California Pain Consultants
New Patient Intake Form

Demographic Information

Name:_____ DOB:_____

Appointment Date:_____ Appointment Location:_____

Gender: □ Male □ Female Height:_____(inches) Weight:_____(lbs)

Home Address
Street, City, State, Zip:_____

Preferred Phone:_____ □ Cell □ Landline

Secondary Phone:_____ □ Cell □ Landline

Email:_____

Emergency Contact Name:_____

Phone:_____Relationship:_____

Insurance Information

Insurance Name:_____Subscriber ID:_____

Secondary Ins:_____Subscriber ID:_____

Are you the primary subscriber □ Yes □ No Subscriber Name if NO_____

I hereby authorize my insurance company to pay my insurance benefits directly to Zachary Cohen MD, or to his corporation. I understand that I am responsible for any of my own non-covered services, co-pays, co-insurance and or deductibles for services rendered. I authorize the provider to release any information required to process claims in accordance with HIPAA. Please note: We collect all co-pays and deductibles before billing insurance. We are committed to providing quality services. Therefore, you may be electronically contacted by the business. This contact may come via text or email. You can opt out of this experience at any time.

Patient Signature_____Date_____

Onset of Symptoms and Reason for Visit Today

1 - When did this pain begin?

_____

2 - What caused your current pain or injury?

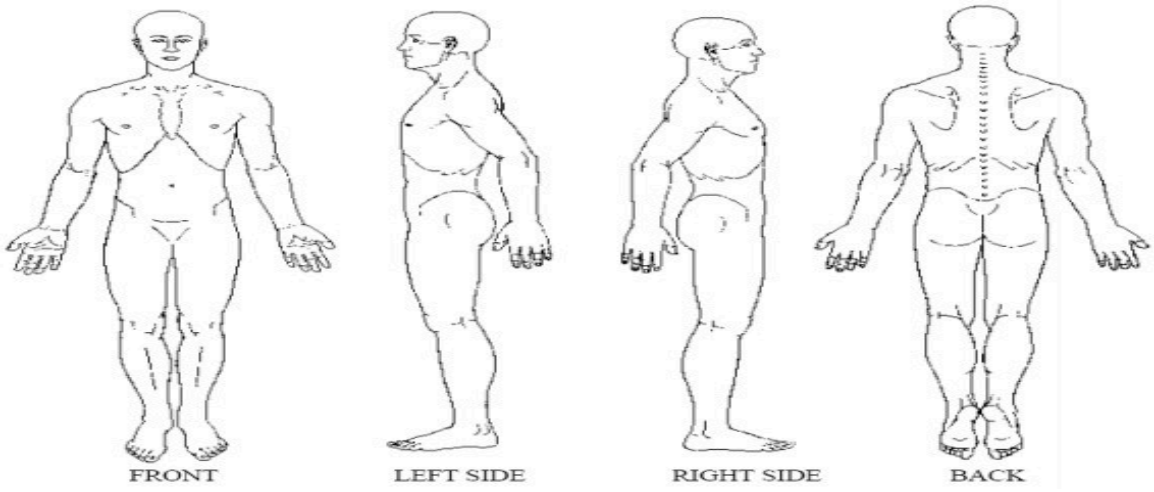
_____

3 - Was the pain or injury due to a motor vehicle accident or personal injury? ☐ Yes ☐ No

Describe Your Pain

Use the diagram below to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N"umbness, "P"ins and Needles, "A"ching, "S"tabbing, "B"urning



4 - What is your current pain level right now? _____ out of 10

5 - What is your pain when it is at its worst? _____ out of 10

6 - Where is your worst area of pain located?_____

7 - Does the pain radiate (starts in one spot, but is felt in other areas as well)? ☐ Yes ☐ No

7a - If Yes, where? ☐ Up ☐ Down the _____ to the _____

8 - Please list additional areas of pain, if any: _____

Describe your Pain - Continued

9 - What word best describes the frequency of your pain? □ Constant □ Intermittent

10 - Since your pain began, has your pain: □ Increased □ Decreased □ Stayed the Same

11 - When is your pain at its worst? □ Mornings □ During the Day □ Evenings □ At Night

12 - Please check all that describe your pain *today*: □ Aching □ Hot/Burning □ Spasms □ Throbbing □ Cold □ Numb □ Squeezing □ Cramping □ Tingling/Pins and Needles □ Shock-like □ Stabbing/Sharp □ Tiring/Exhausting □ Dull □ Shooting

