Pain Management Services

New Patient Intake Questionnaire

We are committed to providing you with the best possible health care. To help us assess your current health care needs, we would like you to complete the following form. We know that we are asking you many questions, but we feel that it is important that you take the time to complete all pages. Our comprehensive questionnaire helps us determine the best diagnosis and treatment plan.

Patient Information

Last Name:	**First Name:**	**MI:**	**Last Four of Sponsor's SSN:**	**Gender:**	**Age:**

DATE:	**What problem/diagnosis brings you here?**

Physician Information

Please list the name(s) of any healthcare provider(s) who are currently treating you or prescribing medications to you:
(If more space is needed, please continue list on last sheet

Name	**Reason**	**Name**	**Reason**
1.	*Primary Care Provider*	3.	
2.		4.	

Clinical Information

Allergies: _____

Current Medications: *(If more space is needed, please continue list on last sheet)*

Name	Dose	Frequency	Purpose

Sleep

How many hours (average) of sleep do you get each night?

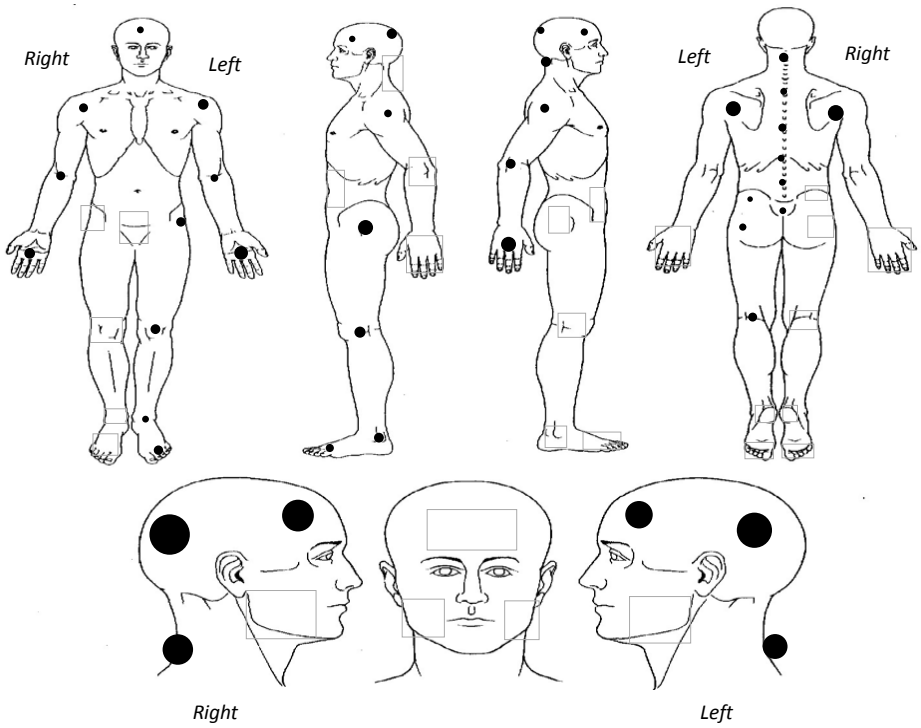
If you are not sleeping well, what is the cause? (Check all that apply)

☐ Pain ☐ Nightmares ☐ Diagnosed with restless leg syndrome

☐ Racing thoughts (anxiety) ☐ Diagnosed with sleep apnea ☐ Other (explain):

Pain History

On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



When did your pain begin?

How did your pain begin? (Injury in OIF/OEF, sports, auto accident, etc)

What does the pain feel like? Mark the words that describe your pain, choose all that apply.

☐ Aching	☐ Sickening	☐ Shooting	☐ Stabbing	☐ Penetrating	☐ Nagging	☐ Numb
☐ Tender	☐ Burning	☐ Exhausting	☐ Radiating	☐ Squeezing	☐ Dull	☐ Deep
☐ Miserable	☐ Unbearable	☐ Cramping	☐ Gnawing	☐ Pricking	☐ Sharp	☐ Intermittent

What do you do to make your pain feel better? (for example - heat, medicine, rest)

What do you do to make your pain feel worse? (for example - walking, standing, lifting)

Pain History Continued

What treatments have you had for your pain? (Mark all that apply.)

- ☐ Physical Therapy
- ☐ TENS Unit
- ☐ Chiropractic Care
- ☐ Hypnosis
- ☐ Biofeedback
- ☐ Hot/Cold
- ☐ Group Therapy
- ☐ Reiki Therapy
- ☐ Massage
- ☐ Topical Medications
- ☐ Psychotherapy
- ☐ Other (list)
- ☐ Acupuncture
- ☐ Pool Therapy
- ☐ CBT
- ☐ Injections (list type and date)

What tests have you had to evaluate your pain? (Mark all that apply.)

