



REPLY TO
ATTENTION OF:

DEPARTMENT OF THE ARMY
CARL R. DARNALL ARMY MEDICAL CENTER
36000 DARNALL LOOP
FORT HOOD, TEXAS 76544-4752

MEDICATION REFILL POLICY

1. Appropriately managing pain is a team effort between the Pain Management doctors, the nurse, and the patient. Please be aware that Pain doctors may not be available for patient request and consults due to other obligations.
 - a. No medication will be refilled early.
 - b. You must agree to not ask for opioids medications from any other doctor without the knowledge and consent of your pain doctor.
 - c. Prescriptions refills will be authorized only during regular office hours.
 - d. Please allow 72 hours for all medication refills.
 - e. It is your responsibility to know when your pain medication will run out.
 - f. Pain Management doctors will refill only those medication prescribed by Pain Clinic doctors.
 - g. **Do Not** walk in to the Pain Clinic to request a medication refill.
 - h. Patients requiring medication refills may call the Pain Management Clinic at 288-8931 between 0800-1600 hours every Monday thru Friday. Please leave a message with the secretary or on the voice mail. State exactly which medications you need to have refilled. Please leave a number where you can be reached.
 - i. Doctor will then review your record, contact you, and order appropriate pain medications.
 - j. Patients will be referred to their Troop Medical Clinic, referring physicians, or primary care physician for medication refills requested on any day other than Monday thru Friday or during scheduled clinic appointments.

We understand that emergencies may occur; exceptions may be made to our guidelines under some circumstances.

Aaron Nelson, DO
Chief, Acute and Chronic Pain Service
CRDAMC



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OUTPATIENT PAIN MANAGEMENT APPOINTMENT POLICY

1. The Pain Management Clinic evaluations and procedural appointments resources are limited and time intensive. Therefore, it is very important that appointments are kept or cancelled in a timely manner. The following information will assist in maintaining continuity of treatments and improvements in quality of life.

a. Appointments

All patients are expected to arrive **30 minutes** prior to scheduled appointment time. If late, appointments are rescheduled. Patients are to report in PT uniforms when instructed.

b. Cancelling an Appointment

Patients are required to contact the Pain Management Clinic 48 hours before the scheduled appointment if, an appointment must be cancelled or rescheduled. If the cancellation is received less than 48 hours prior, the patient will be documented as a "No Show." Patients may cancel appointments by calling 254-288-8931 or 288-8971 (voice mail is available).

c. "No Shows"

If there is a "NO SHOW" appointment, Active Duty soldiers are required to bring a written request from the First Sergeant or Unit Commander to continue treatments in the Pain Management Clinic. The Pain Management Clinic will notify the referring physician of "No Show" patients. "NO SHOWS," are required to have a new consult in order to receive a new appointment in The Pain Management Clinic.

PRINT

SIGNATURE

DATE

I agree to adhere to the Pain Clinic's policy and procedures.

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN)

Sections 133, 1071-87, 3012, 5031 and 8012, title 10, United States Code and Executive Order 9397.

2. PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED

This form provides you the advice required by The Privacy Act of 1974. The personal information will facilitate and document your health care. The Social Security Number (SSN) of member or sponsor is required to identify and retrieve health care records.

3. ROUTINE USES

The primary use of this information is to provide, plan and coordinate health care. As prior to enactment of the Privacy Act, other possible uses are to: Aid in preventive health and communicable disease control programs and report medical conditions required by law to federal, state and local agencies; compile statistical data; conduct research; teach; determine suitability of persons for service or assignments; adjudicate claims and determine benefits; other lawful purposes, including law enforcement and litigation; conduct authorized investigations; evaluate care rendered; determine professional certification and hospital accreditation; provide physical qualifications of patients to agencies of federal, state, or local government upon request in the pursuit of their official duties.

4. WHETHER DISCLOSURE IS MANDATORY OR VOLUNTARY AND EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION

In the case of military personnel, the requested information is mandatory because of the need to document all active duty medical incidents in view of future rights and benefits. In the case of all other personnel/beneficiaries, the requested information is voluntary. If the requested information is not furnished, comprehensive health care may not be possible, but CARE WILL NOT BE DENIED.

This all inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record.

