Pain Management Institute
&
Aesthetics

New Patient Checklist

- Bring New Patient paperwork *thoroughly completed*
- Insurance Cards
- Government issued *photo* ID
- Copayment/Coinsurance due at time of service (if applicable)
- Please be prepared to provide a urine sample at your visit

Failure to provide any of those items at the time of your appointment may require us to reschedule your appointment.

499 East Central Parkway Suite 115 Altamonte Springs, FL 32701

Hours of operation

- Monday-Friday 8AM-5PM
- Closed 12PM-1PM daily

Thank you in advance,

The Pain Management Institute & Aesthetics Team.

Pain Management Institute & Aesthetics

PAIN MANAGEMENT INSTITUTE & AESTHETICS
JULIET D. BURRY, M.D.

REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Your patience and cooperation in supplying us with complete and accurate information is very much appreciated. We rely on this data in the event that we need to contact you regarding laboratory reports, prescriptions information, and various medical necessities that may occur. Please notify the front desk receptionist if you require assistance in completing this form.

Patient's last name: First: Middle:	Date of Birth:	Sex: Male Female	Home Phone: #
Mailing Address	How long at present address?		Social Security #
Alternate Mailing Address			
Marital Status	Mothers Name (if minor):	Fathers Name (if minor):	Driver's License #
Occupation	Employer/Company Name	Employers Address	Employer Phone #
Spouse's Name	Spouse's Social Security #	Spouse's Employer	Spouses Employer phone #
Emergency Contact Name:	Emergency Contact Phone #	Emergency Contacts Relationship to patient	

INSURANCE INFORMATION

Primary Insurance Information			Secondary Insurance Information		
Insurance Company			Insurance Company		
Insurance Subscriber ID Number	Group Number		Insurance Subscriber ID Number	Group Number	
Insurance Claims Address from Back of Card			Insurance Claims Address from Back of Card		
City	State	Zip	City	State	Zip

Is the Patient the Policyholder ___ Yes ___ No
****Please Complete the Guarantor section below if the POLICYHOLDER is NOT the PATIENT****

GUARANTOR INFORMATION IN NOT PATIENT

Guarantor's Name	Relationship to Patient	Guarantor's Social Security #
Guarantor's Mailing Address	Guarantor's Phone #	
Guarantor's Employer	Guarantor's Phone #	
Guarantor's Occupation	Guarantor's Driver's License #	

Patient/Guardian signature: _____ *Date:* _____

PAIN MANAGEMENT INSTITUTE & AESTHETICS, LLC

Juliet D. Burry, M.D.

INSURANCE ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

- **AUTHORIZATION TO RELEASE INFORMATION:**

  I hereby authorize PAIN MANAGEMENT INSTITUTE & AESTHETICS, LLC to release any information acquired in the course of my medal examination and treatment, including drug use, alcoholism, and HIV positive test results, to my insurance carrier(s) as necessary to process my insurance claims.

- **AUTHORIZATION PAY BENEFITS:**
  I hereby authorize my insurance carrier(s) to make payment directly to PAIN MANAGEMENT INSTITUTE & AESTHETICS, LLC for surgical and /or medical benefits payable for services rendered.

_____ _____

Patient's Signature Guarantor's Signature

_____

Date

FINANCIAL AGREEMENT

- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the emergency department doctor(s) and NOT A SUBSTITUTE FOR PAYMENT. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay deductible amount, co-insurance, or any other balances not paid by your insurance.
- IN ORDER TO CONTROL YOUR OUTSTANDING BALANCE IT IS OUR POLICY TO COLLECT CO-PAYS, CO-INSURANCE, AND DEDUCTABLES AT THE TIME SERVICE IS RENDERED.
- Failure to provide 24 hour notice to cancel or reschedule an appointment will result in a charge of $40.00. Charges for returned checks will be a minimum of $35.00 and assessed in accordance with current State of Florida NSF (No Show Fee) Schedule.
- If this account is assigned to an attorney or collection agency for collection and/or suit, PAIN MANAGEMENT INSTITUTE & AESTHETICS, LLC shall be entitled to reasonable attorney's fees and/or cost of collection.
- I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

_____ _____

Patient's Signature Guarantor's Signature

_____

Date

HIPAA NOTICE OF PRIVACY PRACTICES

Juliet D. Burry M.D.

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and other outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. To pay your health care bills, to support the operation of the physicians practice, and any other use required by law.