Factors that Affect your Pain

13 - Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down? □ Yes □ No

13a - If Yes, is your pain also alleviated with bending forward (using a shopping cart, leaning on kitchen counter, etc.? □ Yes □ No

14 - Please indicate any factors that affect your pain in the list below:

	Increase	Decrease	No Change		Increase	Decrease	No Change
a) Bending Backward	□	□	□	i) Looking Forward	□	□	□
b) Bending Forward	□	□	□	j) Looking Downward	□	□	□
c) Change in Weather	□	□	□	k) Looking to Side	□	□	□
d) Climbing Stairs	□	□	□	l) Lying Down	□	□	□
e) Cold	□	□	□	m) Sitting	□	□	□
f) Coughing/Sneezing	□	□	□	n) Standing	□	□	□
g) Heat	□	□	□	o) Walking	□	□	□
h) Lifting Objects	□	□	□				

Activity

15 - How many days per week do you exercise? _____

16 - Type of Exercise: _____

17 - Does your pain interfere with any of the following?

a) ☐ Work

b) ☐ School

c) ☐ Home duties

d) ☐ Daily living

e) ☐ Recreational Activities

Diagnostic Tests & Imaging - *Please mark all of the following tests that you have had related to your current pain:*

18 - MRI of the _____ Date: _____ Facility_____

19 - X-ray of the _____ Date: _____ Facility_____

20 - CT of the _____ Date: _____ Facility_____

21 - EMG/NCV of the _____ Date: _____ Facility_____

22 - Other _____ Date: _____ Facility_____

Pain Treatment History - *Please mark the following pain treatments you have undergone PRIOR to today's visit:*

23 - **Chiropractic Therapy** ☐ Yes ☐ No

# of weeks: _____ Date range: _____ Facility: _____

Relief experienced: ☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Execellent Relief

24 - **Home Exercise Program** ☐ Yes ☐ No

# of weeks: _____ Date range: _____ Facility: _____

Relief experienced: ☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Execellent Relief

25 - **Physical Therapy** ☐ Yes ☐ No

# of weeks: _____ Date range: _____ Facility: _____

Relief experienced: ☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Execellent Relief

26 - **Other** _____ ☐ Yes ☐ No

# of weeks: _____ Date range: _____ Facility: _____

Relief experienced: ☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Execellent Relief

27 - **Medication: Anti-inflammatory** ☐ Yes ☐ No

# of weeks: _____ Date range: _____ Name: _____

Relief experienced: ☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Execellent Relief

28 - **Medication: Muscle Relaxant** ☐ Yes ☐ No

# of weeks: _____ Date range: _____ Name: _____

Relief experienced: ☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Execellent Relief

29 - **Medication: Other** ☐ Yes ☐ No

# of weeks: _____ Date range: _____ Name: _____

Relief experienced: ☐ No Relief ☐ Minimal Relief ☐ Moderate Relief ☐ Execellent Relief

Pain Treatment History - Continued

30 - Interventions: Hip/Shoulder Joint Injection/Block ☐ Yes ☐ No

Type/Details:_____

Date: _____ % Relief: _____ Relief Duration: _____

31 - Interventions: Peripheral Joint Injection/Block ☐ Yes ☐ No

Type/Details:_____

Date: _____ % Relief: _____ Relief Duration: _____

32 - Interventions: Epidural ☐ Yes ☐ No

Type/Details:_____

Date: _____ % Relief: _____ Relief Duration: _____

33 - Interventions: Medial Branch / Facet Block and/or RFA ☐ Yes ☐ No

Type/Details:_____

Date: _____ % Relief: _____ Relief Duration: _____

34 - Interventions: SI Joint ☐ Yes ☐ No

Type/Details:_____

Date: _____ % Relief: _____ Relief Duration: _____

35 - Interventions: Spinal Cord Stimulator ☐ Yes ☐ No

Type/Details:_____

Date: _____ % Relief: _____ Relief Duration: _____

36 - Interventions: Other

Type/Details:_____

Date: _____ % Relief: _____ Relief Duration: _____

Current Medications

37 - Are you taking a prescribed blood-thinner? □ Yes:_____ □ No

37a - Name/phone of the prescribing provider: _____

38 - Please list ALL medications you are currently taking, including: OTC medication, ibuprofen, aspirin and fish oil. Attach additional sheets if necessary.

