WELCOME

PATIENT INFORMATION

DATE/FECHA _____
SS/ID# _____
PATIENT NAME/NOMBRE _____
LAST NAME/APELLIDO

_____ _____
FIRST NAME/PRIMERO NOMBRE MIDDLE INITIAL/SEG. INICIAL

ADDRESS/LA DIRECCIÓN_____
CITY/CIUDAD_____
STATE/ESTADO_____ ZIP/CODIGO POSTAL_____
EMAIL_____@_____
SEX/EL SEXO ☐ M ☐ F AGE_____
BIRTHDAY/CUMPLEAÑOS_____
☐MARRIED/CASADO ☐WIDOWED/VIUDA ☐SINGLE /SOLO
☐MINOR/MENOR DE EDAD ☐SEPARATED/APARTADO
☐DIVORCED/DIVORCIADO ☐PARTNERED FOR ___ YEARS/ ACOMPAÑA PARA _____ AÑOS
OCCUPATION/OCUPACIÓN _____
PATIENT EMPLOYER/SCHOOL/EMPLEADOR/ESCUELA
_____
EMPLOYER/SCHOOL ADDRESS/LA DIRECCIÓN DE EMPLEADOR O ESCUELA _____
SPOUSE'S NAME/NOMBRE DE ESPOSO(A) _____
BIRTHDAY/CUMPLEAÑOS DE ESPOSO(A)_____
WHO REFERRED YOU?/QUIEN LO REFIRIÓ?

INSURANCE

WHO IS RESPONSIBLE FOR THIS ACCOUNT? /QUIEN ES EL RESPONSIBLE DEL PAGO? _____
INSURANCE CO./COMPAÑIA DE SEGURO _____
IS PATIENT COVERED BY ADDITIONAL INSURANCE?
LA PACIENTE TIENE SEGURO ADICIONAL? ☐ YES/SÍ ☐ NO
SUBSCRIBER'S NAME/NOMBRE DEL ASEGURADO
_____
BIRTHDATE/CUMPLEAÑOS DEL ASEGURADO_____
RELATIONSHIP/ RELACIÓN CON EL PACIENTE _____

ASSIGNMENT AND RELEASE/ASIGNACIÓN Y LIBERACIÓN

CERTIFICO QUE YO [Y/O MIS DEPENDIENTE(S)] TENEMOS COBERTURA DE SEGURO MÉDICO CON _____
INSURANCE COMPANY/LA COMPAÑIA DE SEGUROS

Y ASIGNAR DIRECTAMENTE AL **DR. ERIC GOLDBERG** TODOS LOS BENEFICIOS DEL SEGURO, DE OTRA MANERA PAGABLE A MÍ POR LOS SERVICIOS PRESTADOS. ENTIENDO QUE SOY FINANCIERAMENTE RESPONSABLE DE TODOS LOS CARGOS PAGADOS O NO POR EL SEGURO. AUTORIZO EL USO DE MI FIRMA PARA TODAS LAS PRESENTACIONES DE SEGURO. EL MÉDICO MENCIONADO ANTERIORMENTE PUEDE UTILIZAR MI INFORMACIÓN DE ATENCIÓN MÉDICA Y PUEDE DIVULGAR DICHA INFORMACIÓN A LA COMPAÑÍA DE SEGUROS MENCIONADA ANTERIORMENTE Y SUS AGENTES CON EL FIN DE OBTENER PAGOS POR SERVICIOS Y DETERMINAR LOS BENEFICIOS DEL SEGURO O LOS BENEFICIOS A PAGAR POR SERVICIOS RELACIONADOS. ESTE CONSENTIMIENTO TERMINARÁ CUANDO SE COMPLETE MI PLAN DE TRATAMIENTO ACTUAL O UN AÑO A PARTIR DE LA FECHA FIRMADA A CONTINUACIÓN.

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE
FIRMA DE PACIENTE, GUARDIÁN O REPRESENTANTE PERSONAL

_____
PRINT NAME/IMPRIME NOMBRE DE PACIENTE, GUARDIÁN O REPRESENTANTE PERSONAL

_____ _____
DATE/FECHA RELATIONSHIP TO PATIENT/RELACIÓN CON EL PACIENTE

PHONE NUMBERS

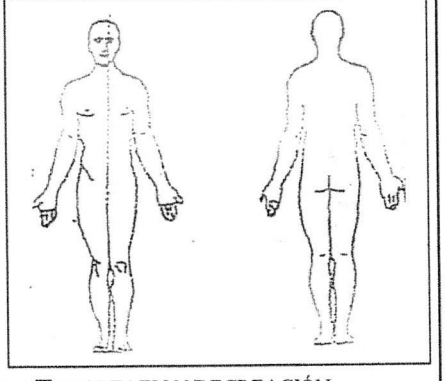
HOME PHONE/TELÉFONO DE CASA _____
CELL PHONE/TELÉFONO MÓVIL _____
BEST TIME & PHONE TO REACH YOU/MEJOR MOMENTO Y TELÉFONO CONTACTARTE _____
IN CASE OF EMERGENCY, CONTACT/CONTACTO DE EMERGENCIA: NAME _____
RELATIONSHIP/RELACIÓN CON EL CONTACTO
_____
PHONE NUMBER/TELÉFONO _____

