Do you have any of the following? (Circle all that apply)

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness of Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints
		Chronic Fatigue

Domestic Situation

With whom do you live?_____

Are there any substance abuse issues in the household? Yes_____ No_____

If yes, please explain_____

Are you able to take care of yourself? Yes_____ No_____

If not, please enter name of caregiver_____

Work History

Job Years worked Why did you leave?

_____

_____

Legal Matters

Are you presently involved in a lawsuit? Yes_____ No_____ If yes, please explain.

_____

_____

Substance Use

Which of the following drugs or substances, if any, have you used in the <u>past</u>? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you used it occasionally ("O"), frequently ("F"), or continuously ("C").

Alcohol _____	Barbiturates_____	Cocaine _____
Heroin_____	Amphetamines ____	Marijuana_____
Other _____ (specify)	Other_____ (specify)	Other _____ (specify)

Are you presently using any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it occasionally ("O"), frequently ("F"), or continuously ("C").

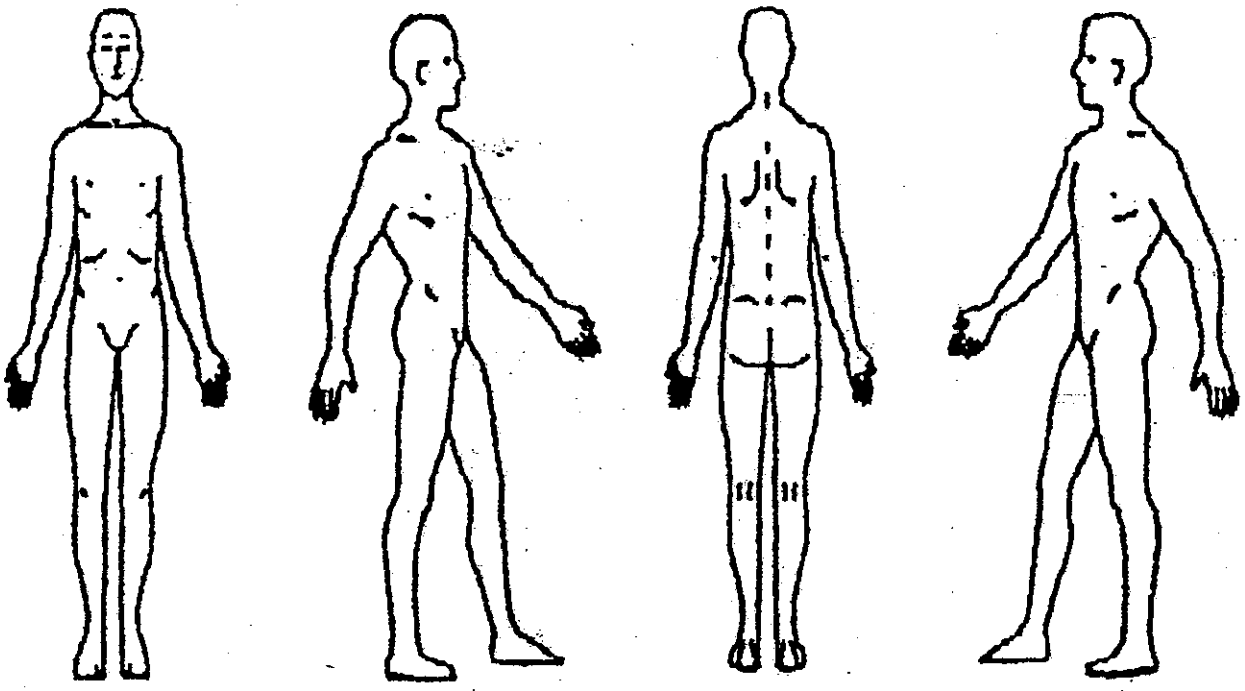
Alcohol _____	Barbiturates_____	Cocaine _____
Heroin_____	Amphetamines ____	Marijuana_____
Other _____ (specify)	Other_____ (specify)	Other _____ (specify)

Do you presently smoke cigarettes or use tobacco in any form? Yes_____ No_____

If not, did you ever smoke cigarettes or use tobacco in any form? Yes_____ No_____

How many packs do (did) you smoke a day? _____ For how many years? _____

On the diagram below, shade the area(s) where you feel pain. "X" the areas that hurt the most



Circle the numbers below that best describe how pain has interfered with your daily functioning this past week.

0 = Does not interfere 10 = Completely interferes

General Activity	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Relations With Other People	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10

Do you have any history of drug or alcohol abuse?

_____ Yes _____ No

Patient Name **Date**

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the days** **Nearly every day**

   b. Feeling down, depressed, or hopeless
   Not at all **Several days** **M ore than half the days** **Nearly every day**

   c. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**

   d. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**

   e. Poor appetite or overeating
   Not at all **Several days** **More than half the days** **Nearly every day**

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the days** **Nearly every day**

   g. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the days** **Nearly every day**

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**