATE, ZIP CODE	TELEPHONE NUMBER ( )	
BIRTHDATE AGE	SOCIAL SECURITY NUMBER	CELL (MOBILE) NUMBER ( )	
LIST ANY OTHER NAMES YOU HAVE USED	OCCUPATION	PHARMACY NUMBER ( )	
EMPLOYER	WORK ADDRESS, STATE, CITY, ZIP CODE	EMAIL ADDRESS	
NAME OF INSURANCE SUBSCRIBER	BIRTHDATE	OCCUPATION	
EMPLOYER	WORK ADDRESS, STATE, CITY, ZIP CODE	EMPLOYER PHONE NUMBER **EXT** ( )	

IF PATIENT IS A MINOR OR STUDENT:

FATHER'S NAME BIRTHDATE	ADDRESS, STATE, CITY, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	WORK ADDRESS, STATE, CITY, ZIP CODE	TELEPHONE NUMBER ( )
MOTHER'S NAME BIRTHDATE	ADDRESS, STATE, CITY, ZIP CODE	TELEPHONE NUMBER ( )
EMPLOYER	WORK ADDRESS, STATE, CITY, ZIP CODE	TELEPHONE NUMBER ( )

EMAIL AND TEXT MESSAGING CONSENT

I WOULD LIKE TO RECEIVE INFORMATION FROM BLATMAN HEALTH AND WELLNESS INCLUDING NEW SERVICES, PROMOTIONAL OFFERS, FREE WELLNESS INFORMATION INCLUDING OUR "DO NOT EAT" LIST, AND THE BLATMAN HEALTH AND WELLNESS WEEKLY NEWSLETTER.

☐ EMAIL ☐ SMS (TEXT MESSAGING)

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY)

PRIMARY INSURANCE _____ PHONE NUMBER _____

SUBSCRIBER NAME _____ EFFECTIVE DATE _____

MEMBER NAME _____ GROUP NUMBER _____

WORKERS COMPENSATION CL# _____ MCO NAME _____

CLAIMS REPRESENTATIVE _____ MCO PHONE NUMBER _____

EMPLOYER AT DATE OF INJURY _____ DATE OF INJURY _____

PLEASE INITIAL TO VERIFY ALL THE INFORMATION IS CORRECT _____

ADDITIONAL INFORMATION

PHYSICIAN INFORMATION

FAMILY PHYSICIAN _____ REFERRING PHYSICIAN_____

STREET ADDRESS _____ STREET ADDRESS_____

CITY, STATE, ZIP _____ CITY, STATE, ZIP_____

TELEPHONE (_____) _____ TELEPHONE (_____) _____

EMERGENCY CONTACT INFORMATION

NAME _____ RELATIONSHIP TO YOU_____

STREET ADDRESS_____ TELEPHONE (_____) _____

CITY, STATE. ZIP CODE_____

WHO IS RESPONSIBLE FOR PATIENT'S MEDICAL EXPENSES

PARENT SIGNIFICANT OTHER SELF

NAME OP PAiUSNT OR SIGNIFICANT OTHER (GUARANTOR) _____

DATE OF BIRTH _____SOCIAL SECURITY NUMBER _____

GUARANTOR SIGNATURE _____ DATE _____

The office of Hal S. Blatman, M.D., Inc will process your primary insurance claim as a courtesy to you, however, the guarantor is fully responsible for all charges regardless of insurance coverage.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize all payments made by the insurance company to be paid directly to Hal S. Blatman, M.D., Inc.

PATIENT SIGNATURE _____ DATE _____

PARENT SIGNATURE (IF MINOR) _____DATE _____

Patient Consent Form

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. H.l.P.P.A.., the Health Insurance Portability and Protection Act requires that all medical providers, insurance companies and others put in place controls to ensure that your personal medical information is safe.

We request that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent

Signature of Patient or Representative _____ Date _____

Name of Patient or Representative (Please Print) _____ Date of Birth_____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request the results of tests and procedures. Under the requirements for H.I.P.PA. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your test results released to family members you must sign this form. Signing this form will only give consent to release laboratory and radiology results to the family members indicated below. This consent form will not allow us to release any other information to these family members.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Blatman Pain Clinic to release my laboratory/radiology results and reports to the following individuals.