ACCIDENT INFORMATION

IS CONDITION DUE TO AN ACCIDENT?/LA CONDICIÓN SE DEBE A UN ACCIDENTE? ☐YES ☐NO DATE _____
TYPE OF ACCIDENT/TIPO DE ACCIDENTE:
☐AUTO ☐WORK/TRABAJO ☐ OTHER/OTRO _____
TO WHOM HAVE YOU REPORTED OF YOUR ACCIDENT?
☐AUTO INSURANCE/SEGURO ☐EMPLOYER/EMPLEADOR
☐WORKERS COMP/COMPENSACIÓN DE TRABAJADORES
ATTORNEY NAME/NOMBRE DEL ABOGADO:

PATIENT CONDITION

REASON FOR VISIT/MOTIVO DE LA VISITA HEIGHT/TALLA _____ WEIGHT/PESA_____
_____
WHEN DID YOUR SYMPTOMS APPEAR?/CUÁNDO COMENZARON TUS SÍNTOMAS? _____
IS CONDITION GETTING PROGRESSIVELY WORSE?/LOS SÍNTOMAS ESTÁN EMPEORANDO?
☐ YES/SÍ ☐ NO ☐ UNKNOWN/DESCONOCIDO
MARK AN X ON THE PICTURE WHERE YOU CONTINUE TO HAVE PAIN, NUMBNESS, OR TINGLING:
MARQUE CON UNA **X** EN LA IMAGEN DONDE SIGUE TENIENDO DOLOR, ENTUMECIMIENTO U HORMIGUEO:
RATE THE SEVERITY OF YOUR PAIN ON A SCALE FROM 1(LEAST PAIN) TO 10 (SEVERE PAIN):
CUAL ES LA SEVERIDAD DE TU DOLOR DEL 1 (MENOS DOLOR) AL 10 (DOLOR SEVERO): _____
TYPE OF PAIN/TIPO DE DOLOR: ☐SHARP/AFILADO ☐DULL/SORDO ☐THROBBING/PALPITANTE
☐NUMBNESS/ENTUMECIDO ☐TINGLING/HORMIGUEO ☐SHOOTING/DOLOR PUNZANTE
☐BURNING/ARDIENTE ☐ACHING/DOLORIDO ☐CRAMPS/CALAMBRES ☐STIFFNESS/RÍGIDO
☐SWELLING/HINCHAZÓN ☐ OTHER/OTRO_____
HOW OFTEN DO YOU HAVE THIS PAIN?/CON QUÉ FRECUENCIA TIENE DOLOR?
_____
IS IT CONSTANT OR DOES IT COME AND GO?/ES CONSTANTE O VA Y VIENE?_____
DOES IT INTERFERE/INTERFIERE CON ☐WORK/TRABAJO ☐SLEEP/DORMIR ☐DAILY ROUTINE/RUTINA ☐RECREATION/RECREACIÓN



HEALTH HISTORY

SU HISTORIAL DE SALUD

What treatment have you received for your condition?/Qué tratamiento ha recibido para su condición?

MEDICATIONS/MEDICAMENTOS SURGERY/CIRUGÍA PHYSICAL THERAPY/TERAPIA FÍSICA

CHIROPRACTIC/QUIROPRÁCTICA NONE/NINGUNO OTHER/OTRO _____

Name & address of other doctors who have treated your condition/Nombre y dirección de otros médicos que han tratado tratado su condición _____

DATE OF LAST PHYSICAL EXAM/Examen físico _____ SPINAL XRAY/Radiografía espinal _____

FECHA DE ÚLTIMA: BLOOD TEST/Análisis de sangre _____ SPINAL EXAM/Examen de columna _____

CHEST X-RAY /Radiografía de pecho _____ URINE TEST/Examen de orina _____

MRI, CT SCAN, BONE SCAN/Resonancia magnética, tomografía computerizada, escaneo de huesos _____

Please mark the "Yes"/"No" to indicate if you have the following/Marca "sí"/"no" para indicar si tienes los siguiente:

AIDS/HIV ☐YES ☐NO	DIABETES ☐YES ☐NO	MEASLES ☐YES ☐NO	
ALCOHOLISMO ☐YES ☐NO	EMFISEMA ☐YES ☐NO	MIGRAINES. . ☐YES ☐NO DOLORES DE CABEZA	RHEUMATIC FEVER ☐YES ☐NO FIEBRE REUMÁTICA
ALERGIAS(VACUNA) ☐YES ☐NO	EPILEPSIA ☐YES ☐NO	MISCARRIAGE ☐YES ☐NO	SCARLET FEVER ☐YES ☐NO ESCARLATINA
ANEMIA ☐YES ☐NO	FRACTURAS ☐YES ☐NO	MONONUCLEOSIS ☐YES ☐NO	STROKE/DERRAME ☐YES ☐NO CEREBRAL
ANOREXIA ☐YES ☐NO	GLAUCOMA ☐YES ☐NO	ESCLEROSIS MÚLTIPLE ☐YES ☐NO	INTENTO DE SUICIDIO ☐YES ☐NO
APENDICITIS ☐YES ☐NO	GOITER ☐YES ☐NO ENFERMEDAD DE BOCIO	MUMPS/PAPERAS ☐YES ☐NO	THYROID ☐YES ☐NO PROBLEMAS TIROIDEOS
ARTRITIS ☐YES ☐NO	GONORREA ☐YES ☐NO	OSTEOPOROSIS ☐YES ☐NO	TONSILITIS ☐YES ☐NO
ASMA ☐YES ☐NO	GOUT/GOTA ☐YES ☐NO	PACEMAKER ☐YES ☐NO	TUBERCULOSIS ☐YES ☐NO
BLEEDING DISORDERS ☐YES ☐NO TRASTORNOS HEMORRAGICOS	HEART DISEASE ☐YES ☐NO CARDIOPATÍA	PARKINSON'S DISEASE ☐YES ☐NO	CRECIMIENTO DE TUMORES ☐YES ☐NO
BREAST LUMP/BULTO EN EL PECHO ☐YES ☐NO	HEPATITIS ☐YES ☐NO	PINCHED NERVE ☐YES ☐NO NERVIO PELLIZCADO	FIEBRE TIROIDEA ☐YES ☐NO
BRONQUITIS ☐YES ☐NO	HERNIA ☐YES ☐NO	NEUMONÍA ☐YES ☐NO	ÚLCERAS ☐YES ☐NO
BULIMIA ☐YES ☐NO	DISCO HERNIADO ☐YES ☐NO	POLIO ☐YES ☐NO	VAGINALES. ☐YES ☐NO INFECCIONES
CÁNCER ☐YES ☐NO	HERPES ☐YES ☐NO	PROBLEMA DE PRÓSTATA ☐YES ☐NO	VENEREAL DISEASE ☐YES ☐NO ENFERMEDAD VENÉREA
CATARATAS ☐YES ☐NO	HIGH CHOLESTEROL ☐YES ☐NO COLESTEROL ALTO	PRÓTESIS ☐YES ☐NO	WHOOPING COUGH ☐YES ☐NO TOS FERINA
CHEMICAL ☐YES ☐NO DEPENDENCIA QUÍMICA	KIDNEY DISEASE. ☐YES ☐NO ENFERMEDAD RENAL	ARTRITIS ☐YES ☐NO REUMATOIDE	OTHER/OTRO _____
CHICKEN POX ☐YES ☐NO VARICELA	LIVER DISEASE ☐YES ☐NO ENFERMEDAD HEPÁTICA	PSYCHIATRIC ☐YES ☐NO ATENCIÓN PSIQUIÁTRICA	

EXERCISE/EJERCICIO	**WORK/ACTIVIDAD DE TRABAJO** ☐ SITTING/SENTADO	**HABITS/HÁBITOS**
☐ NONE/NADA	☐ STANDING/EN PIE	☐SMOKING/DE FUMAR: PACKS A DAY/PAQUETES AL DÍA _____
☐ MODERATE/UN POCO	☐ LIGHT LABOR/TRABAJO LIGERO	☐ALCOHOL: DRINKS A WEEK/BEBIDAS POR SEMANA _____
☐ DAILY/CADA DÍA	☐ HEAVY LABOR/TRABAJO PESADO	☐COFFEE/CAFFEINE/CAFÉ/BEBIDAS CON CAFEÍNA: CUPS/DAY ___
☐ HEAVY/MUCHAS VECES		☐HIGH STRESS/ALTA ESTRÉS CAUSA _____