☐ X-rays ☐ MRI ☐ CT Scan ☐ EMG ☐ Myelogram ☐ Discogram ☐ Other

Have you been treated in the Emergency Department for your pain? ☐ Yes ☐ No

If yes, then how many visits in the last 6 months?

What medications have you tried for pain:

Opioids:

- ☐ Oxycodone (percocet, roxicet, Oxycontin)
- ☐ Morphine (MS Contin, Avinza, Kadian)
- ☐ Hydromorphone (Dilaudid)
- ☐ Methadone
- ☐ Codeine (Tylenol #3, #4)
- ☐ Hydrocodone (Vicoden, Norco)
- ☐ Fentanyl (Duragesic, Actiq)
- ☐ Tramadol (Ultram)
- ☐ Buprenorphine (Suboxone)
- ☐ Others:

NSAIDs:

- ☐ Ibuprofen (Advil, Motrin)
- ☐ Naproxen (Aleve, Naprosyn)
- ☐ Meloxicam (Mobic)
- ☐ Celecoxib (Celebrex)
- ☐ Nambumetone (Relafen)
- ☐ Diclofenac (Voltaren)
- ☐ Piroxicam (Feldene)
- ☐ Others:

Anti-Seizure:

- ☐ Gabapentin (Neurontin)
- ☐ Pregabalin (Lyrica)
- ☐ Topiramate (Topamax)
- ☐ Oxycarbazepine (Trileptal)
- ☐ Leveteracitam (Keppra)
- ☐ Carbamazepine (Tegretol)
- ☐ Others:

Antidepressants:

- ☐ Amitriptyline (Elavil)
- ☐ Nortriptyline (Pamelor)
- ☐ Duloxetine (Cymbalta)
- ☐ Milnacipran (Savella)
- ☐ Paroxetine (Paxil)
- ☐ Citalopram (Celexa)
- ☐ Trazodone (Deseryl)
- ☐ Buproprion (Wellbutrin)
- ☐ Fluoxetine (Prozac)
- ☐ Setraline (Zoloft)
- ☐ Venlafaxine (Effexor)
- ☐ Others:

Muscle Relaxants:

- ☐ Baclofen
- ☐ Cyclobenzaprine (Flexeril)
- ☐ Carisprodol (Soma)
- ☐ Clonazepam (Klonopin)
- ☐ Diazepam (Valium)
- ☐ Metaxalone (Skelaxin)
- ☐ Tizanidine (Zanaflex)
- ☐ Methocarbamol (Robaxin)
- ☐ Others:

☐ Others (please list):

Supplements & herbal therapies (e.g. glucosamine chondroitin, fish oil)

_____

_____

_____

_____

Family History

Please list whether your direct family members are alive or deceased, their ages at death, and any significant medical (*i.e. diabetes, heart disease, cancer),* psychological *(i.e. depression, anxiety, bipolar),* or alcohol/illegal or prescription drug problems, they may have had.

		Major Medical Problems	Psychological Problems	If deceased, cause of death and age at death
Biological Father	☐ Alive ☐ Deceased			N/A
Biological Mother	☐ Alive ☐ Deceased			N/A
Brothers	☐ Alive ☐ Deceased			N/A
Sisters	☐ Alive ☐ Deceased			N/A

Review of Systems

Do you have any other symptoms? Please check any that you are **now** experiencing, or mark none.

☐ None

GENERAL:
☐ Nausea
☐ Vomiting
☐ Sweating
☐ Tiredness
☐ Fever
☐ Loss of Appetite
☐ Weight Gain
☐ Weight Loss

EYES:
☐ Glasses/Contacts
☐ Double Vision
☐ Spots in Vision
☐ Cataracts

EARS/NOSE/THROAT:
☐ Hoarseness
☐ Hearing Loss
☐ Ringing in Ears

NERVOUS SYSTEM:
☐ Muscle Spasm
☐ Memory Loss
☐ Dizziness
☐ Balance Problem
☐ Headache
☐ Weakness

HEART:
☐ Chest Pain
☐ Murmurs
☐ Irregular Heartbeat
☐ Blood Clots

LUNGS:
☐ Short of Breath
☐ Wheezing
☐ Cough
☐ Congestion

URINARY:
☐ Trouble passing urine
☐ Trouble holding urine
☐ Bed Wetting
☐ Pain with Urination
☐ Blood in Urine
☐ Other Urinary problems