Your signature merely acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

SIGNATURE OF PATIENT OR SPONSOR

SSN OF MEMBER OR SPONSOR

DATE

**CRDAMC
PAIN MANAGEMENT CLINIC
PATIENT PAIN PROFILE (P3)**

Name: _____ Date of Visit: ___/___/___ (D/M/YYYY)
(Last, First Middle Initial)

Sex: Female Male Age: _____ Rank: _____ Occupation: _____

E-Mail Address: _____ Phone: _____

Referred by: _____
Name of Doctor/Provider Specialty of Referring Doctor/Provider

INSTRUCTIONS: Please fill out each section; if a section does not apply, please answer with "N/A" if it does not apply.

PAIN DESCRIPTION

1. CHIEF COMPLAINT (Reason for visit): _____

2. Are you currently on a **physical profile**? Yes No
If 'Yes,' what is the reason? _____

Is your profile: Permanent Temporary
If 'Temporary,' what is the duration of the temporary profile? _____

3. Are you currently involved in the **Medical Evaluation Board (MEB)** process? Yes No
If 'Yes,' what is the reason? _____

4. Are you a member of the **Warrior Transition Brigade (WTB)**? Yes No

5. Hand dominance: Right-handed Left-handed Ambidextrous

6. In general, would you say your health is: Excellent Very good Good Fair Poor

7. When did you first notice your pain? _____ Year(s) _____ Month(s)

8. How long have you had the pain for which you are seeking treatment? _____ Year(s) _____ Month(s)

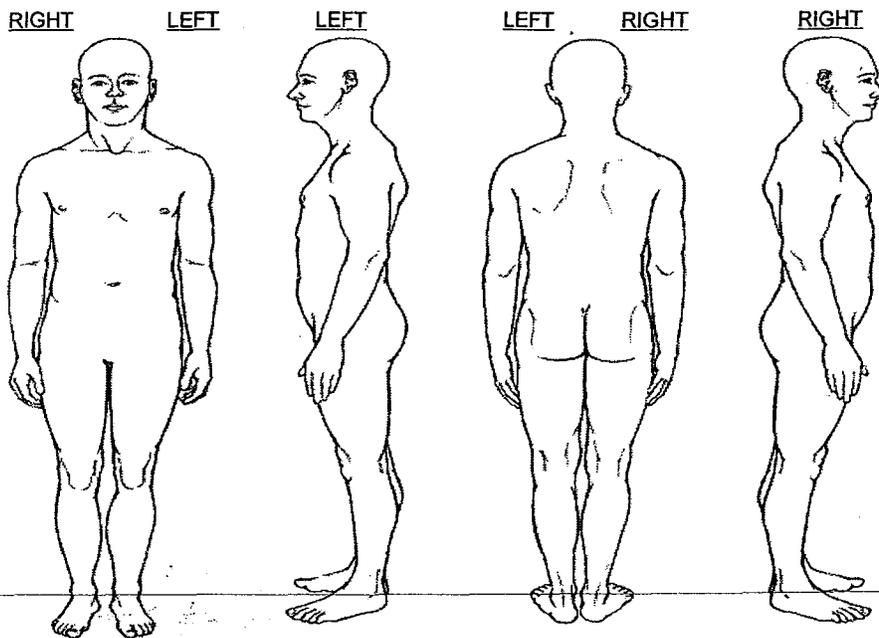
9. How did your pain begin?

- | | |
|---|--|
| <input type="checkbox"/> Pain just began, no reason | <input type="checkbox"/> Other Military Deployment |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Accident at work |
| <input type="checkbox"/> Following Surgery | <input type="checkbox"/> Accident at home |
| <input type="checkbox"/> Operation Iraqi Freedom (OIF) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Operation Enduring Freedom (OEF) | _____ |

10. What is/are the exact location(s) of your pain? (Please place a "1" next to your worst/greatest area of pain, a "2" next to the second most painful area and a "3" next to the third most painful area.)

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Groin | <input type="checkbox"/> Right Ankle/Foot |
| <input type="checkbox"/> Face | <input type="checkbox"/> Left Buttock | <input type="checkbox"/> Left Shoulder |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Right Buttock | <input type="checkbox"/> Right Shoulder |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Right Thigh | <input type="checkbox"/> Left Arm |
| <input type="checkbox"/> Lower Back | <input type="checkbox"/> Left thigh | <input type="checkbox"/> Right Arm |
| <input type="checkbox"/> Mid Back | <input type="checkbox"/> Left calf | <input type="checkbox"/> Left Wrist/Hand |
| <input type="checkbox"/> Upper back | <input type="checkbox"/> Right Calf | <input type="checkbox"/> Right Wrist/Hand |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Left Ankle/Foot | <input type="checkbox"/> Other _____ |