ARE YOU PREGNANT?/ESTÁS EMBARAZADA? ☐YES/SÍ ☐ NO DUE DATE/FECHA DE VENCIMIENTO _____

INJURY/SURGERY HISTORY/HISTORIAL DE LESIONES O CIRUGÍAS:	**DESCRIPTION /DESCRIPCIÓN**	**DATEFECHA**
FALLS/CAÍDAS		
HEAD INJURIES/LESIONES EN LA CABEZ		
BROKEN BONES/HUESOS ROTOS		
DISLOCATIONS/DESLOCALIZACIÓN		
SURGERIES/CIRUGÍAS		

MEDICATIONS/MEDICAMENTOS	**ALLERGIES/ALERGIAS**	**VITAMINS/HERBS/MINERALS/VITAMINAS/HIERBAS/MINERALES**
_____	_____	_____
_____	_____	_____
PHARMACY NAME/NOMBRE DE LA FARMACIA _____	_____	_____
TEL#:		

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

NAME _____ BIRTHDAY _____

SIGNATURE _____

DATE _____

TOTAL MEDICAL N.Y. PC
93-24 QUEENS BLVD. SUITE 1G
REGO PARK, NY, 11374
(T) 718-730-9040 (F) 718-730-9043

ASSIGNMENT AND RELEASE

I CERTIFY THAT I, AND/ OR MY DEPENDANT(S) HAVE INSURANCE COVERAGE WITH

_____
NAME OF INSURANCE COMPANY

AND ASSIGN DIRECTLY TO DR. ERIC GOLDBERG ALL INSURANCE BENEFITS, IF ANY OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. I AUTHORIZE THE USE OF MY SIGNATURE FOR ALL INSURANCE SUBMISSIONS. THE ABOVE-NAMED DOCTOR MAY USE MY HEALTH CARE INFORMATION AND MAY DISCLOSE SUCH INFORMATION TO THE ABOVE- NAMED INSURANCE COMPANY(IES) AND THEIR AGENTS FOR THE PURPOSE OF OBTAINING PAYMENTS FOR SERVICES AND DETERMINING INSURANCE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. THIS CONSENT WILL END WHEN MY CURRENT TREATMENT PLAN IS COMPLETED OR ONE YEAR FROM THE DATE SIGNED BELOW.

_____
SIGNATURE OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____
PLEASE PRINT NAME OF PATIENT, PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

_____ _____
DATE RELATIONSHIP TO PATIENT

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective: February 12, 2014

LAYERED SUMMARY TEXT –

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Signature of Patient_____Print Name of Patient: _____Date: _____

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address: City | State | Zip code

Patient insurance ID#: Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) | 2. Federal tax ID (EIN) of entity in box #1

[1] MD/DO [2] DC [3] PT [4] OT [5] Both PT and OT [6] Home Care [7] ATC [8] MT [9] Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1 | 5. NPI of entity in box #1 | 6. Phone number

7. Address of the billing provider or facility indicated in box #1 | 8. City | 9. State | 10. Zip code

Provider Complete This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

(1) Traumatic (4) Post-surgical →
(2) Unspecified (5) Work related
(3) Repetitive (6) Motor vehicle

Date of Surgery

Type of Surgery

(1) ACL Reconstruction
(2) Rotator Cuff/Labral Repair
(3) Tendon Repair
(4) Spinal Fusion
(5) Joint Replacement
(6) Other ____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° . 2° . 3° . 4° .

Patient Type

(1) New to your office
(2) Est'd, new injury
(3) Est'd, new episode
(4) Est'd. continuing care

Nature of Condition

(1) Initial onset (within last 3 months)
(2) Recurrent (multiple episodes of < 3 months)
(3) Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942
○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other)
Back Index | LEFS

Patient Complete This Section:

(Please fill in selections completely)

Symptoms began on:

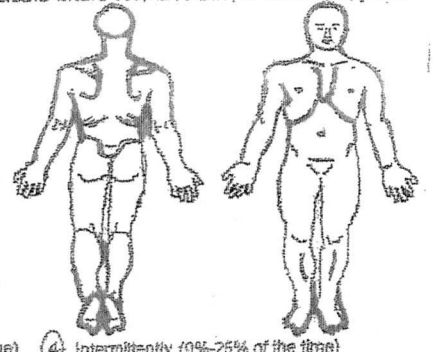
1. **Briefly describe your symptoms:**

2. **How did your symptoms start?**

3. **Average pain intensity:**

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain
Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

Indicate where you have pain or other symptoms:



4. **How often do you experience your symptoms?**

(1) Constantly (75%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% – 50% of the time) (4) Intermittently (0%-25% of the time)

5. **How much have your symptoms interfered with your usual daily activities?** (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. **How is your condition changing, since care began at *this* facility?**

(0) N/A – This is the initial visit (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. **In general, would you say your overall health right now is...**

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X _____ Date: _____