38a - Name/Dose/Frequency: _____

38b - Name/Dose/Frequency: _____

38c - Name/Dose/Frequency: _____

38d - Name/Dose/Frequency: _____

38e - Name/Dose/Frequency: _____

38f - Name/Dose/Frequency: _____

Allergies

39 - Do you have any allergies? □ Yes (see below) □ No Known Allergies

39a - Name & Reaction: _____

39b - Name & Reaction: _____

39c - Name & Reaction: _____

40 - Are you allergic to any of the following?

40a - Iodine □ Yes □ No

40b - Tape □ Yes □ No

40c - Latex □ Yes □ No

40d - X-Ray Contrast □ Yes □ No

Past Medical History / Problem List

41 - Are you currently pregnant? □ Yes □ No

42 - Are you post-menopausal? □ Yes □ No

43 - Do you plan on becoming pregnant? □ Yes □ No

44 - Have you had two or more falls in the last year? □ Yes □ No

45 - Have you received a pneumonia vaccination? □ Yes (date) _____ □ No

46 - Have you been diagnosed with hypertension? □ Yes □ No

47 - Please mark all conditions/diseases that you have been DIAGNOSED with:

□ a) Asthma
□ b) Cancer, type_____
□ c) Diabetes, type_____
□ d) Emphysema/COPD
□ e) Epilepsy
□ f) Fibromyalgia
□ g) Heart Disease
□ h) Hepatitis, type_____
□ i) HIV/AIDS
□ j) High Blood Pressure
□ k) Kidney Disease
□ l) Lupus
□ m) Migraines
□ n) Osteoarthritis/Osteoporosis
□ o) Peripheral Vascular Disease
□ p) Shingles
□ q) Sleep Apnea
□ r) Stroke
□ s) Other_____

□ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

Past Surgical History

48 - Do you currently have an implanted ICD, Pacemaker, or Defibrillator? □ Yes □ No

49 - Please list prior surgeries/procedures in the table below. Attach an additional sheet if necessary.

□ **I HAVE NO SIGNIFICANT SURGICAL HISTORY**

49a - Name/Date/Provider: _____

49b - Name/Date/Provider: _____

49c - Name/Date/Provider: _____

49d - Name/Date/Provider: _____

Family History

50 - Please mark all appropriate diagnoses as they pertain to your BIOLOGICAL family members:

□ a) Anxiety

□ b) Depression

□ c) Cancer

□ d) Diabetes

□ e) Headaches

□ f) Heart Disease/Stroke

□ g) High Blood Pressure

□ h) Kidney Problems

□ i) Liver Problems

□ j) Rheumatoid Arthritis

□ k) Seizures

□ l) Substance Abuse

□ **I HAVE NO SIGNIFICANT FAMILY HISTORY**

□ **I AM ADOPTED (No Medical History Available)**

Social History

51 - Smoking: ☐ Daily ☐ Weekly ☐ Former ☐ Never

52 - Alcohol: ☐ Daily ☐ Weekly ☐ Former ☐ Never

53 - Marijuana: ☐ Daily ☐ Weekly ☐ Former ☐ Never

54 - Illegal Drugs: ☐ Daily ☐ Weekly ☐ Former ☐ Never _____

55 - Narcotic and Prescription Medications: I have abused narcotic/prescription medications:

☐ Yes _____ ☐ No

Review of Systems - *Please mark all of the following symptoms that you CURRENTLY suffer from:*

56 - Constitutional: ☐ Chills ☐ Difficulty Sleeping ☐ Fatigue ☐ Fevers ☐ Night Sweats

57 - Cardiovascular/Respiratory: ☐ Chest Pain ☐ Cough ☐ Difficulty Breathing

☐ Fainting ☐ High Blood Pressure ☐ Swelling in the Feet

58 - Gastrointestinal: ☐ Constipation ☐ Dark/Tarry Stool ☐ Diarrhea ☐ Nausea/Vomiting

59 - Genitourinary/Nephrology: ☐ Blood in Urine ☐ Involuntary Urination ☐ Loss of Bowel Control

☐ Painful Urination ☐ Pelvic Pressure

60 - Eyes/Ears/Nose/Throat/Neck: ☐ Diffculty Hearing ☐ Earaches ☐ Hay fever/Allergies