11. Indicate the location of your pain. (Please shade the painful areas)



12. Describe the duration of your pain: Constant Intermittent (comes and goes)

13. How would you best describe your pain?

- | | | | | |
|---------------------------------|-----------------------------------|------------------------------------|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning | <input type="checkbox"/> Penetrating |
| <input type="checkbox"/> Aching | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Shooting | <input type="checkbox"/> Other _____ |

14. Do you have any of the following symptoms associated with your pain?

- | | | |
|---|---|--|
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Coldness | <input type="checkbox"/> Muscle spasms |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Sweating | <input type="checkbox"/> Loss of control of bowels/bladder |
| <input type="checkbox"/> Weakness (in the arms or legs) | <input type="checkbox"/> Skin discoloration | <input type="checkbox"/> Other _____ |

15. Does your pain travel anywhere? Yes No

If 'Yes,' indicate where? _____

16. What time of the day is your pain MOST painful?

- | | |
|---|---|
| <input type="checkbox"/> Morning, on arising | <input type="checkbox"/> Bedtime |
| <input type="checkbox"/> Later in the morning | <input type="checkbox"/> Night, during usual sleeping hours |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> Pain is always the same |
| <input type="checkbox"/> Evening | <input type="checkbox"/> Pain varies, but is not worse at any particular time |

17. What time of the day is your pain LEAST painful?

- | | |
|---|---|
| <input type="checkbox"/> Morning, on arising | <input type="checkbox"/> Bedtime |
| <input type="checkbox"/> Later in the morning | <input type="checkbox"/> Night, during usual sleeping hours |
| <input type="checkbox"/> Afternoon | <input type="checkbox"/> Pain is always the same |
| <input type="checkbox"/> Evening | <input type="checkbox"/> Pain varies, but is not worse at any particular time |

18. Please indicate if the following increases, decreases, or causes no change to your pain:

Stimulus/Treatment	Increase Pain	Decrease Pain	No Change
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relaxation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying Down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weather Changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sneezing/Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Movement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAIN SCORES

19. Please describe your LEAST pain level (0 = No pain, 10 = Worst pain)

- 0 1 2 3 4 5 6 7 8 9 10

20. Please describe your WORST pain level (0 = No pain, 10 = Worst pain)

- 0 1 2 3 4 5 6 7 8 9 10

21. Please describe your AVERAGE pain level (0 = No pain, 10 = Worst pain)

- 0 1 2 3 4 5 6 7 8 9 10

22. Please describe your PRESENT pain level (0 = No pain, 10 = Worst pain)

- 0 1 2 3 4 5 6 7 8 9 10

FUNCTIONAL SCORES

23. Please rate your ability to COPE with your pain (0 = No able, 10 = Very able)

0 1 2 3 4 5 6 7 8 9 10

24. Please rate your ability to perform your ACTIVITIES OF DAILY LIVING, such as hygiene, household chores, transportation, etc. (0 = No able, 10 = Very able)

0 1 2 3 4 5 6 7 8 9 10

25. Please rate your ability to FUNCTION AND INTERACT well with family and friends (0 = No able, 10 = Very able)

0 1 2 3 4 5 6 7 8 9 10

26. Please rate your ability to WORK in your usual occupation (0 = No able, 10 = Very able)

0 1 2 3 4 5 6 7 8 9 10

PAIN DIAGNOSIS AND TREATMENT HISTORY

27. Please list the diagnostic tests you have received. Include the approximate date(s) and location(s) of the testing.

Diagnostic Test	Body Part/Area	Date(s)	Location (e.g. Ft. Hood)
X-Ray(s)	1.		
	2.		
	3.		
CT Scan(s)	1.		
	2.		
MRI Scan(s)	1.		
	2.		
EMG/Nerve Conduction Study			
Bone Scan			
Other:			

28. Please indicate the date(s) of any treatments you have received directly related to your pain and the amount of relief provided.

Treatment	Date(s)	No Relief (0%)	Minimal Relief (up to 30%)	Moderate Relief (30-60%)	Excellent Relief (60-100%)
Physical Therapy					
Acupuncture					
Chiropractic Care					
TENS Unit					
Traction					
Psychotherapy					
Joint injection(s)	1.				
	2.				
	3.				
Nerve block(s)	1.				
	2.				
	3.				
Epidural steroid injection(s)	1.				
	2.				
	3.				
Surgery	1.				
	2.				
Spinal cord stimulation					
Pain pump					
Lidocaine infusion					
Ketamine infusion					
Other:					

CURRENT PAIN MEDICATIONS

29. Please list all **pain medications** that are currently prescribed to you (including over-the-counter pain medications such as Tylenol and Motrin).

