

ACCOUNT# \_\_\_\_\_ NEW \_\_\_\_\_ UPDATE \_\_\_\_\_

PATIENT LAST NAME		FIRST NAME (legal)		MI	PREFERRED OR NICKNAME	
DATE OF BIRTH	SEX M F	RACE		SOCIAL SECURITY #		
MAILING ADDRESS		APT #	CITY	STATE	ZIP CODE	4 DIGIT
STREET ADDRESS		APT #	CITY	STATE	ZIP CODE	4 DIGIT
HOME PHONE ( )		WORK PHONE ( )		EXT	CELL PHONE ( )	
REFERRING DOCTOR	Other type of Referral Yellow Pages ___ Self ___		MARITAL STATUS			
PRIMARY CARE DOCTOR	Friend/Relative ___ Doctor ___		MARRIED ___		DIVORCED ___	
		Internet ___ Insurance Company ___		SINGLE ___		WIDOWED ___ SEPARATED ___
PHARMACY NAME, PHONE NUMBER AND LOCATION				PREFERRED EMAIL ADDRESS		
<b>PATIENT EMPLOYER (IF NOT EMPLOYED ARE YOU RETIRED ___ OR DISABLED ___)</b>						
EMPLOYER NAME				OCCUPATION		
STREET ADDRESS		CITY	STATE	ZIP CODE	4 DIGIT	
<b>PRIMARY INSURANCE</b>						
INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER			COPAY	
SUBSCRIBER'S NAME		SUBSCRIBER'S EMPLOYER				
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE ___ FEMALE ___		SUBSCRIBER'S ID #		GROUP NUMBER	
<b>SECONDARY INSURANCE</b>						
INSURANCE COMPANY NAME		RELATION TO SUBSCRIBER			COPAY	
SUBSCRIBER'S NAME		SUBSCRIBER'S EMPLOYER				
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SEX MALE ___ FEMALE ___		SUBSCRIBER'S ID #		GROUP NUMBER	
<b>EMERGENCY CONTACT</b>						
(NOT LIVING WITH YOU)		NAME		RELATIONSHIP	PHONE NUMBER-HOME/WORK/CELL	
<b>RESPONSIBLE PARTY</b> WHO IS RESPONSIBLE FOR THE REMAINING BALANCE ON THIS ACCOUNT?						
___ SELF (*If self do not fill in right field.) ___ SPOUSE ___ PARENT ___ GUARDIAN	SOCIAL SECURITY #		LAST NAME		FIRST NAME	MI
	STREET ADDRESS		CITY	STATE	ZIP CODE	4 DIGIT
	HOME PHONE ( )		WORK OR CELL PHONE ( )		EXT	DATE OF BIRTH
WORKERS COMP CLAIM #	DATE OF INJURY	EMPLOYER			STATE OR SELF INSURED?	
I, the patient or guardlan, certify that the information contained on this form is true to the best of my knowledge. I accept responsibility for the charges incurred by the patient, and agree to pay all bills at the time of service, unless prior arrangements have been made. I authorize the physician and clinic to release any information to process insurance claims. I authorize my insurance claim to be paid directly to the clinic. I authorize Western Washington Medical Group to leave messages, which may contain details of my medical condition on my voicemail box if they are unable to reach me.						
PATIENT SIGNATURE _____				DATE _____		
For office use only Dr. _____ Ins. code _____ Acct # _____ Initials _____						



## CONSENT TO RELEASE INFORMATION

### (FAMILY AND FRIENDS)

I, GIVE THE PHYSICIANS AND OFFICE STAFF OF WESTERN WASHINGTON MEDICAL GROUP, PERMISSION TO DISCUSS MY MEDICAL CONDITION (PLEASE LIST FAMILY MEMBERS & FRIENDS ONLY). You may disclose health care information regarding testing, diagnosis, and treatment for the following:

Please check all that apply:  HIV (Aids virus)  Sexually transmitted diseases

Psychiatric disorders/mental health  Drug and/or alcohol use

All health care information \_\_\_\_\_

Health care in my medical record related to the following treatment or condition: \_\_\_\_\_

\_\_\_\_\_

Health care information in my medical records for the date(s): \_\_\_\_\_

Other (e.g., x-rays, bills) specify date(s): \_\_\_\_\_

WITH: \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

AND/OR \_\_\_\_\_

WHO IS \_\_\_\_\_ AT PH# \_\_\_\_\_  
(RELATIONSHIP)

**THIS IS AN INDEFINITE CONSENT FORM UNLESS OTHERWISE SPECIFIED**

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF  
PRIVACY PRACTICES**

By my signature below I, \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices for Western Washington Medical Group.

