The Kahan Center
FOR PAIN MANAGEMENT

Fellow Interventional Pain Physicians
Fellow American Academy of PM&R
www.thekahancenter.com

410-571-9000

2002 Medical Parkway Suite 150
Annapolis, MD 21401

1630 Main Street Suite 215
Chester, Maryland 21619

6503 DeerPointe Rd Suite B
Salisbury, Maryland 21804

Welcome to our practice. Enclosed is your new patient paperwork. Please fill this out and bring it along with any films, records, referral (if required by insurance), insurance card as well as picture ID, copay/patient portion. It is very important to bring all that is required to your appointment, it also imperative that you arrive at least 15-20 minutes early for your appointment; if you fail to do so the office will have to reschedule you.

What to expect at your initial appointment:

Thank you for choosing The Kahan Center for Pain Management. Your first appointment will be an evaluation/consultation. Our professional providers will review with you the information you have supplied. Based on the information and your examination, our providers will determine and recommend the appropriate treatment for your medical care based on their vast knowledge of pain. Once our provider has developed a treatment plan, we will schedule you for follow-ups, appropriate diagnostic tests and therapy in order to help reduce your pain and improve your quality of life. Please understand that this doesn't mean our provider will continue the treatment you have received prior to this exam. Our provider's reserve the right to determine their own treatment plan for your condition and this plan might not agree with what you have been receiving so far. Our providers are making their judgment based on their expertise in the field of pain medicine. If our practice decides that medication will be part of your plan of care please note the following. Medication refills require medical evaluations by our professional providers. Our providers will address all refills within 2 working business days. Please also note that if our office has not seen you as a patient in 6 months or greater you will require an appointment to review your medical treatment.

Thank you,
The Kahan Center for Pain Management

Revised 06/2011,10/2012

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2002 Medical Parkway Suite 150 **1630 Main Street Suite 215A** **6503 Deer Pointe Rd Suite B**
Annapolis, MD 21401 **Chester, MD 21619** **Salisbury, MD 21804**
410-571-9000

PERSONAL INFORMATION

FULL NAME: (Mr. Ms. Mrs. Miss Dr.) ____________________

NICKNAME: ____________________ REFERRED BY: ____________________

ADDRESS: ____________________

CITY: ____________________ STATE: ____________________ ZIP CODE: ____________________

HOME PHONE: ____________________ WORK PHONE: ____________________ CELL: ____________________
SOCIAL SECURITY: ____________________ BIRTH DATE: ____________________ AGE: _____ Gender: _____

MARITAL STATUS: Single ___ Married _____ Divorced _____ Widowed _____ Other _____

EMPLOYER NAME: ____________________ OCCUPATION: ____________________
EMPLOYER'S ADDRESS: ____________________

IF A STUDENT: Full-time ___ Part-Time ___ DATE OF GRADUATION: ____________________
NAME OF SCHOOL ATTENDING: ____________________

PRIMARY CARE PHYSICIAN NAME (if different than "Referred by"): ____________________
PERSON TO NOTIFY IN CASE OF EMERGENCY, RELATIONSHIP AND TELEPHONE

____

INSURANCE INFORMATION

PRIMARY INSURANCE: NAME: ____________________
RELATIONSHIP TO INSURED: Self _____ Spouse _____ Child _____ Specify Any Other ____________________
INSURED'S SSN: ____________________ BIRTH DATE: ____________________ GENDER: Male ___ Female ___
INSURED'S EMPLOYER: ____________________ INSUREDS NAME: ____________________
SUBSRIBERS ID#: ____________________ GROUP: ____________________

SECONDARY INSURANCE: NAME ____________________
RELATIONSHIP TO INSURED: Self _____ Spouse _____ Child _____ Specify Any Other ____________________
INSURED'S SSN: ____________________ BIRTH DATE: ____________________ GENDER: Male ___ Female ___
INSURED'S EMPLOYER: ____________________ INSURED'S NAME: ____________________
SUBSCRIBERS ID#: ____________________ GROUP: ____________________