Name _____Relation to Patient _____ Date _____

Name _____Relation to Patient _____ Date _____

PATIENT NAME _____ PATIENT SIGNATURE _____

Authorization to Leave Messages with Household Members/Answering Machine

From time to time, it is necessary for us to leave messages for patients, The purposes of these messages are to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss lab or procedure results, or to ask a patient to call regarding an issue or concern. At no time will a representative discuss your medical circumstances or condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Patient Name _____

Patient Signature _____ Date _____

Please print and check the appropriate terms.

Long answers may be continued on a separate sheet of paper.

Please skim through the entire form before filling this out.

CURRENT MEDICAL HISTORY

Patient Name_____

Today's Date _____ Age _____ Date of Birth_____

Who Referred You? _____

Family Physician _____ Physician's Phone Number_____

Address of Family Physician_____

What is/are your major concern(s)?

_____

_____

_____

_____

_____

_____

_____

What are your other concerns?

_____

_____

_____

_____

_____

_____

When did your major concern(s) begin (be specific)?

_____

_____

_____

Pain and Problem History

IF you were involved in any auto accidents, please include details about the seat belt, shoulder strap, air bag, position in the care, make and year of what you hit, how the accidents happened, treatment right afterwards, symptoms or change in symptoms after the injury, etc.

What seemed to really start it? If it was an injury, how did it happen?

_____

_____

_____

_____

_____

_____

_____

How long have you had this diagnosis? (year)_____

What was the diagnosis? _____

Name of physician who diagnosed it _____

Specialty of physician_____

Address or General Location of Physician

_____

What kinds of treatments have you tried? When? And what were the results of each?

Include Physical Therapy, Chiropractor, Massage, Doctors, Clinics, Acupuncture, etc.

1._____

_____

_____

2._____

_____

3._____

_____

4._____

_____

5._____

_____

_ *If you have more to list, please include them on a separate sheet of paper.

Please make sure you help me understand how your condition developed over time... from when it started, until now:

IF YOU HAVE SEPARATE TREATMENT HISTORIES FOR OTHER CONDITIONS,

PLEASE SUMMARIZE THEM ON A SEPARATE SHEET OF PAPER.

What home remedies have you tried for these conditions?

What do you do that makes it better or improves your symptoms?

What do you do that makes it feel worse?

List the weather conditions you feel best in:

List the weather conditions you feel worst in:

DIAGNOSTIC TESTING

Please bring a paper copy of test reports, and the actual films of plain x-rays if possible. What TESTS have you had done?

Don't copy the test reports into this table.

Lab tests, Blood tests, MRI scan reports, Ct scan reports, EMG reports, etc.

TEST NAME	DATE TEST WAS DONE	FACILITY WERE TEST WAS DONE	WHAT RESULTS WERE YOU TOLD?

What SURGERIES have you had?

SURGERY	DATE OF SURGERY	REASON FOR SURGERY	SUCESSFUL?

*Continue on separate sheet of paper if needed.

REVIEW OF SYSTEMS

GENERAL			
___ Poor appetite ___ Poor Sleeping ___ Fatigue __ Sweats easily ___ Tremors	___ Strong thirst ___ Poor balance ___ Weight gain ___ Fevers ___ Night Sweats	___ Bleed/bruise easily ___ Weight loss ___ Localized weakness ___ Change in appetite	___ Chills **Cravings for:** **___Sweets** ___ Fats ___ Salty foods ___Other _____

SKIN AND HAIR			
___ Eczema ___ Recent moles ___ Ulcerations	___ Herpes ___ Itching ___ Dandruff	___ Fingernails Chip/Crack/Peel ___ Hives ___ Changes in hair ___ Other _____	___ Changes in skin ___ Rashes ___ Loss of hair ___ Pimples

CARDIOVASCULAR			
___ High blood pressure ___ Low blood pressure ___ Phlebitis	___ Varicose veins ___ Fainting ___ Swelling Feet	___ Cold hands ___ Swelling hands ___ Irregular heartbeat ___ Cold Feet	__ Chest pains ___ Blood clots ___ Difficulty breathing ___Other _____