Medication Name	Strength	Directions	Prescribing Doctor/Provider

30. Do your pain medications provide relief? Yes No I do not take pain medications
 If 'Yes,' how much pain relief do you receive?
 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

31. Do your pain medications improve function? Yes No I do not take pain medications
 If 'Yes,' how much improvement in function do you receive?
 0% 20% 30% 40% 50% 60% 70% 80% 90% 100%

32. Do your pain medications improve your quality of life? Yes No I do not take pain medications
 If 'Yes,' how much improvement in the quality of your life do you receive?
 0% 20% 30% 40% 50% 60% 70% 80% 90% 100%

33. If you take pain medication(s), how many hours does the pain relief last before the pain returns?
 Pain medication doesn't help at all Six to eight hours
 One to two hours Nine to twelve hours
 Three to four hours More than twelve hours
 Five to six hours I do not take pain medication

34. I prefer to take my pain medicine:
 On a regular basis Only when necessary Do not take pain medicine

35. In a 24 hour period, I take my pain medicine:
 not every day 3 to 4 times per day more than 6 times per day
 1 to 2 times per day 5 to 6 times per day I do not take pain medication

36. Do you feel you need a stronger type of pain medication? Yes No Uncertain

37. Do you feel you need to take more of the pain medication than your doctor has prescribed?
 Yes No Uncertain

38. Please indicate any side effects caused by your pain medications.
 Nausea Vomiting Constipation Upset stomach Sedation
 Rash Dizziness Acid reflux Itching No side effects
 Other: _____

39. Other methods I use to relieve my pain include: (Please list all that apply)
 Warm compresses Relaxation techniques Hypnosis Other: _____
 Cold compresses Biofeedback Distraction

PAIN MEDICATION HISTORY

40. Please check all medications that you have tried in the past.

Opiates

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Fentanyl (Actiq, Fentora, Duragesic patch) | <input type="checkbox"/> Demerol | <input type="checkbox"/> Hydrocodone (Lortab, Norco, Vicodin, Vicoprofen) | <input type="checkbox"/> Tramadol (Ultram, Ultram ER) |
| <input type="checkbox"/> Morphine (Avinza, Kadian, Embeda, MS Contin) | <input type="checkbox"/> Oxycodone (Opana, Opana ER) | <input type="checkbox"/> Methadone | |
| <input type="checkbox"/> Oxycodone (Percocet, Oxycontin) | <input type="checkbox"/> Hydromorphone (Dilaudid, Exalgo) | <input type="checkbox"/> Tapentadol (Nucynta) | |
| <input type="checkbox"/> Propoxyphene (Darvocet, Darvon) | <input type="checkbox"/> Codeine (Codeine, Tylenol #3, Tylenol #4) | <input type="checkbox"/> Buprenorphine (Suboxone, Subutex) | |

Anti-inflammatories & Tylenol

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Diclofenac (Arthrotec, Voltaren, Voltaren Gel) | <input type="checkbox"/> Oxaprozin (Daypro) | <input type="checkbox"/> Meloxicam (Mobic) | <input type="checkbox"/> Nabumetone (Relafen) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Indomethacin (Indocin) | <input type="checkbox"/> Ibuprofen (Motrin, Advil) | <input type="checkbox"/> Acetaminophen (Tylenol) |
| <input type="checkbox"/> Celecoxib (Celebrex) | <input type="checkbox"/> Etodolac (Lodine) | <input type="checkbox"/> Naproxen (Naprosyn) | <input type="checkbox"/> Flector patch |
| <input type="checkbox"/> Other: _____ | | | |

Muscle Relaxants

- | | | |
|--|--|--|
| <input type="checkbox"/> Baclofen | <input type="checkbox"/> Methocarbamol (Robaxin) | <input type="checkbox"/> Carisoprodol (Soma) |
| <input type="checkbox"/> Cyclobenzaprine (Flexeril, Amrix) | <input type="checkbox"/> Metaxalone (Skelaxin) | <input type="checkbox"/> Tizanidine (Zanaflex) |
| <input type="checkbox"/> Other: _____ | | |