- I ATTEST THAT ALL THE INFORMATION GIVEN HEREWITH IS TRUE AND CORRECT.
- I AGREE TO NOTIFY **THE KAHAN CENTER FOR PAIN MANAGEMENT** OF ANY CHANGE IN NAME, ADDRESS, PHONE NUMBER, EMPLOYMENT STATUS OR INSURANCE COVERAGE.
- I AUTHORIZE RELEASE OF MY MEDICAL RECORDS AND/OR INFORMATION REGARDING MY TREATMENT TO MY PRIMARY CARE OR REFERRING PHYSICIAN(S), AND/OR SPECIALIST PROVIDER TO WHICH **The Kahan Center for Pain Management** MAY REFER ME. I FURTHER ACKNOWLEDGE THAT A COPY OF THIS RELEASE CAN BE USED IN PLACE OF THE ORIGINAL.
- CONSENT TO TREAT A MINOR- SIGNATURE OF LEGAL GUARDIAN(PERMISSION)

PATIENT OR LEGAL GUARDIAN SIGNATURE: ____________________ DATE: ____________________

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FINANCIAL POLICY (REVISED 04/08, 05/09, 06/11,07/12)

In order to avoid any miscommunications regarding payment for service rendered in this office, there are several payment options available as detailed below. Please select your preferred method of payment and sign in the appropriated area.

1. CASH/CHECK/VISA-MASTERCARD

If you choose this option, all fees are due and payable in full at the time services are rendered. At check in $150.00 will be paid towards your visit and when checking out if any further payment is due it will be expected. No exceptions will be made unless discussed with the Office Manager prior to your appointment.

2. MEDICAL INSURANCE

For your convenience, your health insurance can be billed by this office and you will be responsible for any deductible, co-payments, and co-insurance and denied claims. Claims should be paid within 30-45 days of filing by your health insurance carrier. Any claims still outstanding after this time frame will become the financial liability of the policy holder.*(* Subject to limitations on insurance companies that the physicians are contracted with.) All copay's are due at check in.

3. MEDICARE

Since the physicians are Medicare contracted providers, your insurance claim will be filed on your behalf and an assignment of benefits (a statement that the insurance carrier will pay the doctor directly) must be on file. Please Note: Secondary and supplemental insurance policies will be billed for you, as long as the information is provided on your initial visit. Our office would suggest to you to contact Medicare with your secondary/supplemental information, as they will often forward your claims automatically. Please be advised that if you don't have a secondary/supplemental insurance you will be responsible for the co-insurance Medicare assigns.

4. PERSONAL INJURY / AUTO ACCIDENT

The office prefers **not** accept personal injury protection insurance as a method of payment. Nor does this office wait for settlement of claims. If you have health insurance, we will submit your claims on your behalf. If you do not have health insurance our office will supply the insured all necessary forms /documents to get reimbursed from your personal protection insurance (PIP).

5. WORKER'S COMPENSATION

If you are injured on the job, this is considered a worker's compensation case. You are responsible to provide this office with verification from your employer that you were injured on the job as well as all applicable insurance information. Once verification is received, your bill will be sent to the authorized insurance company. (Taking the responsibility of payment off of the patient) REMEMBER, if your employer or you neglect to meet the requirements of the Worker's Compensation Commission and they deny your claim, you are responsible for all charges. If this information is not provided at your initial visit the office will not bill any back dates of service, those claim then become your responsibility.

6. SPECIAL ARRANGEMENT

If you feel that your case is unique or that none of the options above fit your financial situation, please discuss arrangements with the Office Manager prior to being seen by the Doctor.

* ADDITIONAL INFORMATION *

Our office also reserves the right to charge for all missed appointments and appointments cancelled with less than 24 hours notice. Telephone consults / conferences/ Pages between providers and patient are subject to a fee that may not be reimbursable by insurance. There will be a $30.00 fee for all paper work completed by physicians or office staff. Patient balances copay/co-insurances are due at time of service, if payment is missed our office reserved the right to charge a late fee of $10.00 for any unpaid balance on a monthly basis. All past due accounts will be subject to a collection agency

DISCLOSURE

The physicians and/or employees of this practice own interest in providing physical therapy, pain treatment and rehabilitation services at (**The Kahan Center for Pain Management)** (***Suite 150/215***), **Center for Pain Medicine and Physiatric Rehab**, (***Suite 150A/215A***), **Riva Road Surgical Center,LLC** (***Riva Road***), **Deer Pointe Surgery Center**(***Salisbury,MD***) Given notice the above name physicians and/or employees disclose the existence of ownership of the businesses previously mentioned. Under Maryland Law, this disclosure is to inform you of such and that you may choose to obtain the above-described healthcare services from another health care facility. Maryland law further requires that you acknowledge in writing the receipt of the above statement.