Treatment:We will issue and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This include the coordination or management of your health care with a third party. For example, we will disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health Issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration Requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activityand National Security, Workers Compensation, Inmates, and Required uses and disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights- Following is a statement of your rights with respect to your protected health information.

You have the right to request a restriction of your protected information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want restriction to apply.

HIPAA NOTICE OF PRIVACY PRACTICES CONTINUED

Your physician is not required to agree to a restriction that you may request if your physician believes it is your best interest to permit use and disclosure of your protected health information, protected health information will not be restricted. You then the right to use another Health Care Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

You have the right to receive any accounting or certain disclosures we have made, if any, of your protected health information.

Complaints: You may complain to usor the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main Phone Number.

Signature below is only acknowledgement that you received this Notice of our Privacy Practices:

Print Name_____ Signature _____Date _____

I authorize Pain Management Institute & Aesthetics, LLC to discuss my medical information with the individuals listed below:

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

Juliet D. Burry, M.D.

Dear Patients,

This letter is a request to gain authorization to obtain your pharmacy information. By signing below, you give our facility, PAIN MANAGEMENT INSTITUTE & AESTHETICS, LLCthe authority to view your medication history only. Your medication history will allow the doctor to safeguard against any drug effects that may affect your health.

I, _____ have read and understood the above request. By signing below I authorize the release of my pharmacy and medication information to Dr. Juliet D. Burry with PAIN MANAGEMENT INSTITUTE & AESTHETICS, LLC.

_____ _____

Patient Signature Date

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Complete All Sections, Date, and Sign.

I. I, _____, hereby voluntarily authorize the disclosure of information from my record.

II. The information is to be disclosed by: And is to be provided to:

Name of Facility	Juliet D. Burry, M.D.
Address City/State/Zip	499 E. Central Parkway #115 Altamonte Springs, FL 32701
Phone: Fax:	Phone: 407-671-5115 Fax: 407-671-5116

III. The purpose or need for this disclosure is:

□Further Medical Care □Attorney □School□Research□Personal Use □Insurance □Disability

□Other*(Specify)* _____

IV. The information to be disclosed from my health record: (*Check appropriate box(es)*)

- □ Entire Record
- □ Only information related to *(specify)*_____
- □ Only the period of events from _____ to _____ .
- □ Other *(specify)*_____
- □ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

If you would like any of the following sensitive information disclosed, check the applicable box (es)

- □ Alcohol/Drug Abuse Treatment/Referral
- □ HIV/Aids-Related Treatment
- □ Sexually Transmitted Diseases
- □ Mental Health*(Other than psychotherapy notes)*

V. I understand that I may revoke this authorization in writing submitted at any time to the Privacy Officer, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event. Enter Date if Different from 1 Year: _____

I understand that Pain Management Institute & Aesthetics, LLC will not condition treatment or eligibility for care my providing this authorization except if such care is:

1) Research related or 2) provided solely for the purpose of creating Protected Health Information for disclosure to a 3rd party.
2) I understand that the information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Part 164)

_____ _____

Signature of Patient Date

_____ _____

Signature of Authorized Representative *State relationship or witness (if signature is an "x")* Date

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual under false pretenses may be assessed civil money penalties and/or criminal penalties.

For Office Use Only: Verification of Information Released
Name and Title of Person who release records:

_____

How was the information transferred? Sent by mail on *(date)*

_____

Certified? (Certification number)

Patient Identification: Name:	Record Number:
Address	
City/State	Date of Birth

Juliet D. Burry, M.D.

Anesthesiologist and Pain Management Specialist

www.pmiorlando.com

499 East Central Parkway

Altamonte Springs, FL 32701

407-671-5115

407-671-5116 Fax

Medical Records Release or Request

I, undersigned, authorize Juliet D. Burry, M.D. and her staff either to request from, or release to, any facilities, any and all medical information related to my care. I further authorize Juliet D. Burry, M.D. and her staff to discuss my medical conditions and share information with other physicians or entitles that may have participated in my care in the past or that may in the future. I also authorize Juliet D. Burry, M.D. to share the information with me the patient. I understand that some of this information may transmitted via fax machine, or any other electronic means.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Pain Management Institute
&
Aesthetics

NEW PATIENT INTAKE FORM

Name: _____ DOB: _____ Date: _____

Referring Physician: _____ Primary Care Physician: _____

Did the pain start □ Immediately □ Gradually How bad is the pain on a 0-10 scale *(10 being the worst pain)*? _____

Did the pain start after a specific event? □ Yes □ No If yes, what specific event? _____