☐ Nosebleeds ☐ Recent Visual Changes ☐ Ringing in the Ears ☐ Sinus Problems

61 - Neurological: ☐ Dizziness ☐ Headaches ☐ Instability When Walking

☐ Numbness/Tingling ☐ Weakness

62 - Psychiatric: ☐ Anxiety/Stress ☐ Depressed Mood ☐ Suicidal Thoughts ☐ Suicidal Planning

63 - Musculoskeletal: ☐ Back Pain ☐ Joint Pain ☐ Neck Pain

California Pain Consultants

HIPAA & Third Party Consent Form - Notice of Privacy Practices

To help us prepare for your visit and coordinate the best possible care, our practice partners with technology service providers to securely gather your relevant medical records. By agreeing, you authorize our practice and our designated technology partners to access and use your protected health information. This includes retrieving your medical history, medications, lab results, and other clinical data from other healthcare providers, pharmacies, and health information networks. This information will be compiled into a summary for your care team to review and will only be used for the purposes of your treatment. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights sections describing your patient rights under the law. You have a right to review this notice before signing the consent. The terms of the notice may change, and if this should occur, you may receive a revised copy by contacting the office. **Your data is always handled in accordance with HIPAA.**

Why Your Permission is Important

Authorizing Third Party vendors to support your care team allows us to:

- **Streamline Your Care:** We help ensure your provider has the necessary information when they need it, creating a more seamless and efficient healthcare experience for You.
- **Enhance Care Quality and Safety:** By facilitating access to a more complete health history, we help your care team make well-informed decisions and avoid potential medication conflicts or redundant tests.
- **Enable Advanced Support:** Your consent allows us to provide a spectrum of services to your doctor, from organizing your medical history to supporting clinical consultations and other activities that contribute to your treatment.

To enable California Pain Consultants to provide these care support services for you and your provider, your authorization is required.

Patient Initials:_____

California Pain Consultants

HIPAA & Third Party Consent Form - Notice of Privacy Practices

Authorization for Use of Health Information

Providing your consent means you authorize California Pain Consultants and its partners to access, use, and manage your Protected Health Information (PHI) to facilitate your medical care.

- **What information may be accessed?** This may include any and all of your health information needed for your treatment, such as your medical history, diagnoses, medications, lab results, and other clinical or demographic data.
- **Where may this information come from?** We securely retrieve this information from your other healthcare providers, clinics, hospitals, pharmacies, and through secure networks known as Health Information Exchanges (HIEs).
- **Who will see this information?** Your information will be accessible to your treating provider and their authorized care team. Third party utilization team members and portals may access your information only as needed to provide and support our services to your care team.
- **How will your information be used?** Your health information will be used to provide services that support your provider in your treatment. These services may include organizing your medical records, creating clinical summaries, facilitating specialist consultations, and enabling other clinical support activities. ***We will never sell your identifiable information***

To help improve healthcare for everyone, we may use or share de-identified information (from which all personal details have been removed) for research, analytics, and service improvement.

Patient Initials:_____

California Pain Consultants

HIPAA & Third Party Consent Form - Notice of Privacy Practices

Your Rights: Privacy, Control & Communication

You are always in control of your information.

- **Control Your Data**: You can revoke this authorization at any time by emailing us at support@californiapain.com. Revoking your authorization is not retroactive but will stop all future activities on your behalf. You may also request the deletion of the data we have collected for you by contacting the same email address.
- **Identity & Communications:** To protect your privacy, we may ask you to verify your identity before acting on a request to revoke authorization or delete data. We will also send you text or email updates related to your requests. Standard message rates may apply, and you can opt out of non-essential messages at any time.
- **Effective Period:** This authorization does not expire. It will remain in effect until you choose to revoke it, unless a shorter period is required by state law.

For a complete list of California Pain Consultants third party vendors, you may ask your clinic staff to provide you the most up to date list at any time. This list will be provided as an attachment to this document. By signing below, I acknowledge that I have read, understand, and agree to the terms and conditions outlined above. I hereby authorize California Pain Consultants and select third party vendors to access, use, and manage your Protected Health Information (PHI) to facilitate your medical care. By signing this form, you consent to our use and disclosure of PHI about you for treatment, payment, or healthcare operations. You have a right to revoke this consent in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in relation to you on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Printed Name:_____

Patient Signature:_____

Date:_____

CALIFORNIA PAIN CONSULTANTS

5395 RUFFIN ROAD STE 204 - SAN DIEGO, CA 92123 ● 5360 JACKSON DRIVE STE 100 - LA MESA, CA 91942
750 MEDICAL CTR CT STE 14B - CHULA VISTA, CA 91911 ● 16466 BERNARDO CTR CT STE 150 - SAN DIEGO, CA 92128
Phone: (858) 571-3630 ● Fax: (858) 295-3948

OFFICE POLICIES & PATIENT RESPONSIBILITIES

Thank you for choosing California Pain Consultants. Please review and sign below as acknowledgement of your responsibilities as a patient for our specialized services.