Antidepressants

- | | | | |
|---|--|--|-------------------------------------|
| <input type="checkbox"/> Cymbalta | <input type="checkbox"/> Nortriptyline (Pamelor) | <input type="checkbox"/> Remeron | <input type="checkbox"/> Wellbutrin |
| <input type="checkbox"/> Effexor | <input type="checkbox"/> Paxil | <input type="checkbox"/> Serzone | <input type="checkbox"/> Zoloft |
| <input type="checkbox"/> Amitriptyline (Elavil) | <input type="checkbox"/> Pristiq | <input type="checkbox"/> Imipramine (Tofranil) | |
| <input type="checkbox"/> Lexapro | <input type="checkbox"/> Fluoxetine (Prozac) | <input type="checkbox"/> Trazadone | |
| <input type="checkbox"/> Other: _____ | | | |

Sleep Aids

- | | | |
|---|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Zolpidem (Ambien, Ambien CR) | <input type="checkbox"/> Lunesta | <input type="checkbox"/> Rozerem |
| <input type="checkbox"/> Xyrem | <input type="checkbox"/> Restoril | <input type="checkbox"/> Sonata |
| <input type="checkbox"/> Other: _____ | | |

Other Medications

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Axert | <input type="checkbox"/> Hydroxyzine | <input type="checkbox"/> Lyrica | <input type="checkbox"/> Zonegran |
| <input type="checkbox"/> Buspar | <input type="checkbox"/> Imitrex | <input type="checkbox"/> Maxalt | <input type="checkbox"/> Clonazepam (Klonopin) |
| <input type="checkbox"/> Frova | <input type="checkbox"/> Keppra | <input type="checkbox"/> Gabapentin (Neurontin) | <input type="checkbox"/> Temazepam (Xanax) |
| <input type="checkbox"/> Gabitril | <input type="checkbox"/> Lidoderm patch | <input type="checkbox"/> Relpax | |
| <input type="checkbox"/> Other: _____ | | | |

SLEEP BEHAVIOR

41. Do you have difficulty falling to sleep? Yes No
 42. Do you have difficulty remaining asleep? Yes No
 43. Are you ever awakened by your pain? Yes No
 44. Approximately how many hours do you sleep per night?
 1 2 3 4 5 6 7 8 9 10 More than 10

COMPLETE MEDICAL HISTORY

In order to develop your individualized plan of treatment, we need to gather detailed information about your past medical history, past surgical history, past psychological history, family history, and social history. Please answer the following questions accurately and honestly. Use the back of this form if more space is needed.

Past Medical History

45. Are you pregnant? Yes No N/A
46. Weight _____ lbs Height _____ ft _____ inches
47. Have you ever been diagnosed with the following? (Please check all that apply)
- | | | | |
|--|---|--|---------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Lupus | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis (A, B, C, D) | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy/Seizure disorder | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Peripheral vascular disease | |
| <input type="checkbox"/> Other: _____ | | | |

Past Surgical History

48. Please list all prior surgeries or procedures in the table below.

Date	Surgery/Procedure	Physician	Location

Medications

49. Please list all currently prescribed medications that not used for the treatment of your pain.

Name	Strength	Directions	Prescribing Doctor/Provider

50. Please indicate if you are taking any of the following blood-thinning medications.

<input type="checkbox"/> Aggrenox (aspirin and dipyridamole)	<input type="checkbox"/> Ginko or Ginko Biloba	<input type="checkbox"/> Plavix (clopidogrel bisulfate)
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Heparin	<input type="checkbox"/> Pletal (cilostazol)
<input type="checkbox"/> Coumadin (warfarin)	<input type="checkbox"/> Lovenox (enoxaparin)	<input type="checkbox"/> Ticlid (ticlopidine)
<input type="checkbox"/> Other: _____		

Allergies

51. If you are allergic to any medications, foods (e.g. shellfish), or topical or intravenous agents (e.g. tape, iodine), please list them, the reaction, and severity of reaction in the table below.

Medication/Agent	Reaction	Severity

Family Medical History

52. Please indicate whether any of your listed blood relatives may have had or are currently suffering from any of the following medical or psychiatric conditions.