I AGREE TO USE PLAN #_____ FOR MY CARE.

By signing below, I agree to the following:

*I authorize the use of this form on all of the insurance submissions.
*I authorize release of information to all my insurance companies.
*I understand I am responsible for my bill.
*I authorize my doctor to act as my agent in helping me obtain payments from my insurance company
*I authorize payment directly to my doctor
*I permit a copy of this authorization to be used in place of the original.

PATIENT OR LEGAL GUARDIAN SIGNATURE

____

DATE

WITNESS SIGNATURE

____

CANCELLATION POLICY

If you cancel an appointment with our office

less than 24 hours notice you will be charged a fee:

Cancellation fees:

New Patient appointment:	$75.00
Office visit:	$ 25.00
Procedure:	$100.00
EMG	$50.00

Effective September 2005

Revised 10/2009

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW THE KAHAN CENTER FOR PAIN MANAGEMENT MAY USE AND DISCLOSE YOUR HEALTHCARE INFORMATION AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Kahan Center for Pain Management is required by law to maintain the privacy of your protected health information. This information consists of all records related to your health, including demographic information, either created by The Kahan Center for Pain Management or received by The Kahan Center for Pain Management from other healthcare providers.

We are required to provide you with our legal duties and privacy practices with respect to your protected health information. These legal duties and privacy practices are described in this Notice. The Kahan Center for Pain Management will abide by the terms of this Notice, or the Notice currently in effect at the time of the use or disclosure of your protected health information.[1]

The Kahan Center for Pain Management reserves the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. Patients will be provided a copy of any revised Notices upon request. An individual may obtain a copy of the current Notice from our office at any time.

Uses and Disclosures of Your Protected Health Information not Requiring Your Consent

The Kahan Center for Pain Management may use and disclose your protected health information, without your written consent or authorization, for certain treatment, payment and healthcare operations. There are certain restrictions on uses and disclosures of treatment records, which included registration and all other records concerning individuals who are receiving, or who at any time have received services for mental illness, developmental disabilities, alcoholism, or drug dependence. There are also restrictions on disclosing HIV test results.

Treatment may include:

- Providing, coordinating, or managing healthcare and related services by one or more healthcare providers;
- Consultations between healthcare providers concerning a patient;
- Referrals to other providers for treatment;
- Referrals to nursing homes, foster care homes, or home health agencies

For example, The Kahan Center for Pain Management may determine that you require the services of a specialist. In referring you to another doctor, The Kahan Center for Pain Management may share or transfer your healthcare information to that doctor.

Payment activities may include:

- Activities undertaken by The Kahan Center for Pain Management to obtain reimbursement for services provided to you;
- Determining your eligibility for benefits or health insurance coverage;
- Managing claims and contacting your insurance company regarding payment;
- Collection activities to obtain payment for services provided to you;
- Reviewing healthcare services and discussing with your insurance company the medical necessity of certain services or procedures, coverage under your health plan, appropriateness of care, or justification of charges;
- Obtaining pre-certification and pre-authorization of services to be provided to you.

For example, The Kahan Center for Pain Management will submit claims to your insurance company on your behalf. This claim identifies you, your diagnosis, and the services provided to you.

Healthcare operations may include

- Contacting healthcare providers and patients with information about treatment alternatives;
- Conducting quality assessment and improvement activities;
- Conducting outcomes evaluation and development of clinical guidelines;
- Protocol development, case management, or care coordination;
- Conducting or arranging for medical review, legal services, and auditing functions.

For example, The Kahan Center for Pain Management may use your diagnosis, treatment, and outcome information to measure the quality of the services that we provide, or assess effectiveness of your treatment when compared to patients in similar situations.

The Kahan Center for Pain Management may contact you, by telephone or mail, to provide appointment reminders. You must notify us if you do not wish to receive appointment reminders.

We may not disclose your protected health information to family members or friends who may be involved with your treatment or care without your written permission. Health information may be released without written permission to a parent, guardian, or legal custodian of a child; the guardian of an incompetent adult; the healthcare agent designated in an incapacitated patient's healthcare power of attorney; or the personal representative or spouse of a deceased patient.