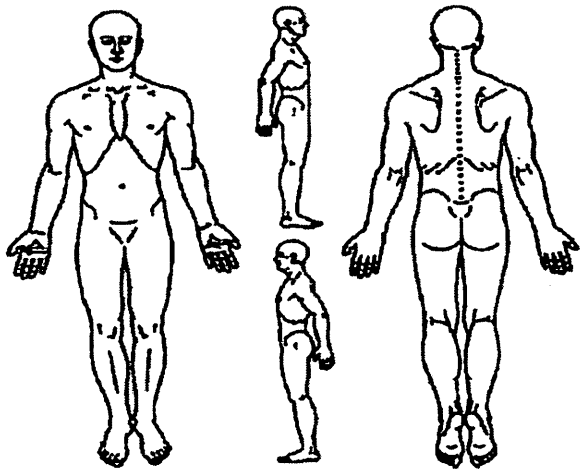
Is there litigation pending about your pain complaint? □ Yes □ No

Does the pain radiate to the arms or legs? □ Yes □ No How long have you had this pain? ____ Months ____ Years

Area of pain you are being referred for?_____

Have you had any surgical procedures related to this pain? □ Yes □ No

PLEASE SHADE IN THE AREAS YOU ARE HAVING PAIN



Describe your pain *(check all that apply)*:

□ Sharp □ Burning □ Shooting □ Stabbing □ Dull □ Aching □ Throbbing □ Other: _____

Any additional symptoms *(check all that apply)*:

□ Numbness □ Muscle Weakness □ Difficulty walking □ Sexual dysfunction □ Other: _____

What makes the pain worse *(check all that apply)*?

□ Coughing/Sneezing □ Stress □ Sitting □ Bending/twisting □ Heat □ Standing □ Weather Changes □ Cold □ Lying

What makes the pain better *(check all that apply)*?

□ Nothing □ Medications □ Heat □ Rest □ Exercise/Activity □ Cold □ Other: _____

TREATMENT HISTORY

Do you take medications for this pain? □ Yes □ No If yes, list medication, dose and frequency_____

_____

_____

Have you tried and failed any other medications, in the past for this pain? □ Yes □ No If yes, what medications?

_____

_____

Previous treatments for your pain: (please choose all that apply)

□ Traction □ Tens Unit □ Physical Therapy □ Chiropractor □Acupuncture □Heat/Ice □ Injections

Have you had any diagnostic testing/imaging of the affected area? □ Yes □ No (MRI, X-RAY ETC.)

Do you have any treatment records from other **PAIN** physicians? □ Yes □ No

If yes, please provide the names of the other pain physicians you have seen, and why you are no longer with them:

_____

_____

Please CHECK any of the following that you are CURRENTLY experiencing related to your pain complaint:

Constitutional: □ trouble sleeping □ weight loss □ weight gain □ poor appetite

Ear/Nose/Throat: □ snoring □ hearing loss □ dizziness □ ringing in the ears

Cardiovascular: □ swelling in feet/legs □ leg pain/poor circulation □ chest pain

Respiratory: □ chronic cough □ wheezing □ shortness of breath □ home oxygen

Gastrointestinal: □ constipation □ diarrhea □ nausea/vomiting □ abdominal pain

Genitourinary: □ incontinence of urine □ kidney stones

Skin: □ rashes □ infections

Neurologic: □ headache □ difficulty walking □ recent falls □ poor memory □ progressive weakness □ progressive sensation loss

Musculoskeletal: □ joint pain □ joint stiffness □ muscle cramps/spasms □ muscle loss

Psychiatric: □ frequent sadness □ excessive worry □ anxiety

PAST MEDICAL/SURGICAL/FAMILY/SOCIAL HISTORY

Do you take prescription "blood thinners", such as Coumadin (Warfarin), Persantine (Dipyridamole), Plavix (Clopidogrel), Lovenox (Enoxaparin), Ticlid (Ticlopidine), Aspirin? □ Yes □ No

If yes, which drug_____ Prescribing physician: _____

Are you or could you be pregnant? □ Yes □ No Do you have a pacemaker? □ Yes □ No

Have you ever been treated for cancer? □ Yes □ No If yes, what type? _____Year?_____

Are you currently being treated for an infection of ANY kind? □ Yes □ No

Please list any surgeries you have had in the past: _____

_____

_____

Have you ever been diagnosed with any of the following? *(Check all that apply)*

□Asthma/COPD/Emphysema □Fibromyalgia □Hypertension □Peripheral Neuropathy □ Stroke □ Blood Disorder
□ Glaucoma □ Kidney Disease □ Diverticulitis/Chrones□ Urinary Incontinence □ Bowel Incontinence □ Headache
□ Liver Conditions □ Seizure □ HIV/Aids □ Heart Conditions □ Arthritis/Joint Disease □ Autoimmune Disease
□ Stomach Ulcer/reflux/gastritis □ Diabetes □ Thyroid/Endocrine Cond. □ Other: _____

Please provide a current medication list if this has not been updated in our system recently.