Our office hours are Monday - Friday 7:50am to 4:45pm
We are closed every day for lunch from 11:50 to 12:50

⚫**Copays: All copays are due at the time of service.** Our office accepts cash and all major credit cards. When paying with cash, please bring the exact amount as our office does not carry any change. Our office does not accept checks. Please note: California Pain Consultants is a specialist office. Therefore, your co-pay may differ from your normal primary care office visits.

⚫**Phone Calls**: **Please limit your phone calls and requests to a maximum of 2 phone calls per day**. If your call goes to our voicemail: Please leave a detailed message with your name, DOB, and phone number. We will return your voicemail within 1 business day.

We are not able to provide walk-in services to patients - No Exceptions.

⚫**Appointment Policy**: **If you are not able to make your scheduled appointment, please call the office at least 24 hours in advance**. If you don't show up to your appointment and don't notify us, it will be considered a "no-show". If you reschedule your appointment less than 24 hours from the scheduled time, this will be considered a "late-reschedule". **If you arrive more than 15 minutes after your scheduled appointment time, your appointment will need to be rescheduled and will be considered as a "late-reschedule" occurrence.**

"Late-reschedules/cancellations" and/or "no-shows" will incur a fee of $50 for office visits, $150 for injections that must be paid prior to your next appointment.

If you have frequent "late-reschedules/cancellations" and/or "no-shows": You will be redirected back to your referring clinic for new pain management.

Patient Name:_____ Initials:_____ Date:_____

⚫**In the untimely event of an emergency**: California Pain Consultants does not have an on-call doctor, so please be aware that we will not be able to accommodate you on an emergency basis. Go to the nearest Urgent Care, Emergency Room, or call for 911 Emergency Services.

⚫**Prescription Requests**: All pharmacy requests outside of your scheduled appointment time may take up to 24 to 48 hours to process. If a prior authorization is needed, this time may increase. Please note: Our office will only process prior authorizations for opiate medications.

⚫**Lost/Stolen Medications**: California State Law requires a police report to be filed and on-hand in order to refill lost/stolen medication. There is no exception to this rule. Please use safe storage and cautious handling of your medications.

⚫**Medical Records/Documents**: A flat processing fee of $35.00 will apply to all requests for Medical Records from: The Patient, an Attorney (excluding work comp attorneys), a Copy Service, or Social Security. Any packets over 20 pages will be an additional $1 per page. If you bring an unopened USB, only the flat rate will apply. Releases to doctor's offices are free of charge. Any FMLA, DMV Placard, or EDD Documents will need to be reviewed and accepted by the provider before our office will fill it out. FMLA & EDD documents: $75. DMV documents: $50. All records and document requests must be prepaid and have a turnaround time of at least 10 business days.

⚫**Children**: Please plan to make appropriate child care accommodations for your child (under 18) during injection appointments. We will not be able to provide childcare services during these encounters.

⚫**Acceptable Behavior**: Our staff and providers work diligently to help every patient under our care. Please treat our staff, providers, and fellow patients with decency and respect. During your visit and in the lobby, please refrain from any form of harassment, bullying, assault, or other behavior deemed to be inappropriate within the confines of our offices or in communications with our office. Should any untoward behavior take place, you will be discharged from the office and, if necessary, the proper authorities will be contacted.

I have read, understand, and agree to abide by the office policies detailed on pages 1 and 2. My signature below indicates that I understand and agree to abide by these policies.

_____ _____

Patient / Responsible Party - *Print and Sign* **Date**

PATIENT-PHYSICIAN ARBITRATION AGREEMENT

ARTICLE 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contractual agreement were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contractual agreement, by entering into it, are giving up their constitutional right to have such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

ARTICLE 2: I understand and agree that this Arbitration Agreement binds me and anyone else who may have a claim arising out of or related to all treatment or services provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn at the time of the occurrence giving rise to any claim. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress, or punitive damages. I further understand and agree that if I sign this Agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound by this Agreement, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this Agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete resolution of any dispute arbitrated under this Agreement, as set forth in the Medical Arbitration Rules of the California Medical Association and the California Hospital Association.

