Name: DOB:

ColumbiaDoctors

Adult New Patient Intake Form

Patient Information

Last Name: _____ First Name: _____ DOB: _____

Gender: _____ Home Phone: _____ Mobile Phone: _____

Preferred Phone: Home or Mobile (circle one) Email: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____ Patient Marital Status: _____

Occupation: _____ Employer: _____

Primary Care Provider (PCP): _____ PCP Phone: _____

Referring Provider: _____ Referring Phone: _____

Preferred Pharmacy: _____ Pharm Phone: _____

Preferred Pharmacy Address: _____

Please list ALL active treating physicians (i.e. pulmonologist, oncologist, internist, cardiologist, etc…)

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Doctor's Name: _____ Specialty: _____

Collection of the following information is encouraged by federal health agencies. This information is used to monitor and improve the quality of care provided to all patients.

Ethnicity:

- □ Decline Response
- □ Hispanic or Latino
- □ Not Hispanic or Latino

Race:

- □ Decline Response
- □ American-Indian or Alaska Native
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Pacific Islander
- □ White
- □ Other

Preferred Language:

- □ Decline Response

Patient Financial Obligation Agreement

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company. I authorize my insurance benefits be paid directly to ColumbiaDoctors for services rendered. I authorize representatives of ColumbiaDoctors to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the ColumbiaDoctors Notice of Privacy Practices (NOPP).

□ Received □ N/A (only if you received the notice from ColumbiaDoctors previously)

Information Disclosure and Consent

ColumbiaDoctors will provide you with the health plans that your provider(s) accepts*. If you decide to be treated by a provider who does not accept your health plan, you will be asked to sign a consent form agreeing that you accept treatment from that provider.

I read and agree to all of the above (Financial Agreement, Notice of Privacy, Insurance Information).

Patient or Legal Guardian Name (Print): _____

Patient or Legal Guardian Signature: _____ Date: _____

***Please refer to our website: columbiadoctors.org, for a list of insurances accepted by your provider.**

Name: DOB: ColumbiaDoctors

Reason for today's visit:

General Medical Questionnaire

Have you EVER had any of the following?

Asthma/Breathing Problems..... □ Y □ N
Arthritis..... □ Y □ N
Bleeding/Clotting Disorder..... □ Y □ N
Blood Pressure Disorder..... □ Y □ N
Blood Transfusion ..... □ Y □ N
Bowel/Stomach Problems..... □ Y □ N
Cancer..... □ Y □ N
Cholesterol Disorder ..... □ Y □ N
Diabetes..... □ Y □ N
Eye Disorder (i.e. Glaucoma, cataract)..... □ Y □ N
Women Only: Gynecological Issues..... □ Y □ N

Heart Disease/Disorder ..... □ Y □ N
Lung Disorder..... □ Y □ N
Liver Disease ..... □ Y □ N
Neurological Disorder/Chronic Headaches.. □ Y □ N
Psychiatric Disorder/Illness..... □ Y □ N
Pulmonary Embolism/DVT ..... □ Y □ N
Stroke..... □ Y □ N
Seizure or Epilepsy ..... □ Y □ N
Thyroid Disorder ..... □ Y □ N
Urinary/Kidney Disorder..... □ Y □ N

Please list any other medical illnesses or problems and provide details for any of the above conditions:

Please list all past surgeries and hospitalizations and the approximate date.

Procedure/ Hospitalization	Date	Complications

Please indicate any major conditions/illnesses that your immediate family members have had:

Relative	Condition and description	Living?	If deceased, at what age?
Mother		□ Y □ N	
Father		□ Y □ N	
Sibling		□ Y □ N	
Other:		□ Y □ N	

Do you currently smoke? □ Y □ N If no, previously? □ Y □ N Years smoked _____ Packs/day _____

Do you use other tobacco products? □ Y □ N Consume alcohol? □ Y □ N If yes, drinks/week: _____

Women Only: Any past pregnancies? □ Y □ N How many? ___ How many deliveries? ____

Name: DOB: ColumbiaDoctors

Do you have any allergies to medications or other substances (pets, food, etc.)? □Y □N
If yes, please list allergies and reactions (including rash, hives, throat swelling, anaphylaxis):

Allergy	Reaction	Allergy	Reaction

Please list ALL of your current medications, including over the counter medications, supplements, and herbs:

Medication Name	Dose	Medication Name	Dose

Review of Systems

Please indicate ALL that you have experienced within the past 6 – 12 months.