Please list any known allergies *(food, drug, environmental)* _____

Family history of medical problems *(include parents, and siblings **ONLY**)*: _____

_____

_____

Occupation: _____ □ Full Time □ Part Time □ Retired □ Disabled □ Workers' Comp

Do you have physical work restrictions? □ Yes □ No

Do you live alone? □ Yes □ No If not whom else lives in the home with you? _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

Number of Children? _____ Ages: _____

Do you smoke currently? □ Yes □ No If yes, how much? #____ packs per day for ____ years

Did you smoke previously? □ Yes □ No If yes, how much? #____ packs per day for ____ years Year Quit? _____

Have you used recreational (street) drugs in the last 5 years? □ Yes □ No

Do you use Alcohol? □ Yes □ No If yes, how much? _____ how often? _____

Do you have a history of drug abuse? □ Yes □ No Have you been to rehab for substance abuse? □ Yes □ No

Do you have an advanced directive (Living Will)? □ Yes □ No

By signing below, I hereby certify that the above information is true and correct to the best of my knowledge.

_____ _____

Patient Signature Date Physician Signature Date Received

Pain Management Institute & Aesthetics, LLC

Juliet D. Burry, M.D.

Narcotic Agreement

We are committed to doing all we can to treat your chronic pain condition. In some cases, controlled substances are used as a therapeutic option in the management of chronic pain, which is strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the physician by establishing guidelines, within the laws, for proper and controlled substance use. The words "we" and "our" refer to the facility and the words "I", "me", or "my" refer to you, the patient.

1. All controlled substances must come from the physician whose signature appears below unless specific authorization is obtained for an exception, I understand that I must tell the physician whose signature appears below all drugs that I am taking, have purchase, or obtained, even over-the-counter medications. Failure to do so may result in drug interactions or overdose that could result in harm to me, including death. I will not seek prescriptions for controlled substances from any other physicians, healthcare provider, or dentist. I understand it is unlawful to be prescribed a controlled medication by more than one physician at a time without each physician's knowledge. I also understand that it is unlawful to obtain or attempt to obtain a prescription for a controlled substance by knowingly misrepresenting facts to physicians, or his/her staff, or knowingly withholding facts from a physician or his/her staff including failure to inform the physician or his/her staff of all controlled substances that I have purchased.

___initial

2. All controlled substances must be obtained at the same pharmacy, where possible. Should the need arise to change the pharmacies, our office must be informed. The pharmacy that you have selected is:

   _____ Phone: _____

3. You may not share, sell, or otherwise permit others, including spouse or family members, to have access to any controlled substances that you have been prescribed.
4. ___initial Unannounced urine or serum toxicology specimens may be requested from you, and your cooperation is required.
5. ___initial Unannounced pill counts may be requested from you, and your cooperation is required.
6. ___initial I will not consume excessive amounts of alcohol in conjunction with controlled substances. I will not use, purchase, or otherwise obtain, any other legal drug except as specifically authorized by the physician whose signature appears below as set forth in Section 1 above. I will not use, purchase, or otherwise obtain illegal drugs including marijuana, cocaine, etc. I understand that driving while under the influence of any substance, including a prescribed controlled substance, or any combination of substance (e.g. alcohol and prescribed drugs) which impairs my driving ability, may result in DUI charges.
7. Medication or written prescriptions may not be replaced if they are lost, stolen, get wet, are destroyed, left on airplane, etc. If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities. A report narrating what you told authorities is not enough.
8. Early refills will not be given. Renewals are based upon keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends.
9. In the event you are arrested or incarcerated related to legal or illegal drugs (including alcohol), refills on controlled substances will not be given.
10. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician and that law enforcement officials may be contacted.
11. I affirm that I have the full right and power to sign and be bound by this agreement, and that I have read it, understand, and accept all of its terms.

_____	_____	_____
Patients Full Name	Patients Signature	Date
_____		_____
Physician's Signature		Date

PAIN MANAGEMENT INSTITUTE AND AESTHETICS, LLC

JULIET D. BURRY, M.D.