GASTROINTESTINAL:
☐ Constipation
☐ Diarrhea
☐ Blood in Stool
☐ Indigestion
☐ Abdominal Pain

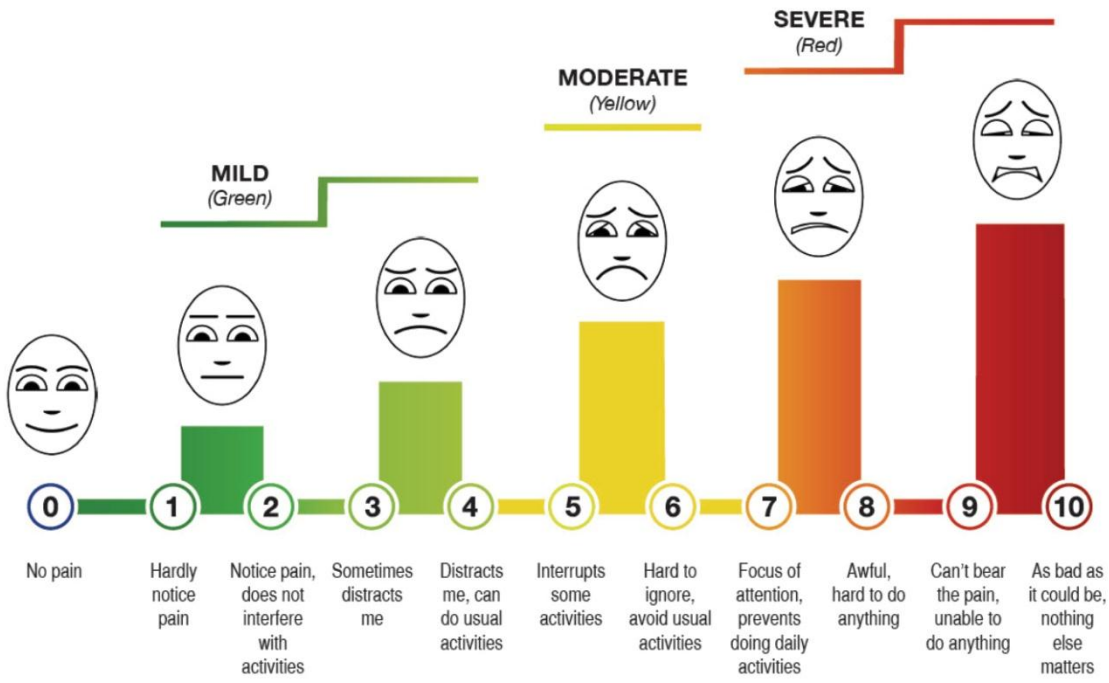
HEMATOLOGY:
☐ Unexplained Bleeding
☐ Easy Bruising
☐ Anemia (low blood count)

SKIN:
☐ Skin Ulcers
☐ Rash
☐ Itching
☐ Lumps

List any additional symptoms:

Pain Assessment

Defense and Veterans Pain Rating Scale



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Using the pain rating scale above as your guide, please respond to each item below by marking one box per row.

1. What is your level of pain right now?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

2. In the past 7 days, how intense was your pain at its worst?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

3. In the past 7 days, how intense was your average pain?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4. Choose the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does not interfere — Completely interferes

5. Choose the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does not interfere — Completely interferes

6. Choose the one number that describes how, during the past 24 hours, pain has affected your MOOD:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does not interfere — Completely interferes

7. Choose the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does not interfere — Completely interferes

Last Name:_____ **Last 4 Sponsor SSN:**_____

Pain Assessment Continued

In the past 7 days	Not at all	A little bit	Somewhat	Quite a bit	Very Much
1. How much did pain interfere with your ability to concentrate?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. How much did pain interfere with your enjoyment of life?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. How much did pain interfere with your enjoyment of recreational activities?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. How much did pain interfere with doing your tasks away from home (e.g. getting groceries, running errands)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. How often did pain keep you from socializing with others?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

PCS

We are interested in the types of thoughts and feelings that you have when you are in pain. The next statements will be describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feeling when you are experiencing pain. Please enter corresponding number in box next to each statement.