Constitutional

□Y□N Fever
□Y□N Chills
□Y□N Fatigue
□Y□N Feeling Poorly
□Y□N Sweats
□Y□N Weight Gain (___ Lbs)
□Y□N Weight Loss (___ Lbs)
□Y□N Unexp. Weight Change
□Y□N Sleep Disturbances
□ Other:

Head, Eyes, Ears, Nose, and Throat

□Y□N Vision Problem
□Y□N Decreased Hearing
□Y□N Double Vision
□Y□N Light Sensitivity
□Y□N Itchy Eyes
□Y□N Red Eyes
□Y□N Eye Pain
□Y□N Runny Nose
□Y□N Neck Stiffness
□Y□N Nosebleed
□Y□N Congestion
□Y□N Snoring
□Y□N Dry Mouth
□Y□N Flu-Like Symptoms
□Y□N Sore Throat
□Y□N Hoarseness
□Y□N Ringing in Ears
□Y□N Vertigo
□Y□N Earache
□Y□N Other:

Cardiovascular

□Y□N Chest Pain
□Y□N Palpitations
□Y□N Leg Swelling
□Y□N Cold Extremities
□Y□N Cold Hands or Feet
□Y□N Leg Pain w/ Walking
□Y□N Irregular Heart Rhythm
□Y□N Other:

Respiratory

□Y□N Shortness of Breath
□Y□N Cough
□Y□N Rapid Breathing
□Y□N Wheezing
□Y□N Shortness of Breath
□Y□N Chest Congestion
□Y□N Coughing Up Blood
□Y□N Coughing Up Sputum
□ Other:
□

Gastrointestinal

□Y□N Abdominal Pain
□Y□N Blood in Stool
□Y□N Vomiting
□Y□N Nausea
□Y□N Diarrhea
□Y□N Black/Tarry Stools
□Y□N Decreased Appetite
□Y□N Yellow Skin
□Y□N Change in Bowels
□Y□N Vomiting Blood
□Y□N Bowel Incontinence
□Y□N Rectal Pain
□Y□N Painful Swallowing
□ Other:

□Y□N Constipation □Y□N Trouble Swallowing □Y□N Heartburn

Neurological

□Y□N Headache	□Y□N Unsteady	□Y□N Numbness	□Y□N Tremor
□Y□N Dizziness	□Y□N Disorientation	□Y□N Tingling	□Y□N Memory Lapses/Loss
□Y□N Decreased Strength	□Y□N Confusion	□Y□N Seizures	□ Other:
□Y□N Poor Coordination	□Y□N Burning Sensation	□Y□N Fainting (Syncope)	

Musculoskeletal

□Y□N Joint Pain	□Y□N Limb Pain	□Y□N Muscle Pain	□ Other:
□Y□N Neck Pain	□Y□N Joint Swelling	□Y□N Muscle Weakness	
□Y□N Back Pain	□Y□N Muscle Cramps	□Y□N Leg Swelling	

Genitourinary

□Y□N Frequent Urination	□Y□N Pelvic Pain	□Y□N Painful Intercourse	□Y□N Heavy Period Bleeding
□Y□N Incontinence	□Y□N Nocturia	□Y□N Discharge- Vaginal	□ Other:
□Y□N Urinary Urgency	□Y□N Itching- Genital	□Y□N Vaginal Bleeding	
□Y□N Painful Urination	□Y□N Change in Libido	□Y□N Irreg. Monthly Cycles	

Integumentary

□Y□N Rash	□Y□N Skin Wound	□Y□N Unusual Growth	□Y□N Skin Cancer
□Y□N Dry Skin	□Y□N Change in A Mole	□Y□N Itching	□ Other:

Psychiatric

□Y□N Depression □Y□N Anxiety □Other:

Hematologic/Lymphatic

□Y□N Easy Bruising □Y□N Easy Bleeding □Y□N Swollen Lymph Nodes □ Other:

Endocrine

□Y□N Excessive Thirst	□Y□N Heat Intolerance	□Y□N Changes- Skin
□Y□N Cold Intolerance	□Y□N Changes- Hair	□ Other:

OFFICE USE ONLY: Provider Signature: _____ Date: _____

ColumbiaDoctors | *Orthopedics*

Additional Orthopedic Department Form

Office Use Only
MRN #: _____ Age: _____ Height: _____
Weight: _____ Pulse: _____ BP: _____
BMI: _____

Name of person completing form: _____ Relationship (if not patient): _____

Referring provider's name: _____ Phone number: _____

Address: _____ Fax number: _____

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*

Primary care provider's name: _____ Phone number: _____

Address: _____ Fax number: _____

Would you like a copy of today's consult note sent to this doctor? ☐ *Yes* ☐ *No*

Reason for today's visit: _____

Which side hurts? ☐ *Left* ☐ *Right* ☐ *Both* How long has your reason for today's visit been going on? _____

How did it start? _____

Hand dominance: ☐ *Left* ☐ *Right*

Pain description: ☐ *Dull* ☐ *Sharp* ☐ *Tingling* ☐ *Other:* _____

When does pain occur? ☐ *At rest* ☐ *With activity* ☐ *At night* ☐ *Other*: _____

Rate pain: *(Check box)*

No pain	1	2	3	4	5	6	7	8	9	10	Most extreme
	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

What reduces the pain? ☐ *Medicine* ☐ *Ice* ☐ *Heat* ☐ *Rest* ☐ *Elevation*

Your problem has: ☐ *Improved* ☐ *Worsened*

Any other symptoms associated with the current problem? _____

Does your home have: *(Check all that apply)* ☐ *1 story* ☐ *2 stories* ☐ *3+ stories* ☐ *Entrance steps* ☐ *Elevator*

Do you take public transportation? ☐ *Y* ☐ *N*

Do you exercise regularly? ☐ *Y* ☐ *N* Are you involved in organized sports? ☐ *Y* ☐ *N*

Required Information:

Did this injury happen while working? ☐ *Yes* ☐ *No* Does this injury relate to an auto accident? ☐ *Yes* ☐ *No*

Is this injury related to a pending lawsuit? ☐ *Yes* ☐ *No*

_____ _____

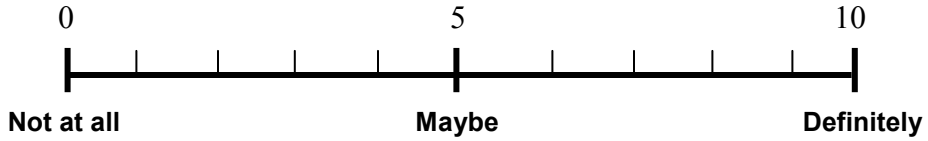
Patient Signature Date

PLEASE USE BLUE OR BLACK INK ONLY

NAME:_____**DATE OF BIRTH:**_____**AGE:** _____ **DATE:**_____

1. Chief complaint (check all that apply):
   - ☐ Spinal Deformity (Scoliosis, Kyphosis, Flatback Syndrome, etc.)
   - ☐ Neck pain Arm: ☐ Pain ☐ Numbness ☐ Weakness
   - ☐ Back pain Leg: ☐ Pain ☐ Numbness ☐ Weakness
   - Other_____

2. If recommended, please rate how interested you are in having surgery to treat your problem:



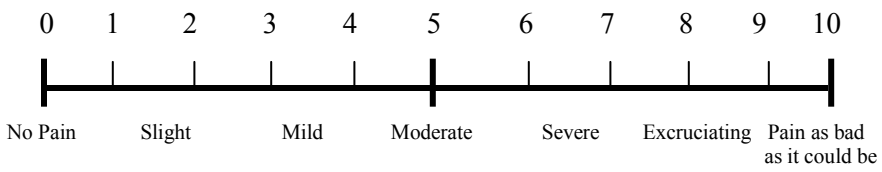
A. *****ALL PATIENTS SHOULD ANSWER THE FOLLOWING*****