RESPIRATORY			
___ Cough ___Coughing blood ___ Bronchitis	___ Shortness of breath with minimal exercise ___ Pneumonia	___ Difficulty breathing when laying down ___ Asthma Other _____	___ Shortness of breath ___ Pain with deep breath

HEAD, EYES, EARS, NOSE, AND THROAT				
___ Concussions ___ # of silver fillings ___ Migraine ___ Sinus problems	___ Jaw clicks (TMJ) L or R ____ ___ # of Root canals ___ Other headache ___ Nose bleeds ___ Cataracts	___ Tooth problems ___ Eye Pain ___ Type of Headache _____ ___ Earaches	___ # of teeth pulled ___ Trouble with taste or smell ___ Other _____ ___ Trouble with night vision	___ Sores on lips/tongue ___ Glasses ___ Spots in front of eyes ___ Poor vision ___ Grinding teeth

IMMUNOLOGY		
___ Rheumatoid disease? (Y or N) ___ Cancer? (Y or N) What kind? _____ Other communicable disease? _____	___ Tested for Lyme disease? (Y or N) ___ Hepatitis? (Y or N) What kind? _____ ___ Diabetes? (Y or N)	___ AIDS? (Y or N) ___ Thyroid problems? (Y or N) ___ Breast implants? (Y or N) What kind? _____

GASTROINTESTINAL				
___ Nausea ___ Vomiting ___ Gas ___ Constipation	___ Abdominal pain/cramps ___ Diarrhea ___ Blood in stool ___ Pancreatitis	___ Indigestion ___ Black stool ___ Bad breath ___Hemorrhoids	How many bowel movements a day? ___ How many bowel movements a week? ___	___ Belching ___ Heartburn ___ Rectal pain

GENITOURINARY			
___ Pain with urination ___ Unable to hold urine ___ Problem with sexual function	___ Frequent urination ___ Kidney stone #: ___ ___ Impotency ___ Decrease in flow	___ Blood in urine ___ Loss of libido (desire) ___ Urgency to urinate Other _____	___ Wake up to urinate ___ Pain with intercourse ___ Sexually transmitted disease of exposure ___ Sores on genitals

PREGNANCY AND GYNECOLOGY				
___Pregnant (Y or N) First date of last menses: _____ # of children ___ Ages of children _____	___ Planning a pregnancy (Y or N) ___ Painful periods ___ Breast lumps ___ Unusual character (Heavy light) of menses	___ Post menopausal (Y or N) ___ Menopause symptoms ___ Hot flashes ___ Irregular periods	___ Vaginal discharge ___ Fibrocystic breast (Y or N) ___ Birth control (Y or N) Type of birth control _____	___ Clots ___ Vaginal sores # of vagial deliveries ___ # of C-section devlieries ___ # of abortions ___

MUSCULOSKELETAL					
___ Muscle pain ___ Shoulder pain ___ Finger pain ___ Knee pain	___ Scoliosis ___ Jaw pain ___ Arm pain ___ Lower back pain	___ Hip pain ___ Foot pain ___ Neck pain ___ Hand pain	___ Osteoporosis ___ Muscle weakness ___ Elbow pain ___ Upper back pain	___ Ankle pain ___ Chest pain ___ Face pain ___ Wrist pain	__ Thigh pain ___ Toe Pain ___ Leg pain Other _____

NEUROPSYCHOLOGICAL		
___ Seizures ___ Poor memory ___ Bad temper Ever considered suicide? ___ Ever attempted suicide? ___	___ Dizziness ___ Concussion ___ Easily susceptible to stress ___ Treated for emotional problems ___ Loss of balance	___ Lack of coordination ___ Anxiety ___ Aneurysm ___ Areas of numbness Where? _____ Other _____

Other information you think is important that did not come up during the review of systems:

_____

_____

_____

Family History

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/seizures						
Bleeding disorder						
Kidney disease						
Thyroid disease						
Mental Illness						
Osteoporosis						
Fibromyalgia						
Other						

Additional History

Childhood Illnesses: _____

Childhood accidents and ay lasting effects:

_____

_____

_____

Current Medications

Current Medication Name	Who Prescribed Them	What Are They For	Are They Helpful

Pharmacy

Current Pharmacy _____

Address or Location _____

Phone _____

Allergies to medication and environment:

Medication allergies – list medication and reaction:

_____

_____

_____

_____

_____

Environmental allergies – list agent and reaction:

_____

_____

_____

_____

_____

_

History of allergy testing and treatment:

_____

_____

_____

_____

_____

Drug/Substance Abuse

Have you ever smoked Tobacco? _____ How many packs per day? _____ Now? _____

How many years have you been a smoker? ____ How many times did you quit? ____

When?_____

Do you have a history of alcohol or drug abuse? Treatment for abuse? Please explain:

_____

_____

_____

Diet

Red meat – number of meals per week _____

Milk – number of glasses per week _____ or per day _____

Cheese – number of glasses per week _____ or per day _____

Coffee or tea – number of cups per week _____ or per day _____

Soda – number of cans per week _____ or per day _____ What kind usually? _____

Other sugar – what sweets do you usually eat and how much?

_____

_____

Bread – what kind? _____ How much? _____

Do you use margarine or butter? _____

What cooking oils do you use? _____

What are your favorite foods?

_____

_____

Vitamins: what do you take, and why (only list why for unusual supplements or herbs)?

_____

_____

Daily Routine

Sleep

How many hours of sleep do you usually get a night? _____

How well do you sleep?

_____

If not well, why not?

_____

_____

What position do you sleep in? _____

Do you use a pillow? _____ What kind? _____

Where placed? _____

Stomach

Do you have stomach sensitivity to aspirin (Y or N)? ___

Do you have irritable bowel (Y or N) ? ____ For how long? _____

How is this treated?

_____

_____

Who is the treating doctor? _____

Do you have a history of ulcer or indigestion (Y or N)? ___

Please explain:

_____

_____

How is it treated and who is the doctor?

_____

_____

_____

Check-ups

When was your last complete physical examination? _____

For what reason?

_____

_____

Work

What is your occupation? _____

List any relevant work history:

_____

_____

If you are disabled, when did you last work?_____

What is your disability caused by? _____

Anything else you work like us to know?

_____

_____

_____

_____

_____

_____

If you are not working, do you plan to return to work, and how soon?

_____

_____

_____

_____

_____

What are your goals for this treatment? What do you expect to change regarding your pain and life? How hard are you willing to work to reach your goals?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

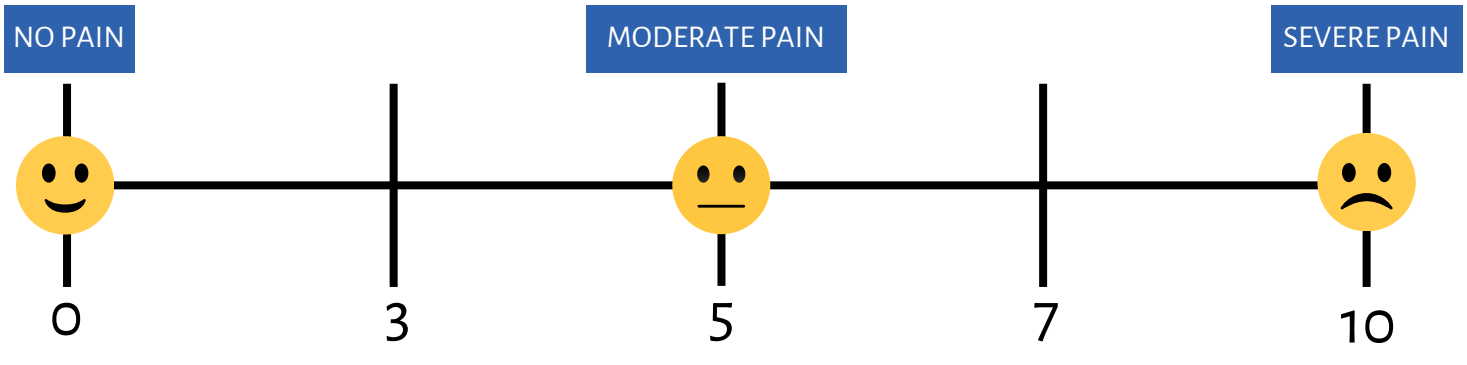
_____

To the best of my knowledge, this form is complete and accurate.