When I am in pain . . .	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
1. I worry all the time about whether the pain will end.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2. I feel I can't go on.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. It's terrible and I think it's never going to get any better.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
4. It's awful and I feel that it overwhelms me.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I feel I can't stand it anymore.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I become afraid that the pain will get worse.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7. I keep thinking of other painful events.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I anxiously want the pain to go away.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I can't seem to keep it out of my mind.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10. I keep thinking about how much it hurts.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
11. I keep thinking about how badly I want the pain to stop.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
12. There's nothing I can do to reduce the intensity	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
13. I wonder whether something serious may happen.	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

This list contains some sentences that people have used to describe themselves when they have pain. When you read them, you may find that some standout because they describe you today. As you read the list, think of yourself today. When you read a sentence that describes you today, please select the 'yes' column. If the sentence does not describe you, select the 'no' column.

Select 'yes' if the sentence describes you <u>today.</u>	**Yes**	**No**
I stay at home most of the time because of my pain.	☐	☐
I change position frequently to try and make my body comfortable.	☐	☐
I walk more slowly than usual because of my pain.	☐	☐
Because of my pain, I am not doing any of the jobs that I usually do around the house.	☐	☐
Because of my pain, I use the handrail to go upstairs	☐	☐
Because of my pain, I lie down and rest more often.	☐	☐
Because of my pain, I have to hold on to something to get out of an easy chair	☐	☐
Because of my pain, I ask other people to do things for me.	☐	☐
	Yes	**No**
I get dressed more slowly than usual because of my pain	☐	☐
I only stand for short periods because of my pain.	☐	☐
Because of my pain, I try not to bend or kneel down.	☐	☐
I find it difficult to get out of a chair because of my pain.	☐	☐
I experience pain most of the time.	☐	☐
I find it difficult to turn over in bed because of my pain.	☐	☐
My appetite is not very good because of my pain.	☐	☐
I have trouble putting on my socks (or stockings) because of my pain.	☐	☐
	Yes	**No**
I only walk short distances because of my pain.	☐	☐
I sleep less because of my pain.	☐	☐
Because of my pain, I get dressed with help from someone else.	☐	☐
I sit down most of the day because of my pain.	☐	☐
Because of my pain, I am more irritable and bad tempered with people.	☐	☐
I avoid heavy jobs around the house because of my pain.	☐	☐
Because of my pain, I go upstairs more slowly than usual.	☐	☐
I stay in bed most of the time because of my pain.	☐	☐

Behavioral Health History

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	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. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more.	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐ 0	☐ 1	☐ 2	☐ 3

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on the 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's 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

If you checked off any problems, how difficult have these 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

What do you consider your three greatest sources of stress?(list from most to least)

1.
2.
3.

Name three functional goals you would like to improve (e.g. walking, running, sleeping)

1.
2.
3.

What do you perceive as possible barriers to your engagement in pain management strategies?

Assessments PCL

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
2. Repeated, disturbing *dreams* of a stressful experience from the past?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
3. Suddenly acting or feeling as if a stressful experience *were happening again* (as if you were reliving it)?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
4. Feeling *very upset* when something *reminded you* of a stressful experience from the past	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
5. Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded you* of a stressful experience from the past?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
6. Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
7. Avoid *activities* or *situations* because *they reminded you* of a stressful experience from the past?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
8. Trouble *remembering important parts* of a stressful experience from the past?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
9. *Loss of interest* in things that you used to enjoy?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
10. Feeling *distant* or *cut off* from other people?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
12. Feeling as if your *future* will somehow be *cut short*?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
13. Trouble *falling* or *staying asleep*?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
14. Feeling i*rritable* or having *angry outbursts*?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
15. Having *difficulty concentrating*?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
16. Being "*super alert*" or watchful on guard?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
17. Feeling *jumpy* or easily startled?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Behavioral Health History - *Please be honest so that we may help you.* ORT

Do you use tobacco? ☐ Yes ☐ No Type:	How much/ how often?	For how long?	Have you ever tried to quit?	Do you want to quit?

How often do you have a drink containing alcohol?

☐ Never ☐ Monthly or less ☐ 2-4 times per month ☐ 4 or more times per week

How many standard drinks containing alcohol do you have on a typical day?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Do you have a family history of substance abuse? ☐ Alcohol ☐ Illegal drugs ☐ Prescription drugs ☐ Other

Do you have a personal history of substance abuse? ☐ Alcohol ☐ Illegal drugs ☐ Prescription drugs ☐ Other

Do you have a history of pre-adolescent sexual abuse? ☐ **Yes** ☐ **No**

Have you ever been diagnosed with a psychiatric disorder?

Attention Deficit Disorder (ADD or ADHD)	☐ Yes	☐ No
Obsessive Compulsive Disorder (OCD)	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No

Have you ever or are you currently taking your pain medication differently than prescribed by your provider?
(i.e. taking more than prescribed, more/less frequently, not taking them, etc.) ☐ Yes ☐ No

If yes, why?