\_\_\_\_\_  
Signature of client (or personal representative)

\_\_\_\_\_  
Date

**If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

**For Office Use Only**

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date

This form will be retained in your medical record

PLACE LABEL  
HERE

**Present History**

How did the pain start?

- |  |                                  |   |  |
|--|----------------------------------|---|--|
| <input type="checkbox"/> Suddenly                    | <input type="checkbox"/> Fall    | <input type="checkbox"/> Injured at work          | <input type="checkbox"/> Injured during sports |
| <input type="checkbox"/> Gradually                   | <input type="checkbox"/> Bending | <input type="checkbox"/> Injured in auto accident | <input type="checkbox"/> No apparent cause     |
| <input type="checkbox"/> Lifting                     | <input type="checkbox"/> Pulling | <input type="checkbox"/> Hit from behind          | <input type="checkbox"/> Injured at home       |
| <input type="checkbox"/> Other (specify below) _____ |                                  |   |  |

If other, please specify \_\_\_\_\_

Do you have any emotional reactions to your current problem?       Yes  No

If yes, what are the emotional reactions you have related to your current problem?

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> I feel nothing matters | <input type="checkbox"/> I feel angry                              | <input type="checkbox"/> I feel sad (depressed) |
| <input type="checkbox"/> I feel frustrated      | <input type="checkbox"/> I feel like taking my own life (suicidal) | <input type="checkbox"/> Nothing can help me    |

**Pain**

**My pain is**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Present Intermittently     | <input type="checkbox"/> Present but varies in intensity | <input type="checkbox"/> Improving                     |   |
| <input type="checkbox"/> Worse - present more often | <input type="checkbox"/> Worse - more intense            | <input type="checkbox"/> Worse - changing in character | <input type="checkbox"/> Worse - changing in location |

Please mark the severity of pain that corresponds to the area of your body. Rate how much pain hurts on an average day.

- |                  |                                 |                         |                         |                         |                         |                         |                         |                         |                         |                         |                                   |
|------------------|---------------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-----------------------------------|
| <b>Back pain</b> | <input type="radio"/> 0<br>none | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10<br>worst |
| <b>Leg pain</b>  | <input type="radio"/> 0<br>none | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10<br>worst |
| <b>Neck pain</b> | <input type="radio"/> 0<br>none | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10<br>worst |
| <b>Arm pain</b>  | <input type="radio"/> 0<br>none | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> 4 | <input type="radio"/> 5 | <input type="radio"/> 6 | <input type="radio"/> 7 | <input type="radio"/> 8 | <input type="radio"/> 9 | <input type="radio"/> 10<br>worst |

**Past Treatments for this Problem**

Have you had any troubles with this problem before?  Yes  No

If yes, when was the FIRST time it happened: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you seen any other doctors for your current problem?

If yes, list their name and date seen \_\_\_\_\_

Yes  No

Which of the following treatments have you had for this problem?

- |   |  |   |
|---|--|---|
| <input type="radio"/> Physical therapy      | <input type="radio"/> TENS Unit                  | <input type="radio"/> Chiropractic Manipulation |
| <input type="radio"/> Home exercise program | <input type="radio"/> Epidural Steroid Injection | <input type="radio"/> N/A - no prior treatments |
| <input type="radio"/> Brace                 |  |   |

If you answered yes to any of the post treatments listed above, please provide additional details below. If you have not had any prior treatments for this problem please continue to the next section.

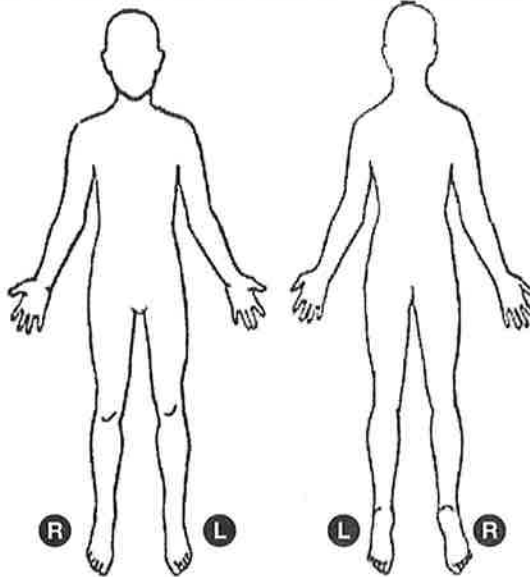
Physical Therapy \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Where? \_\_\_\_\_      # of Sessions: \_\_\_\_\_