ARTICLE 3: I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: On behalf of myself and all others bound by this Agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Medical Association and the California Hospital Association, as they may be amended from time to time, which Rules are hereby incorporated into this Agreement. A copy of these Rules is included in the pamphlet in which this Agreement is found. Additional copies of the Rules are available from the California Medical Association, 1201 J Street, Suite #200 Attention: Publication Department, Sacramento, CA 95814 or at www. cmanet.org. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

ARTICLE 5: OPTIONAL: RETROACTIVE EFFECT If I intend this Agreement to cover services rendered before the date this Agreement is signed (for example, emergency treatment), I have indicated the earlier date ▶ intend this Agreement to be effective from as confirmed by my initials immediately below.

Earlier effective date:_____ Patient's Initials:_____

ARTICLE 6: I have read and understand all of the information in this pamphlet, including the Introduction to the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY SIGNING THIS CONTRACTUAL AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS AGREEMENT.

_____ _____

(Patient, Parent, Guardian or Legally Authorized Representative of Patient) Dated

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

I agree to be bound by the terms set forth in this Agreement and in the Rules specified in Article 5 above.

_____Dated: _____

(Physician or Duly-Authorized Representative)

The Sunshine Act and Open Payments

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

This data is published annually in a database known as Open Payments. The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I hereby acknowledge that I have been offered a copy of California Pain Consultants notice of Open Payments. I have been advised that a copy of the notice is posted in the reception area and a copy of this acknowledgement will be placed in my chart.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

PATIENT NAME (please print) _____ PATIENT DATE OF BIRTH _____

Name:_____ DOB:_____

Date:_____

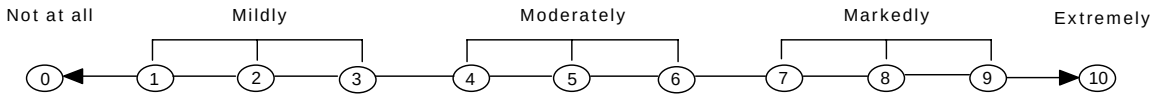
SHEEHAN DISABILITY SCALE

A BRIEF, PATIENT RATED, MEASURE OF DISABILITY AND IMPAIRMENT

Please mark ONE circle for each scale.

WORK* / SCHOOL

The symptoms have disrupted your work / school work:

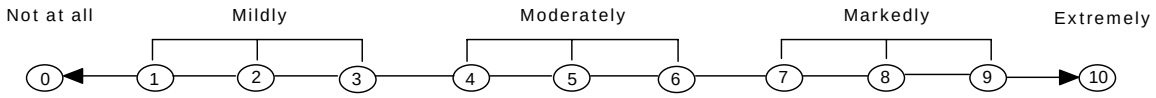


☐ I have not worked /studied at all during the past week for reasons unrelated to the disorder.

* Work includes paid, unpaid volunteer work or training

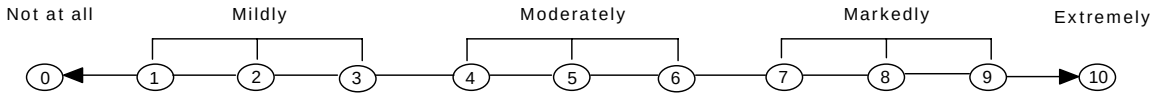
SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:



DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNDERPRODUCTIVE

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? _____

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OPIOID RISK TOOL (ORT)

Patient Name: _____DOB:_____

Date:_____

			Mark each Box that applies	Item Score *Female*	Item Score *Male*
1 Family History of Substance Abuse		Alcohol	[ ]	1	3
		Illegal Drugs	[ ]	2	3
		Prescription Drugs	[ ]	4	4
2 Personal History of Substance Abuse		Alcohol	[ ]	3	3
		Illegal Drugs	[ ]	4	4
		Prescription Drugs	[ ]	5	5
3 Age: _____ **Mark Box if 16-45**			[ ]	1	1
4 History of Preadolescent Sexual Abuse			[ ]	3	0
5 Psychological Disease	A.	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	B.	Depression	[ ]	1	1
			TOTAL:	_____	_____

Reference: Webster LR Predicting aberrant behaviors in opioid-treated patients. Preliminary validation of the opioid risk tool. Pain Medicine 2005;6(6): 432-442. Used with permission.