NARCOTIC INFORMED CONSENT

The goal of my therapy is to reduce my pain to a level that is tolerable and will allow me to improve my day to day functioning.

I understand that daily use of a narcotic increases certain risk, which includes but are not limited to:

- Addiction
- Nausea, Vomiting, and Constipation
- Impaired Judgment, Sleepiness, and Confusion
- Allergic Reactions, Overdose, and Fatal Complications
- Breathing Problems
- Dizziness
- Impaired Ability to Operate Machines, or Drive Motor Vehicles
- Development of Tolerance

I agree to the following guidelines:

1. I will take medications as prescribed by my physician. I will not vary dosage or interval without authorization from my physician,
2. I agree to see Dr. Burry for on-going case management and will schedule regular appointments as long as I am taking narcotic medications.
3. If I do not follow these guidelines I understand that my treatment may be terminated.

I have discussed the risks, benefits, and alternatives to narcotic treatment with my physician. I have had an opportunity to ask questions and receive answers to those questions to my satisfaction. I have also received a copy of this agreement for my own records.

_____	_____	_____
Patient's Full Name	Signature	Date

_____	_____
Physician's Signature	Date

Pain Management Institute
&
Acsthetics

Juliet D. Burry, M.D.

Anesthesiologist and Pain Management Specialist

www.pmiorlando.com

499 East Central Parkway

Altamonte Springs, FL 32701

407-671-5115

407-671-5116 Fax

Following are questions given to patients in pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your treatment will not be determined solely by the answers provided. Thank you.

Patient: _____

Please Print Name

Please answer all the questions below by circling the number that most accurately matches your response. Use the following scale:

0= Never 1=Seldom 2=Sometimes 3=Often 4= Very Often

1.	**How often do you feel that your pain is "out of control?"**	**0**	**1**	**2**	**3**	**4**
2.	**How often do you have mood swings?**	**0**	**1**	**2**	**3**	**4**
3.	**How often do you do things that you later regret?**	**0**	**1**	**2**	**3**	**4**
4.	**How often has your family been supportive and encouraging?**	**0**	**1**	**2**	**3**	**4**
5.	**How often have others told you that you have a bad temper?**	**0**	**1**	**2**	**3**	**4**
6.	**Compared to other people, how often have you been in a car accident?**	**0**	**1**	**2**	**3**	**4**
7.	**How often do you smoke a cigarette within an hour after you wake up?**	**0**	**1**	**2**	**3**	**4**
8.	**How often have you felt a need for higher doses of medication to treat your pain?**	**0**	**1**	**2**	**3**	**4**
9.	**How often do you take more medication than you are supposed to?**	**0**	**1**	**2**	**3**	**4**
10.	**How often have any of you family members, including parents and grandparents had a problem with alcohol or drugs?**	**0**	**1**	**2**	**3**	**4**
11.	**How often have any of your close friends had a problem with alcohol or drugs?**	**0**	**1**	**2**	**3**	**4**

12. How often have others suggested that you have a drug or alcohol problem?	**0**	**1**	**2**	**3**	**4**
13. How often have you attended an AA or NA meeting?	**0**	**1**	**2**	**3**	**4**
14. How often have you had a problem getting along with doctors that prescribe you medicine?	**0**	**1**	**2**	**3**	**4**
15. How often have you taken medication other than the waythat it was prescribed?	**0**	**1**	**2**	**3**	**4**
16. How often have you been seen by a psychiatrist ormental health counselor?	**0**	**1**	**2**	**3**	**4**
17. How often have you been treated for an alcohol or drug problem?	**0**	**1**	**2**	**3**	**4**
18. How often has your medication been lost or stolen?	**0**	**1**	**2**	**3**	**4**
19. How often have others expressed concern over your use ofmedication?	**0**	**1**	**2**	**3**	**4**
20. How often have you felt a craving for medication?	**0**	**1**	**2**	**3**	**4**
21. How often has more than one doctor prescribed pain medication for you at the same time?	**0**	**1**	**2**	**3**	**4**
22. How often have you been asked to give a urine screen for substance abuse?	**0**	**1**	**2**	**3**	**4**
23. How often have you used illegal drugs (such as marijuana, cocaine, etc.) in the past five years?	**0**	**1**	**2**	**3**	**4**
24. How often in your lifetime, have you had legal problems or been arrested?	**0**	**1**	**2**	**3**	**4**

Please include any additional information you wish about the answers above. Thank you.

_____

_____

_____

Signature: _____ **Date:** _____