if physical therapy, what was done and was it helpful? \_\_\_\_\_

- |                               |                    |  |  |
|-------------------------------|--------------------|--|--|
| Exercise                      | ____ / ____ / ____ | Are you currently doing home exercises?  | <input type="radio"/> Yes <input type="radio"/> No |
| Brace                         | ____ / ____ / ____ | If yes, what type of brace?              |  |
| TENS Unit                     | ____ / ____ / ____ | Are you currently using a TENS unit?     | <input type="radio"/> Yes <input type="radio"/> No |
| Epidural Steroid Injection    | ____ / ____ / ____ | Was it helpful and how long did it last? | _____  |
| Epidural Steroid Injection #2 | ____ / ____ / ____ | Was it helpful and how long did it last? | _____  |
| Epidural Steroid Injection #3 | ____ / ____ / ____ | Was it helpful and how long did it last? | _____  |

Please continue to the next page...

Mark the areas on your body where you feel the sensations described above, using the appropriate symbol. Mark the areas to which your pain spreads.



- ✓ Stabbing
- Tingling
- Numbness
- + Pins and Needles
- ▲ Aching
- × Burning

Do you have loss of bowel or bladder control?

Yes  No

My weight is

Increasing  Decreasing  Steady

Are there any problems with weak muscles?

None  Weak in arms  Weak in legs  Generally weak

Sleep pattern

No difficulty with sleep  Unable to fall asleep  Can't maintain sleep  Wake frequently due to pain

**Functional Activities**

I can comfortably sit for  1 min  5 min  10 min  15 min  20 min  30 min  45 min  1 hour  2 hours +

I can comfortably stand for  1 min  5 min  10 min  15 min  20 min  30 min  45 min  1 hour  2 hours +

I can comfortably walk for  1 min  5 min  10 min  15 min  20 min  30 min  45 min  1 hour  2 hours +

**Daily Activities**

I can do \_\_\_ of my housework  All  Some  None

I can do \_\_\_ of my leisure activities  All  Some  None

I can do \_\_\_ of my work  All  Some  None

My sex life is  normal with no pain  normal with some pain  nearly normal, but painful  severely restricted by pain  nearly absent because of pain  absent, pain prevents any sex

Do you have any difficulty with sexual function?  Yes  No  N/A

**Prior Tests**

What tests have you had done for your problem?  X-ray  Myelogram  CT  Bone scan  MRI  EMG  Discogram  N/A

If you have had any of the tests listed above, please provide additional details if you know them.

X-ray	____ / ____ / ____	Where? _____	Results _____
Myelogram	____ / ____ / ____	Where? _____	Results _____
CT	____ / ____ / ____	Where? _____	Results _____
Bone Scan	____ / ____ / ____	Where? _____	Results _____
MRI	____ / ____ / ____	Where? _____	Results _____
EMG	____ / ____ / ____	Where? _____	Results _____
		Where?	Results

Current Medications, inhalers, eye drops, patches...	Dose and Frequency	What do you take it for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Supplements, Herbal remedies, currently taking	Dose and Frequency	What do you take it for?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies	Reaction that you had	Serious injuries or fractures
<input type="checkbox"/> Latex	_____	_____
<input type="checkbox"/> Iodine	_____	_____
<input type="checkbox"/> Penicillin	_____	_____
<input type="checkbox"/> Sulfa	_____	_____
Other _____	_____	_____
Other _____	_____	_____
Other _____	_____	_____
<input type="checkbox"/> Food Allergies:	_____	_____