1. Coughing or sneezing ☐ Increases ☐ Sometimes increases ☐ Does not increase the pain.
2. There is: ☐ No loss of bowel or bladder control ☐ Loss of bowel or bladder control since_____.
3. I have: ☐ Not missed any work because of this problem ☐ Missed (how much?) _____ work.
4. Treatments have included: ☐ No medicines, therapy, manipulations, injections, or braces

Neck	Back		Neck	Back	
☐	☐	Physical therapy, exercise	☐	☐	Anti-inflammatory medications
☐	☐	Massage & ultrasound	☐	☐	Narcotic medication
☐	☐	Traction	☐	☐	Epidural steroid injections _____ times which relieved the pain for (how long)?_____
☐	☐	Manipulation			
☐	☐	Tens Unit	☐	☐	Trigger point injections _____ times which relieved the pain for (how long)?_____
☐	☐	Shoulder injections			
☐	☐	Braces	☐	☐	Other _____

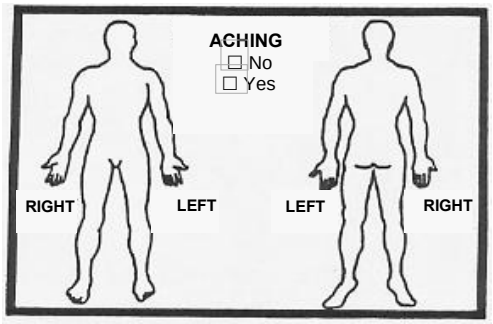
5. Generally speaking, are your symptoms getting better or worse? (Fill in **one** circle)
   ○ Getting much better ○ Getting somewhat better ○ Staying about the same
   ○ Getting somewhat worse ○ Getting much worse
6. If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it? (Fill in **one** circle)
   ○Very dissatisfied ○Somewhat dissatisfied ○Neutral ○Somewhat satisfied ○Very satisfied

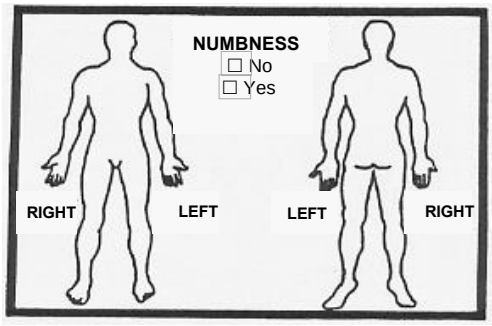
MY PAIN / DISCOMFORT IS: (circle number)

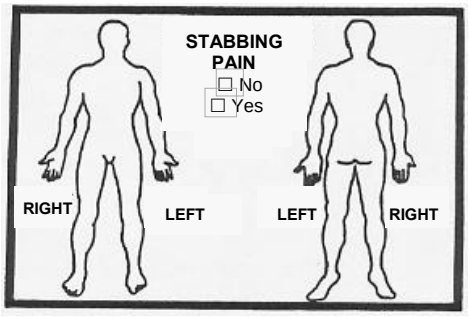


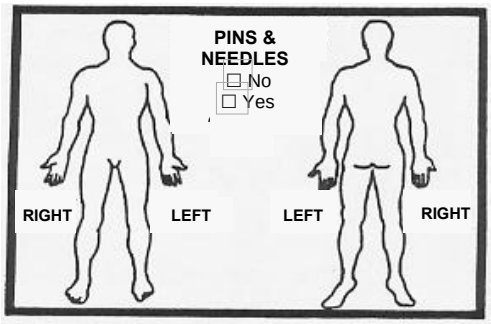
NAME:_____**DATE OF BIRTH:**_____**DATE:** _____