There are additional situations when The Kahan Center for Pain Management is permitted or required to use or disclose your protected health information without your consent or authorization. Examples include the following:

- As permitted or required by law.
  In certain circumstances we may be required to report individual health information to legal authorities, such as law enforcement officials, court officials, or government agencies. For example, we may have to report abuse, neglect, domestic violence or certain physical injuries. We are required to report gunshot wounds or any other wound to law enforcement officials if there is reasonable cause to believe that the wound occurred as a result of a crime.
- For public health activities.
  We may release healthcare records, with the exception of treatment records, to certain government agencies or public health authority authorized by law, upon receipt of written request from that agency. We are required to report positive HIV test results to the state epidemiologist. We may also disclose HIV test results to other providers or persons when there has been or will be risk of exposure.

We may report to the state epidemiologist the name of any person known to have been significantly exposed to a patient who tests positively for HIV. We are required by law to report suspected child abuse and neglect and suspected abuse of an unborn child, but cannot disclose HIV test results in connection with the reporting or prosecution of alleged abuse or neglect. We may release healthcare records, including treatment records and HIV test results, to the Food and Drug Administration when required by federal law. We may disclose healthcare records, except for HIV test results, for the purpose of reporting elder abuse or neglect, provided the subject of the abuse or neglect agrees, or if necessary to prevent serious harm. Records may be released for the reporting of domestic violence if necessary to protect the patient or community from imminent and substantial danger.

- For health oversight activities.
  We may disclose healthcare records, including treatment records, in response to a written request by any federal or state governmental agency to perform legally authorized functions, such as management audits, financial audits, program monitoring and evaluation, and facility or individual licensure or certification. HIV test results may not be released to federal or state governmental agencies, without written permission, except to the state epidemiologist for surveillance, investigation, or to control communicable diseases.

- Judicial and Administrative Proceedings.
  Patient healthcare records, including treatment records and HIV test results, may be disclosed pursuant to a lawful court order. A subpoena signed by a judge is sufficient to permit disclosure of all healthcare records except HIV test results.

- For activities related to death.
  We may disclose patient healthcare records, except for treatment records, to a coroner or medical examiner for the purpose of completing a medical certificate or investigating a death. HIV test results may be disclosed under certain circumstances.

- For research.
  Under certain circumstances, and only after a special approval process, we may use and disclose your health information to held conduct research.

- To avoid a serious threat to health or safety.
  We may report a patient's name or other relevant data to the Department of Transportation if it is believed the patient's vision or physical or mental condition affects the patient's ability to exercise reasonable or ordinary control over a motor vehicle. Healthcare information, including treatment records and HIV test results, may be disclosed where disclosure is necessary to protect the patient or community from imminent or substantial danger.

- For worker's compensation.
  We may disclose your health information to the extent such records are reasonably related to any injury for which workers compensation is claimed.

The Kahan Center for Pain Management will not make any other use or disclosure of your protected health information without your written authorization. You may revoke such authorization at any time, except to the extent that The Kahan Center for Pain Management has taken action in reliance thereon. Any revocation must be in writing.

<u>Your Rights Regarding Your Protected Health Information</u>

You are permitted to request that restrictions be placed on certain uses or disclosures of your protected health information by The Kahan Center for Pain Management to carry out treatment, payment or healthcare operations. You must request such a restriction in writing. We are not required to agree to your request, but if we do agree, we must adhere to the restriction, except when your protected health information is needed in an emergency treatment situation. In this event, information may be disclosed only to healthcare providers treating you. Also a restriction would not apply when we are required by law to disclose certain healthcare information.

You have the right to review and/or obtain a copy of your healthcare records, with exception of psychotherapy notes, or information compile for use (or in anticipation for use) in a civil, criminal, or administrative action or proceeding. The Kahan Center for Pain Management may deny an access under other circumstances, in which case you have the right to have such a denial reviewed. We may charge a reasonable fee for copying your records.

You may request that The Kahan Center for Pain Management send protected health information, including billing information, to you by alternative means or to alternative locations. You may also request that The Kahan Center for Pain Management not send information to a particular address or location or contact you at a specific location, perhaps your place of employment. This request must be submitted in writing. We will accommodate reasonable requests for you.

You have the right to request that The Kahan Center for Pain Management amend portions of your healthcare records, as long as such information is maintained by us. You must submit this request in writing, and under certain circumstances the request may be denied.

You may request to receive an accounting of the disclosures of your protected health information made by The Kahan Center for Pain Management for the six years prior to the date of the request, beginning with disclosures made after April 14, 2003. We are not required, however, to record disclosures we make pursuant to a signed consent or authorization.