Illness	Father	Mother	Brother/Sister	Other Blood Relative
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug addiction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

53. Do you smoke? Yes, currently Yes, in the past No, never
 If 'Yes, currently,' how long have you smoked? Years: _____ Months: _____
 If 'Yes, currently,' how many packs per day? 0-1/2 1/2-1 1-2 More than 2
 If 'Yes, in the past,' when did you quit? _____

54. Do you use alcohol? Yes No
 If 'Yes,' how many drinks do you consume (answer only 1 of the options below)?
 I consume _____ drinks every day week month

55. Have you ever had a problem with prescription medications (misuse, abuse, addiction)?
 Yes, currently Yes, in the past No, never

56. Have you ever had a problem with illegal drugs (cocaine, marijuana, intravenous drugs, etc.)?
 Yes, currently Yes, in the past No, never

57. Have you ever been treated for addiction or alcoholism? Yes No
 If 'Yes,' what treatment have you received? _____

58. Marital status: Single Married Divorced Widow/Widower

Psychological Treatment

59. Have you ever had psychiatric, psychological, or social work treatments/evaluations? Yes No
 If 'Yes,' for what diagnosis or problem were you treated? _____
 When were you treated? _____ Name of therapist: _____

60. Have you ever considered suicide? Yes No Date: _____

61. Have you ever planned suicide? Yes No Date: _____

62. Have you ever attempted suicide? Yes No Date: _____

Review of Systems

63. Please indicate whether you are experiencing any of the following symptoms, problems, or medical conditions.

General		Endocrine	
Decreased appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexpected weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypothyroid (low thyroid)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unexpected weight gain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyperthyroid (high thyroid)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal	
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heartburn/Reflux	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chills	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nausea/Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Night sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Skin		Irregular bowel habits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of control of bowels	<input type="checkbox"/> Yes <input type="checkbox"/> No
Itching	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No
Unusual hair loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gallstones	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sores/Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis (A, B, C, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyes		Cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Visual changes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blind field of vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	Neurologic	
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear/Nose/Throat		Memory changes/loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hear loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ringing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore throat/Hoarseness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinusitis/Sinus drainage	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory/Lung		Musculoskeletal	
Sleep apnea/CPAP mask	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint pain/Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Back/Neck pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Persistent cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle aching	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiovascular		Blood/Lymph	
Chest pain/angina	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary artery disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bruising easily	<input type="checkbox"/> Yes <input type="checkbox"/> No
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Past blood transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling in feet/legs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen/Tender lymph nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal heart rhythm	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Renal/Urinary/Kidney		Psychiatric	
Renal failure/insufficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hallucinations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electrolyte disturbances	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney stones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No
Painful urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Suicidal thoughts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty with urination	<input type="checkbox"/> Yes <input type="checkbox"/> No	Homicidal thoughts	<input type="checkbox"/> Yes <input type="checkbox"/> No
Urinary tract infection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gynecologic	
Enlarged prostate	<input type="checkbox"/> Yes <input type="checkbox"/> No	Currently pregnant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney/Prostate cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Endometriosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Interstitial cystitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heavy periods	<input type="checkbox"/> Yes <input type="checkbox"/> No

Patient's Signature

Date

Oswestry Disability Questionnaire

This questionnaire has been designed to give us information as to how your back or leg pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realise you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem**.

Section 1: Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

- I can look after myself normally without causing extra pain
- I can look after myself normally but it causes extra pain
- It is painful to look after myself and I am slow and careful
- I need some help but can manage most of my personal care
- I need help every day in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights but it gives me extra pain
- Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
- Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights
- I cannot lift or carry anything

Section 4: Walking*

- Pain does not prevent me walking any distance
- Pain prevents me from walking more than 2 kilometres
- Pain prevents me from walking more than 1 kilometre
- Pain prevents me from walking more than 500 metres
- I can only walk using a stick or crutches
- I am in bed most of the time

Section 5: Sitting

- I can sit in any chair as long as I like
- I can only sit in my favourite chair as long as I like
- Pain prevents me sitting more than one hour
- Pain prevents me from sitting more than 30 minutes
- Pain prevents me from sitting more than 10 minutes
- Pain prevents me from sitting at all

Section 6: Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it gives me extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than 30 minutes
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7: Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain I have less than 6 hours sleep
- Because of pain I have less than 4 hours sleep
- Because of pain I have less than 2 hours sleep
- Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

- My sex life is normal and causes no extra pain
- My sex life is normal but causes some extra pain
- My sex life is nearly normal but is very painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9: Social Life

- My social life is normal and gives me no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
- Pain has restricted my social life and I do not go out as often
- Pain has restricted my social life to my home
- I have no social life because of pain

Section 10: Travelling

- I can travel anywhere without pain
- I can travel anywhere but it gives me extra pain
- Pain is bad but I manage journeys over two hours
- Pain restricts me to journeys of less than one hour
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from travelling except to receive treatment