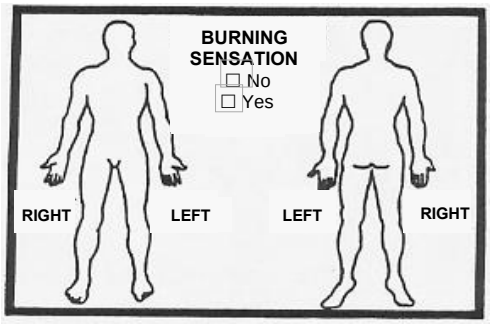
Please fill in drawings:
(shade the areas)











My main goal(s) today is (are) to get (check all that apply):

- ☐ Second opinion
- ☐ Recommendation for Physical therapy
- ☐ Medications
- ☐ Injection treatments
- ☐ Surgery

If you have seen other surgeons for this problem and were not happy, why?

- ☐ Didn't answer my questions
- ☐ Had no suggestions on what to do
- ☐ Personality issues
- ☐ Office staff problems
- ☐ Spent too little time with me
- ☐ Other

_____

For the following sections, patients being seen for a neck problem should only fill out section B. Even if you have other problems such as back or leg pain, do not fill out Section C. Likewise, patients with back or leg problems should only fill out Section C and not section B.

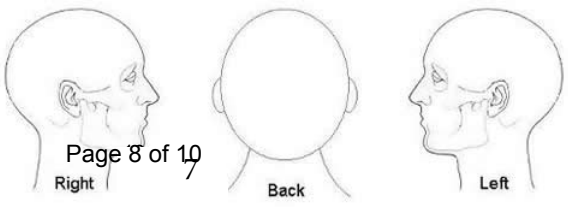
NAME:_____DATE OF BIRTH:_____DATE: _____

B. For patients with NECK OR ARM problems: DON'T DO IF BEING SEEN FOR A BACK PROBLEM

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)
   ☐ Neck 0%, Arm 100% ☐ Neck 10%, Arm 90% ☐ Neck 25%, Arm 75% ☐ Neck 40%, Arm 60%
   ☐ Neck 50%, Arm 50% ☐ Neck 60%, Arm 40% ☐ Neck 75%, Arm 25% ☐ Neck 90%, Arm 10%
   ☐ Neck 100%, Arm 0%
2. There is: ☐ No arm pain ☐ Arm pain is as follows (check the following):
   a. ☐ Right 0%, Left 100% ☐ Right 10%, Left 90% ☐ Right 25%, Left 75% ☐ Right 40%, Left 60%
   ☐ Right 50%, Left 50% ☐ Right 60%, Left 40% ☐ Right 75%, Left 25% ☐ Right 90%, Left 10%
   ☐ Right 100%, Left 0%
   b. The arm pain is present in the (check the following):
   Right: ☐ Upper back ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
   Left: ☐ Upper back ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
3. Raising the arm: ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain
4. Moving the neck: ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain
5. There is: ☐ No weakness of the arms and hands ☐ Weakness of the (check the following):
   Right: ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
   Left: ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
6. There is: ☐ No numbness of the arms and hands ☐ Numbness of the (check the following):
   Right: ☐ Upper arm ☐ Forearm ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Small finger
   Left: ☐ Upper arm ☐ Forearm ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Small finger
7. There (☐ is ☐ is no) difficulty picking up small objects like coins or buttoning buttons.
8. There (☐ is a ☐ is no) problem with balance or tripping frequently.
9. There are: (☐ Frequent ☐ Occasional ☐ No) headaches in the back of the head.

Patients with HEADACHES.

1. If you have headaches, how would you describe their intensity and frequency?
   I have (check one): ☐ slight ☐moderate ☐ severe headaches
   They come (check one): ☐ infrequently ☐ frequently ☐ almost all the time
2. The headaches are located (check the following):
   a. ☐ In the back of my neck b. ☐ In the back of my head
   c. ☐ The side of my head/temple area d. ☐ In the front of my head (near my eyes)
3. How long have you suffered from headaches? ☐ Several days ☐ Several weeks
   ☐ Several months ☐ Greater than 1 year
4. When do the headaches occur most commonly?
   ☐ Morning ☐ Afternoon ☐ While at work ☐ Evening ☐ No pattern
5. What is your average headache pain level throughout the day? (please circle)
   0 1 2 3 4 5 6 7 8 9 10
6. How would you describe your pain? ☐ Throbbing ☐ Squeezing ☐ Pressure
   ☐ Dull ☐ Stabbing ☐ Shooting
7. What medications (either prescription or over-the-counter) do you take for your headaches?
   _____
8. Please shade in the areas where you experience your discomfort.