You may request and receive a paper copy of this Notice, if you had previously received or agreed to receive the Notice electronically.

Any person or patient may file a complaint with The Kahan Center for Pain Management and/or the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with The Kahan Center for Pain Management , please contact the Privacy Officer at the following:

Privacy Officer
Brian S. Kahan, DO, PA / The Kahan Center for Pain Management
2002 Medical Parkway, Suite 150
Annapolis, MD 21401
(410) 571-9000

It is the policy of The Kahan Center for Pain Management that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance or violation of the privacy standards.

This Notice of Privacy Practices is effective April 14, 2003

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ______________________________ acknowledge that I have received a copy o
(Name of Patient)

Center for Pain Medicine & Physiatric Rehabilitation's Notice of Privacy Practices. This Notic describes how Center for Pain Medicine & Physiatric Rehabilitation may use and disclose m protected health information, certain restrictions on the use and disclosure of my healthcar information, and rights I may have regarding my protected health information.

____

(Signature of Patient, or Personal Representative) (Date)

____

(Relationship to Patient)

HIPAA

NEW PATIENT INFORMATION FORM

PATIENT NAME: ________________________________ **DATE:** ____________________

HISTORY

CHIEF COMPLAINT:____

HISTORY of PRESENT ILLNESS: ***For an "Extended" history, document at least 4 of these elements**

***Location**__________________________
(Where is the pain/problem (ex: back,neck,knee ?)

***Quality**______________________________
How does it feel(ex. Sharp,dull,aching,stabbing)

***Severity**__________________________
(How severe is the pain/problem ex:mild/moderate ?)

***Duration**____________________________
(How long have you had this pain/problem or date of onset?)

***Timing**__________________________
(Does this pain/problem occur at a specific time?)

***Context:** ____________________________
(Where were you at the onset of this pain/problem?)
(Has this injury resulted in a lawsuit)__________

***Associated symptoms:** ____________________
(Ex: numbness/walking difficulty)

***Modifying factors:** ______________________
(What makes the pain/problem worse or better?)

MEDICAL HISTORY *For a "Pertinent" history - **at least 1 specific item for ANY ONE of the 3 histories**
* For a "Complete" history - **at least 1 specific item for EACH ONE of the 3 histories**

***Patient medical history**

Diabetes	No	Yes
Hypertension.	No	Yes
Cancer	No	Yes type:_________
Stroke	No	Yes
Heart Trouble	No	Yes
Arthritis/Gout(circle)	No	Yes
Bleeding Tendency	No	Yes
Stomach Problems (ex:GERD/ulcer)	No	Yes

Previous Hospitalizations/Surgeries/Injuries
____
____
____
(Previous Work / Auto injuries)

Medications
1)______________ 2)______________
3)______________ 4)______________
5)______________ 6)______________

*** Patient Social History**

Who Do you Live with:________________ **Are you able to take care of yourself:** _____
Marital Status: Single _____ Married_____Separated_____Divorced_____Widowed_____
Use of Alcohol:Never _____ Rarely _____Moderate _____Daily_______No. Drinks_______
Use of Tobacco:Never _____ Previously, but quit (packs/years) _____Current Packs/Day______
Use of Drugs:Never _____Type/Frequency:_________ Past/ Current ___History of Abuse:_______
Excessive exposure at home or work to:Fumes ___Dust ___Solvents __Air-borne particles___Noise
Employment: ____

***Family Medical History**

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			

Review of Systems

*Constitutional Symptoms

Good general health	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

*Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lens	No	Yes
Blurred vision/double vision	No	Yes
Glaucoma	No	Yes

*Ears/Nose/Mouth/Throat

Hearing loss or ringing	No	Yes
Earaches or damage	No	Yes
Chronic sinus problems	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Swollen glands	No	Yes

*Cardiovascular

Heart trouble/attack	No	Yes
Chest pain/angina	No	Yes
Shortness of breath with walking	No	Yes
Swelling of feet/ankles/hands	No	Yes

*Respiratory

Chronic or frequent coughs	No	Yes
Spitting up of blood	No	Yes
Shortness of breath	No	Yes
Asthma/wheezing	No	Yes

*Gastrointestinal

Loss of appetite	No	Yes
Change in bowel habits	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Rectal bleeding/blood in stool	No	Yes
Abdominal pain/heartburn	No	Yes
Peptic ulcer	No	Yes

*Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Difficulty starting/stopping	No	Yes
Incontinence	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male-testicular pain	No	Yes
Female- pain with periods	No	Yes
Female- irregular periods	No	Yes
Female- vaginal discharge	No	Yes

Female- #pregnancies_____ #miscarriages

Female- date of last PAP smear__________

*Musculoskeletal

Joint pain	No	Yes
Joint stiffness/swelling	No	Yes
Weakness of muscles or joints	No	Yes
Muscle pain or cramps	No	Yes
Back pain	No	Yes
Neck pain	No	Yes
Cold extremities	No	Yes
Difficulty in walking	No	Yes

*Integumentary (skin, breast)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes
Breast cancer	No	Yes

*Neurological

Frequent or recurring headaches	No	Yes
Light headed or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

*Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Insomnia	No	Yes
Depression	No	Yes

*Endocrine

Glandular or hormone problem	No	Yes
Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst or urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dryer	No	Yes
Change in hat or glove size	No	Yes

*Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes
Enlarged glands	No	Yes

*Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine, Demerol, narcotics	No	Yes
Novocaine or anesthesia	No	Yes
Aspirin or other pain remedies	No	Yes
Other drugs or foods	No	Yes

DO/MD signature:________

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 past? (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").

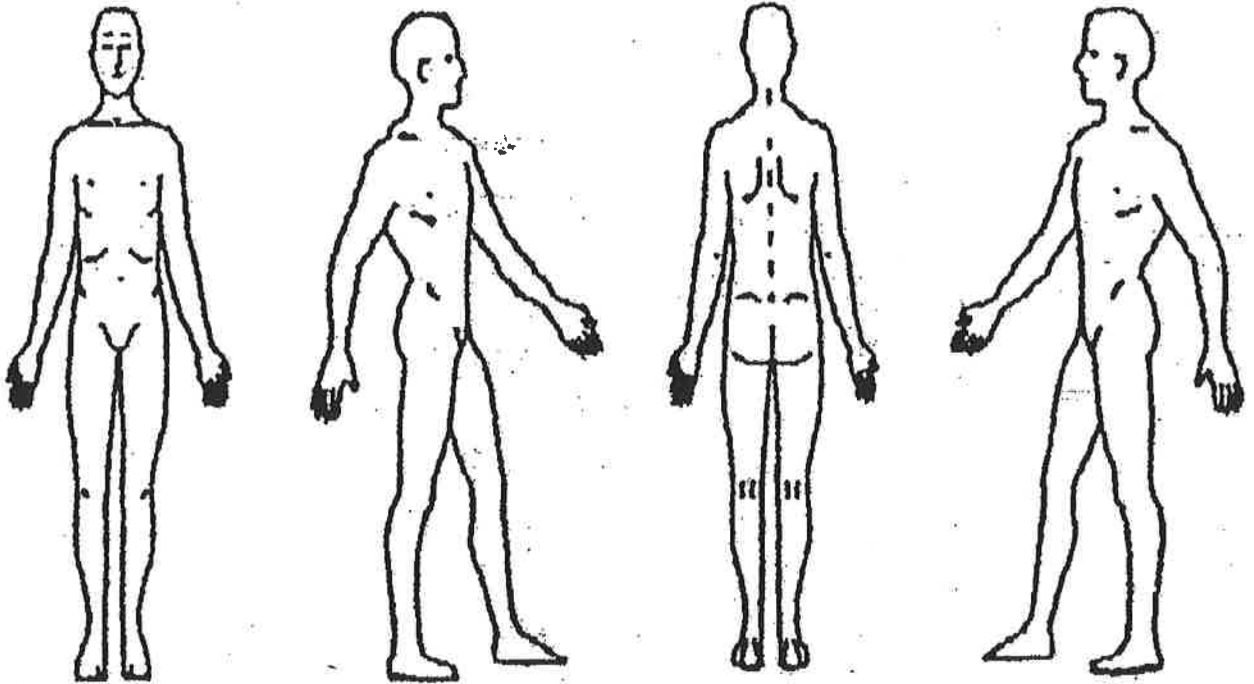
Alcohol _______	Barbiturates _______	Cocaine _______
Heroin _______	Amphetamines _____	Marijuana _______
Other _______ (specify)	Other _______ (specify)	Other _______ (specify)

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 <u>interfered</u> 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