Signature _____ Date _____

PAIN SCALE

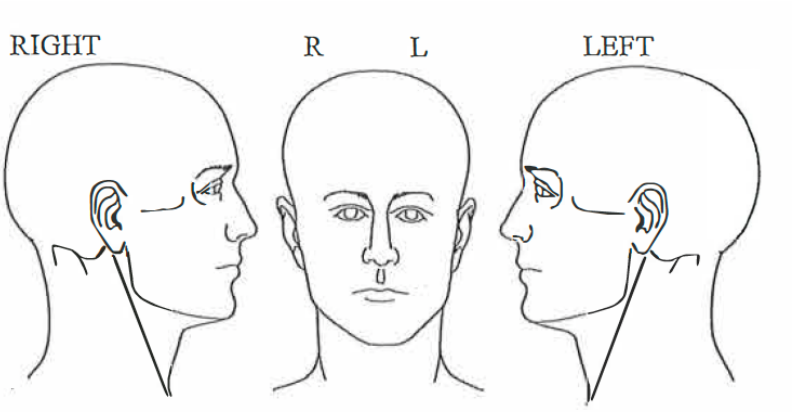
0	=	No pain.
1	=	You are slightly uncomfortable. Occasional minor twinges. No medicine needed.
2	=	Pain is a minor bother. No medicine needed.
3	=	Pain is annoying enough to be distracting. Mild painkillers like Aspirin or Tylenol help.
4	=	Pain can be ignored if you are really involved; it is still distracting. Mild painkillers help for 3-4 hours.
5	=	Pain can't be ignored for more than 30 minutes. Mild painkillers help for 3-4 hours.
6	=	Pain can't be ignored, but you can still work. Stronger narcotic painkillers help for 3-4 hours.
7	=	It is hard to concentrate. Pain bothers sleep. You can still function. Painkillers only help some.
8	=	Your activity is limited a lot. You can read and talk with effort. Nausea and dizziness are part of the pain.
9	=	You are unable to speak. You are crying out or moaning.
10	=	You are unconscious. Pain makes you pass out.