NAME:_____DATE OF BIRTH:_____DATE: _____

C. For patients with BACK OR LEG Problems: DON'T DO IF BEING SEEN FOR A NECK PROBLEM

1. What % of your pain is back pain and what % is leg or buttock pain? (check appropriate box):
   ☐ Back 0%, Leg 100% ☐ Back 10%, Leg 90% ☐ Back 25%, Leg 75% ☐ Back 40%, Leg 60%
   ☐ Back 50%, Leg 50% ☐ Back 60%, Leg 40% ☐ Back 75%, Leg 25% ☐ Back 90%, Leg 10%
   ☐ Back 100%, Leg 0%
2. There is: ☐ No leg pain ☐ Leg pain as follows (check the following):
   a. ☐ Right 0%, Left 100% ☐ Right 10%, Left 90% ☐ Right 25%, Left 75% ☐ Right 40%, Left 60%
      ☐ Right 50%, Left 50% ☐ Right 60%, Left 40% ☐ Right 75%, Left 25% ☐ Right 90%, Left 10%
      ☐ Right 100%, Left 0%
   b. The pain is present in the (check the following):
      Right: ☐ Buttock ☐ Thigh-front ☐ Thigh-back ☐ Calf ☐ Foot
      Left: ☐ Buttock ☐ Thigh-front ☐ Thigh-back ☐ Calf ☐ Foot
3. There is: ☐ No weakness of the legs ☐ Weakness of the (check the following):
   Right: ☐ Thigh ☐ Calf ☐ Ankle ☐ Foot ☐ Big toe
   Left: ☐ Thigh ☐ Calf ☐ Ankle ☐ Foot ☐ Big toe
4. There is: ☐ No numbness of the legs ☐ Numbness of the (check the following):
   Right: ☐ Thigh ☐ Calf ☐ Foot **Left**: ☐ Thigh ☐ Calf ☐ Foot
5. The worst position for the pain is: ☐ Sitting ☐ Standing ☐ Walking
6. How many minutes can you stand in one place without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+
7. How many minutes can you walk without pain? ☐ 0-10 ☐ 15-30 ☐ 30-60 ☐ 60+
8. Lying down: ☐ Eases the pain ☐ Does not ease the pain ☐ Sometimes eases the pain
9. Bending forward: ☐ Increases the pain ☐ Decreases the pain ☐ Doesn't affect the pain

In the past week, how often have you suffered: (Please circle the number that applies)

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
10. Low back and/or buttock pain……	1	2	3	4	5	6
11. Leg pain……	1	2	3	4	5	6
12. Numbness or tingling in leg and/or foot……	1	2	3	4	5	6
13. Weakness in leg and/or foot (such as difficulty lifting foot)……	1	2	3	4	5	6

In the past week, how bothersome have these symptoms been? (Please circle the number that applies)

	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
14. Low back and/or buttock pain……	1	2	3	4	5	6
15. Leg pain……	1	2	3	4	5	6
16. Numbness or tingling in leg and/or foot…	1	2	3	4	5	6
17. Weakness in leg and/or foot (such as difficulty lifting foot)…….	1	2	3	4	5	6

For patients with a SPINAL DEFORMITY/ BACK CURVATURE.

1. How was your spinal deformity discovered? _____
2. Do you know your present curve measurement(s)? _____
3. Reason(s) for seeking treatment at this time: ☐ progressive deformity ☐ pain ☐ can't stand straight
   ☐ I don't like the appearance of my back/waistline ☐ Other: _____

NAME:_____DATE OF BIRTH:_____DATE:_____

Back Disability Index

*****For patients with a back problem or spinal deformity only; NECK PATIENTS SKIP THIS PAGE*****

Please read: This questionnaire has been designed to give the doctor information as to how your **back pain or deformity** has affected your ability to manage in everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section related to you, but please just mark the box which most closely describes your problem.