Have you, your doctor, or family member felt that you have a problem with pain medications? ☐ Yes ☐ No

If yes, explain?

Medical History

Please list any significant medical or health problems that you have or have had in the past.

☐ Arthritis	☐ Heart Disease	☐ High Blood Pressure	☐ Diabetes	☐ Cancer
☐ Stroke	☐ Lung Disease	☐ Kidney Disease	☐ Thyroid Disorder	☐ Bleeding Disorder

List any additional/other problems:

Please list all previous surgeries and or hospitalizations.

Legal

Any recent/past legal issues other than speeding tickets (i.e. DUIs, arrests, charges, convictions)? (If yes, please explain) ☐ Yes ☐ No

Is there any litigation regarding your injury? (If yes, please explain) ☐ Yes ☐ No

Any other disciplinary or legal actions *(i.e. UCMJ, Chapter, Article 15)?* ☐ Yes ☐ No

Are you currently getting or applying for SSI disability or workman's comp (civilian)? ☐ Yes ☐ No

Social Life

Are you experiencing any sexual concerns *that are related to your pain*? ☐ Yes ☐ No

How many close friends do you have, not including immediate family?

Who would you say really cares about you and that you could ask for help if needed?

How do your family/friends respond to your expression of pain?

Are you geographically isolated from your family? ☐ Yes ☐ No

Have you recently isolated yourself from family and friends? ☐ Yes ☐ No

Are you using any community resources or supports? (i.e. chaplain, ASAP, social work, 12-step meetings, support groups) ☐ Yes ☐ No

If yes, please identify:

What is your religious/spiritual affiliation, if any?

How much is your religious/spiritual affiliation a source of strength and comfort for you?

☐ Not at all ☐ Not very much ☐ Somewhat ☐ Quite a bit ☐ A great deal

Employment

Occupation/MOS (Job Title):

Fitness for Duty: *(Military)*
☐ Fit for duty ☐ Nondeployable ☐ Medical Board
☐ Perm Profile ☐ Temp Profile

Last APFT Date/Score:
☐ Go ☐ No Go

2nd MOS:

If currently on profile, please explain and give dates:

Potential for Active Duty Retention: ☐ Very Likely ☐ Likely ☐ Unlikely

Have you ever: ☐ been fired ☐ been laid off ☐ left a job without giving notice

Rate your current MOS/job satisfaction:

Not at all — *Moderately Satisfied* — *Very Satisfied*

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Any current or recent financial problems? *(If yes, please explain)* ☐ Yes ☐ No

Education

Highest level of education achieved:

☐ Did not complete high school
☐ GED
☐ High School diploma
☐ Some college/technical courses
☐ Associates degree
☐ Bachelors degree
☐ Graduate school

Average grades in high school / college:

Were you ever held back a grade in high school or required to attend special education classes? ☐ Yes ☐ No

Childhood Background

Who raised you?	Were you adopted?	Number of siblings:
	☐ Yes ☐ No	*Biological-* *Step-*

How would you describe your childhood home:

☐ Loving ☐ Chaotic ☐ Poor ☐ Wealthy

☐ Comfortable ☐ Abusive ☐ Middle class ☐ Other (describe)

Family Life

Marital Status:	Number of times married	Number of children	Do your children live with you?
☐ Single, never married ☐ Separated ☐ Married ☐ Divorced ☐ In a relationship			

Rate your satisfaction with your current marriage or relationship:

Not at all ***Moderately Satisfied*** ***Very Satisfied***

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Exercise History

Were you athletic in high school? ☐ Yes ☐ No	Prior to your pain, what activities/exercises were you doing?	What are you currently doing for exercise?
What sports did you play?	Type: Frequency:	Type: Frequency:

Support & Resources

Have you or your spouse ever been involved with Child Protective Services or Family Advocacy? ☐ Yes ☐ No	Are you using any community resources or support? (i.e. Chaplain, ASAP, Social Work, AA) ☐ Yes ☐ No

Have you ever experienced : ☐ emotional abuse ☐ physical abuse ☐ sexual abuse

Additional Space

Please use the blank space below to add information that did not fit in the provided fields. You may also use this space to tell us any information related to your health that you feel is important for us to know.

If your appointment is within the next **FIVE** days, please **CONTINUE**. If not, please **STOP** and complete the remaining pages within **FIVE** days of your appointment. *Then* send completed packet back to the IACH Pain Clinic.

Last Name:_____ **Last 4 Sponsor SSN:**_____