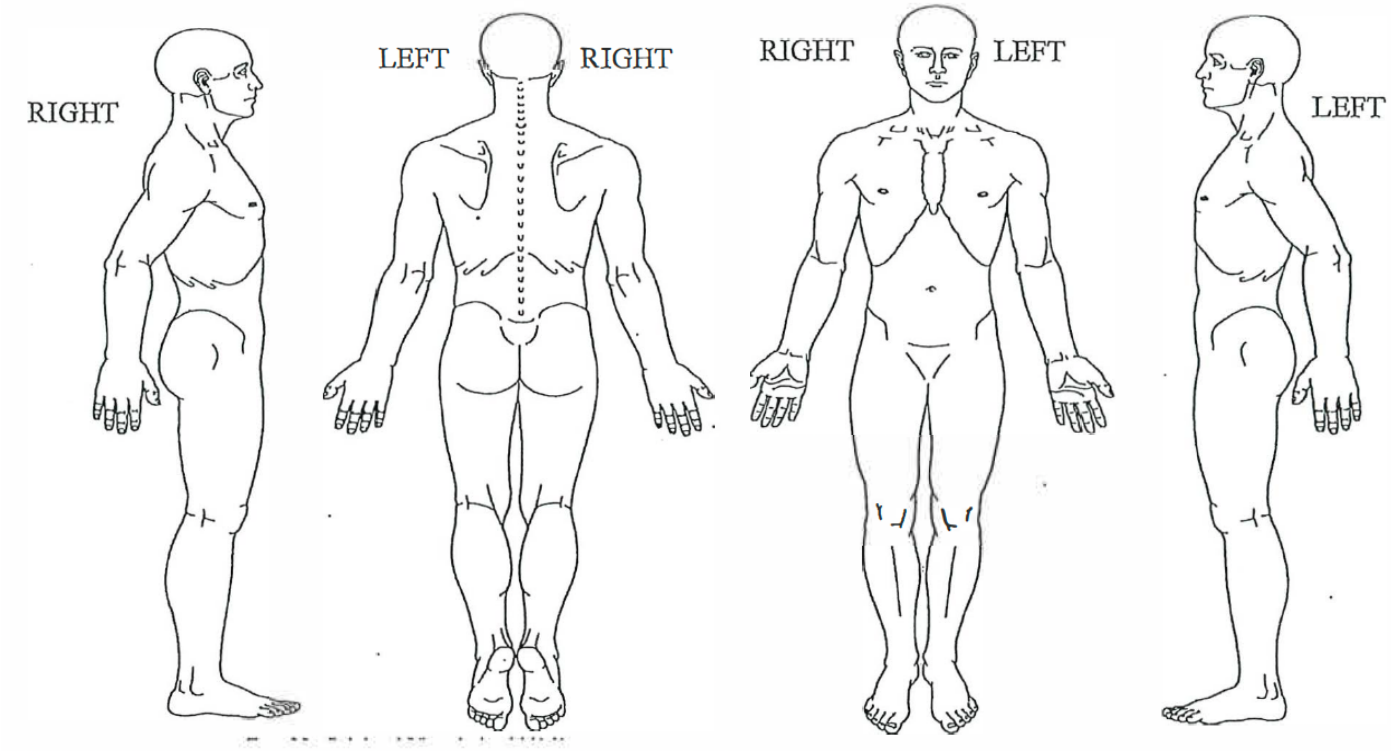


PLEASE COLOR THE FIGURES ACCORDING TO TYPES OF PAIN AND LOCATION.

Name: _____ Date: _____

Blue ——— **Pain**
Red ——— **Burning**
Green ——— **Cramping**
Yellow ——— **Numbness, Tingling**





Circle the number that best describes your pain at its **worst during the last month.**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST IMAGINABLE PAIN

Circle the number that best describes your pain at its **least during the last month.**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST IMAGINABLE PAIN

Circle the number that best describes your pain **on average during the last month.**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST IMAGINABLE PAIN

Circle the number that best describes your pain **as it is right now.**

NO PAIN 0 1 2 3 4 5 6 7 8 9 10 WORST IMAGINABLE PAIN

Zung Self-Rating Depression Scale (SDS)

Reply to questions using one of the four replies below (A – D) A – Little or none of the time
B – Some of the time
C – A large part of the time
D – Most or all of the time

	A	B	C	D	
	Little or none of the time	**Some of the time**	**A large part of the time**	**Most or all of the time**	**RESPONSE (1,2,3,4)**
1.I feel downhearted and blue	1	2	3	4	
2.Morning is when I feel the best	4	3	2	1	
3.I have crying spells or feel like it	1	2	3	4	
4.I have trouble sleeping at night	1	2	3	4	
5.I eat as much as I used to	4	3	2	1	
6.I still enjoy sex	4	3	2	1	
7.I notice that I am losing weight	1	2	3	4	
8.I have trouble with constipation	1	2	3	4	
9.My heart beats faster than usual	1	2	3	4	
10.I get tired for no reason	1	2	3	4	
11.My mind is as clear as it used to be	4	3	2	1	
12.I find it easy to do the things I used to do	4	3	2	1	
13.I am restless and can't keep still	1	2	3	4	
14.I feel hopeful about the future	4	3	2	1	
15.I am more irritable than usual	1	2	3	4	
16.I find it easy to make decisions	4	3	2	1	
17.I feel that I am useful and needed	4	3	2	1	
18.My life is pretty full	4	3	2	1	
19.I feel others would be better off if I was dead	1	2	3	4	
20.I still enjoy the things that I used to	4	3	2	1	

Some questions ask the information positively and others negatively but in all cases the symptom severity is Scored from 1 to 4. The total score is often converted to a 100 point scale (SDS index)
SDS Index = (score / 80 total points) x 100 or SDS Index = score x 1.25

Total SDS raw score	
SDS Index (score x 1.25)	