01. Pain Intensity
- ◯ I can tolerate the pain I have without having to use pain killers.
- ◯ The pain is bad but I manage without taking pain killers.
- ◯ Pain killers give complete relief from pain.
- ◯ Pain killers give moderate relief from pain.
- ◯ Pain killers give very little relief from pain.
- ◯ Pain killers have no effect on the pain, I do not use them.

02. Personal Care (Washing, Dressing, etc.)
- ◯ I can look after myself normally without it 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 manage most of my personal care.
- ◯ I need help everyday in most aspects of self care.
- ◯ I do not get dressed, wash with difficulty and stay in bed.

03. Lifting
- ◯ I can lift heavy weights without extra pain.
- ◯ I can lift heavy weights but it gives extra pain.
- ◯ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned. (e.g., on a table.)
- ◯ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ◯ I can lift only very light weights.
- ◯ I cannot lift or carry anything at all.

04. Walking
- ◯ Pain does not prevent me from walking any distance.
- ◯ Pain prevents me walking more than 1 mile.
- ◯ Pain prevents me walking more than 1/2 mile.
- ◯ Pain prevents me walking more than 1/4 mile.
- ◯ I can only walk using a stick or crutches.
- ◯ I am in bed most of the time and have to crawl to the toilet.

05. Sitting
- ◯ I can sit in any chair as long as I like.
- ◯ I can only sit in my favorite chair as long as I like.
- ◯ Pain prevents me from sitting more than one hour.
- ◯ Pain prevents me from sitting more than thirty minutes.
- ◯ Pain prevents me from sitting more than ten minutes.
- ◯ Pain prevents me from sitting at all.

06. Standing
- ◯ I can stand as long as I want without extra pain.
- ◯ I can stand as long as I want but it gives extra pain.
- ◯ Pain prevents me from standing more than one hour.
- ◯ Pain prevents me from standing more than thirty minutes.
- ◯ Pain prevents me from standing more than ten minutes.
- ◯ Pain prevents me from standing at all.

07. Sleeping
- ◯ Pain does not prevent me from sleeping well.
- ◯ I can sleep well only by using tablets.
- ◯ Even when I take tablets I have less than six hours sleep.
- ◯ Even when I take tablets I have less than four hours sleep.
- ◯ Even when I take tablets I have less than two hours sleep.
- ◯ Pain prevents me from sleeping at all.

08. Employment/Homemaking
- ◯ My normal homemaking/job activities do not cause pain.
- ◯ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ◯ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities. (e.g. lifting, vacuuming).
- ◯ Pain prevents me from doing anything but light duties.
- ◯ Pain prevents me from doing even light duties.
- ◯ Pain prevents me from performing any job or homemaking chores.

09. 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., dancing, etc.).
- ◯ Pain has restricted my social life and I do not go out as often.
- ◯ Pain has restricted my social life to home.
- ◯ I have no social life because of pain.

10. Traveling
- ◯ I can travel anywhere without extra pain.
- ◯ I can travel anywhere but it gives extra pain.
- ◯ Pain is bad but I manage journeys over two hours.
- ◯ Pain restricts me to journeys less than one hour.
- ◯ Pain restricts me to short journeys under thirty minutes.
- ◯ Pain prevents me from traveling except to the doctor or hospital.

Please take time to review the questionnaire for completeness. Your complete medical information is very important to us! Thank you!

_____ _____ _____ _____

Patient Signature Date Physician Signature Date

NAME **DATE OF BIRTH** **DATE COMPLETED**

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(*For office coding: Total Score T*____ = ____ + ____ + ____)

NAME **DATE OF BIRTH** **DATE COMPLETED**

PATIENT HEALTH QUESTIONNAIRE-8 (PHQ-8)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING _0_ **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