**Review of Systems (check all that apply)**

Constitutional	<input type="checkbox"/> Fever	<input type="checkbox"/> Sweats	<input type="checkbox"/> Recent weight loss	<input type="checkbox"/> No complaints
	<input type="checkbox"/> Chills	<input type="checkbox"/> Fatigue		
If recent weight loss, how many pounds lost? _____				
Skin	<input type="checkbox"/> Rashes	<input type="checkbox"/> Sores	<input type="checkbox"/> Scars	<input type="checkbox"/> No complaints
Cardiovascular	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Swelling hands/feet/ankles	<input type="checkbox"/> No complaints
Respiratory	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Cough	<input type="checkbox"/> Coughing blood	<input type="checkbox"/> No complaints
Hematologic	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Blood clots	<input type="checkbox"/> No complaints
Stomach/Intestinal	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Constipation	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> No complaints
Urology	<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> No complaints
Musculoskeletal	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Sprains	<input type="checkbox"/> Swelling	<input type="checkbox"/> No complaints
Neurological	<input type="checkbox"/> Headaches	<input type="checkbox"/> Numbness	<input type="checkbox"/> Dizziness	<input type="checkbox"/> No complaints
Mental Health	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Sleep problems	<input type="checkbox"/> No complaints

This form was completed by \_\_\_\_\_  Patient  Parent/Guardian Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record at Western Washington Medical Group.

Patient Name \_\_\_\_\_

Today's Date \_\_\_\_\_

**REVIEW OF SYSTEMS**

*Have you had any of the following during the past year?  
Please circle Yes if any apply to you*

**Cardiac**

- Chest pain ..... Yes
- Swelling in legs/ Edema ..... Yes
- Leg cramps or calf pain ..... Yes
- Palpitations or arrhythmias ..... Yes

**Constitutional/ General**

- Fevers ..... Yes
- Headaches ..... Yes
- Sleeping difficulty ..... Yes
- Fainting ..... Yes

**Eyes**

- Double or blurry vision ..... Yes
- Wear Glasses or contacts ..... Yes
- Eye disease or injury ..... Yes

**Gastrointestinal**

- Blood in stool ..... Yes
- Diarrhea ..... Yes
- Constipation ..... Yes
- Nausea or vomiting ..... Yes
- Acid indigestion/ heartburn ..... Yes

**Genitourinary**

- Blood in urine ..... Yes
- Frequency in urination ..... Yes
- Burning or painful urination ..... Yes
- Incontinence or dribbling ..... Yes

**Hematology**

- Bruises or bleeds easily..... Yes
- Bleeding disorder..... Yes
- Blood clot, DVT, or a Pulmonary embolism... Yes

**Pulmonary**

- Shortness of breath ..... Yes
- Wheezing ..... Yes
- Asthma..... Yes
- Frequent cough ..... Yes
- COPD or Emphysema..... Yes

**Skin**

- Rashes or itching..... Yes
- Changes in moles or skin lesions Yes
- Psoriasis..... Yes

**Musculoskeletal**

- Limping..... Yes
- Joint pain..... Yes
- Joint stiffness..... Yes
- Joint swelling..... Yes
- Numbness to arm or leg..... Yes

**Patient's Signature:** \_\_\_\_\_  
(or parent/legal guardian)

Practitioner's Initials \_\_\_\_\_

**PAST MEDICAL HISTORY**

*Have you ever had any of the following?  
Please circle Yes if any apply to you*

- Yes Diabetes
- Yes Thyroid disorder
- Yes Kidney or Renal disorder
- Yes Stroke/TIA
- Yes Seizures or Epilepsy
- Yes Anemia
- Yes Varicose Veins
- Yes High Blood Pressure
- Yes High Cholesterol
- Yes Heart Problems \_\_\_\_\_
- Yes Heart Attack/ Myocardial Infarction
- Yes Heart Stents or Balloon Angioplasty
- Yes Atrial Fibrillation
- Yes Irregular Heartbeat
- Yes Pacemaker
- Yes Heartburn, Acid reflux
- Yes Ulcers or Gastritis
- Yes Esophagitis, Barrett's or Hiatal Hernia
- Yes Seasonal Allergies
- Yes Sleep Apnea, if Yes CPAP use? \_\_\_\_\_
- Yes Tuberculosis
- Yes Gout
- Yes Cancer \_\_\_\_\_
- Yes Migraines
- Yes Depression
- Yes Anxiety
- Yes Fibromyalgia
- Yes Chronic Pain \_\_\_\_\_
- Yes Hepatitis A , B , C (circle which)
- Yes HIV or exposure to it
- Yes History of MRSA, VRE, Staph infections
- Yes Anesthesia problems? \_\_\_\_\_
- Yes Post Operative Nausea/Vomiting

**Other Diagnoses or Symptoms that we should be aware of?**

---



---



---

**Surgery**

Have you had surgeries for this problem?  Yes  No

If yes, please list surgeon, if it was helpful and what was done.

Have you had breast implants? (necessary for surgeries that require you to lie on your stomach)  Yes  No  N/A

Would you accept blood products or blood transfusion if necessary?  Yes  No

Have you ever had complications with surgery?  Yes  No

If so, please list the name of the surgery and any complications below. You may wish to include problems before, during, or after your procedure, as well as any problems you may have had with anesthesia.

Complication \_\_\_\_\_ Year \_\_\_\_\_

Complication \_\_\_\_\_ Year \_\_\_\_\_

**Employment Status**

Are you currently employed?  Yes  No Present employer \_\_\_\_\_

What is your occupation? \_\_\_\_\_ How long have you worked there? \_\_\_\_\_

My present job consists of:  Ladders  Lifting  Sitting  Standing  Stairs  Walking

**Other Job Duties**

Per work day, how many hours do you sit?  <1  1  2  3  4  5  6  7  8  >8

Per work day, how many hours do you stand?  <1  1  2  3  4  5  6  7  8  >8

How many pounds do you lift for your job?  <15 lbs  15-25 lbs  25-40 lbs  40-60 lbs  >60 lbs

If unemployed or currently not working, please provide a date for at least one of the following.

Retired on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Total disability \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Medical leave began \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Social Security disability \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Laid off \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ When did you last work? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Would your employer allow you to return to work with restrictions?  Yes  No

**Social History**

What sports, exercise activity, or hobbies do you participate in? \_\_\_\_\_

Do you live alone or as only adult in the house?  Yes  No

Alcohol use: Never Rarely Moderate Daily # of drinks \_\_\_\_\_ Recovery Treatment \_\_\_\_\_

Tobacco use: Never Yes, current packs/day \_\_\_\_\_ How many years \_\_\_\_\_ Quit-year \_\_\_\_\_

This form was completed by  Patient  Parent  Guardian  POA  Family member  Other

Agreement

I have reviewed and fully completed these forms to the best of my ability. I understand this information will become part of my permanent medical record.

X \_\_\_\_\_ DATE \_\_\_\_\_



### Pain Catastrophizing Scale

Everyone experiences painful situations at some point in their lives. We are interested in the types of thoughts and feeling that you have when you are in pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

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

### Neuropathic Pain Questionnaire

1 Numbness: rate your usual pain:



2 Tingling Pain: rate your usual pain:



3 Increased Pain Due To Touch: rate your usual pain:



## Opioid Assessment for Patients

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1 How often do you have mood swings?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 How often have you felt the need for higher doses of medication to treat you pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3 How often have you felt impatient with your doctors?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 How often have you felt that things are just too overwhelming that you can't handle them?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 How often is there tension in the home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 How often have you counted pain pills to see how many are remaining?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 How often have you been concerned that people will judge you for taking pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 How often do you feel bored?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9 How often have you taken more pain medication than you were supposed to?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 How often have you worried about being left alone?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11 How often have you felt a craving for medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12 How often have others expressed concern over your use of medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13 How often have any of your close friends had a problem with alcohol or drugs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14 How often have others told you that you had a bad temper?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15 How often have you felt consumed by the need to get pain medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16 How often have you run out of pain medication early?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17 How often have others kept you from getting what you deserve?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18 How often, in your lifetime, have you had legal problems or been arrested?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19 How often have you attended an AA or NA meeting?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 How often have you been in an argument that was so out of control that someone got hurt?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21 How often have you been sexually abused?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22 How often have others suggested that you have a drug or alcohol problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23 How often have you had to borrow pain medications from your family or friends?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24 How often have you been treated for an alcohol or drug problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_



**OSSH**  
**Orthopedic, Sports,**  
**Spine and Hand**  
**Center**

Western Washington Medical Group

## **CANCELLATION FEE**

A scheduled appointment is a commitment of time between the doctor and patient. We have reserved time just for you. When appointments are missed or canceled late, that time is lost.

We ask that when you schedule an appointment you make every effort to keep that appointment. We understand that emergencies do arise, and we will take that into consideration.

I acknowledge a \$75.00 No Show Fee will be charged to me personally if I do not arrive for, or cancel my scheduled appointment without 24 hours notice.

## **DOCUMENT FEES**

A Fee of \$10 will be charged for any documents requiring your provider's review and signature. Payment of service will be required before documents are completed and/or forwarded. Commercial or private insurance are not financially responsible for this fee.

Patient  
Signature \_\_\_\_\_

Date of Birth \_\_\_\_\_

Print Name \_\_\_\_\_

Today's Date \_\_\_\_\_