BROCK PAIN MEDICINE

Dear New Patient:

We are glad that you have chosen Brock Pain Medicine and Anesthesia, PA, for your pain management healthcare needs. We appreciate the opportunity to treat you and want to make the pre-visit process as simple and convenient as possible.

Therefore, we have provided the necessary forms that the office and your physician will use during the course of your care. These forms need to be filled out in their entirety and given to the receptionist when you sign in for your first visit.

It is our goal to see patients as close as possible to their scheduled time, so please plan to arrive in the office 30 minutes prior to your appointment. We appreciate your understanding and look forward to the opportunity of having you as our patient. If you have any questions, please feel free to call the office.

Thank you for your cooperation,

Lee A. Brock, MD
The Physicians and Staff of Brock Pain Medicine.

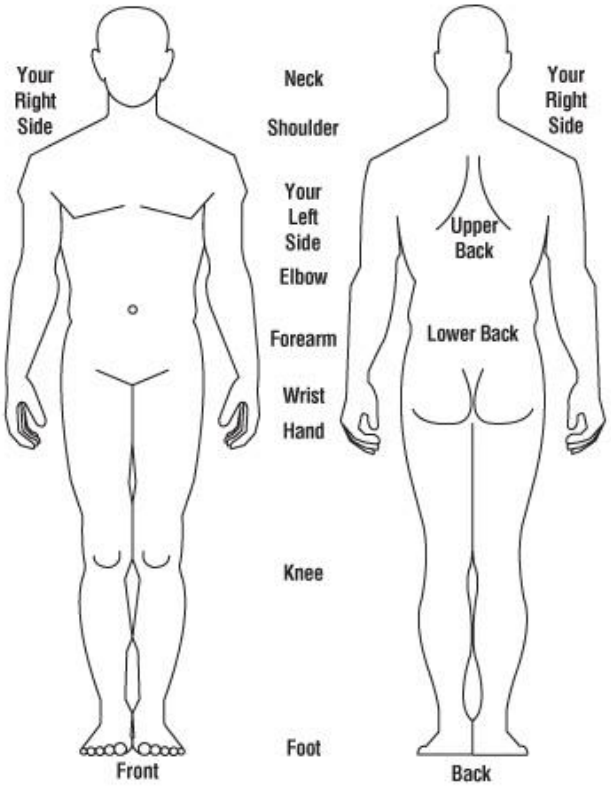
Name: _____ Date: _____

Date of Birth: _____ Allergies to Medications: _____

Current Medications: (please list all current medications, prescriptions, over the counter, vitamins, & herbal remedies)
_____
_____

Where is your pain now? Highlight the area on the diagram and mark the areas on your body where you feel the sensations described below, using the appropriate symbols.

Aching	Numbness	Tingling	Burning	Stabbing
^^^^^	- - - - - -	ooooo	xxxx	/////



Rate your pain: Circle the level of your pain today

No Pain _____ Worst Pain

0 1 2 3 4 5 6 7 8 9 10

Circle the words that describe your pain:

Aching	Burning	Dull	Sharp	Shooting	Stabbing	Throbbing
Pressure	Crushing	Cramping	Spasmodic	Pulling	Tender	Tight	Sore

1. Please list any modalities you use for pain relief besides medication: _____
2. Please list any activities/movements that increase your pain: _____

1. Name of current Family Physician: _____
2. Name of preferred pharmacy: _____
    a. Pharmacy Address: _____
    b. Pharmacy Phone Number: _____
3. Are you on blood thinners such as Coumadin, Plavix, etc. (Y / N) _____
4. Do you have a pacemaker or ICD? (Y / N) _____
5. How many hours (total) do you sleep at night? _____
6. Number of times you wake during the night due to pain? _____
7. Are you currently engaged in regular physical activity or physical therapy? _____ How often? _____
8. Have you tried psychological intervention or biofeedback? (Y / N) _____
9. Have you tried a tens unit or an IF-27? (Y / N) _____ How much did it help? _____
10. If you had a recent block, how much did it help? _____
11. Do you use alcohol? (Y /N) _____ How many drinks a week? _____
12. Do you smoke? (Y / N) _____ How many packs a week? _____
13. Is there a chance you are pregnant? (Y / N) _____ **If yes, alert the staff.**

Circle your answer:

Are your medications helping? YES or NO

Are you having any side effects from your medications? YES or NO

Are you having any constipation? YES or NO

Do you worry about addiction? YES or NO

Has anyone ever told you that you are taking too much medication? YES or NO

Do you have sleep apnea or snore? (circle) Sleep Apnea Snore Neither

Today's Date: _____ Primary Care Physician: _____

Patient Information:

Patient's Name: _____ Marital Status: (circle) Single/Mar/Div/Sep/Widow

Is this your legal name? Yes/No

If not, what is your legal name? _____ Maiden Name _____

Date of Birth: _____ Age: _____ Race: _____ Sex: Male/Female

Street Address: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____ Social Security: _____

Patient Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Referring Physician: _____ Referring Physician Phone: _____

Insurance Information

Name of Primary Insurance (if applicable): _____

Subscriber's Name: _____ Subscriber's SSN: _____

Subscriber's DOB: _____

Policy #: _____ Group #: _____ Co-Pay: _____

Patients Relationship to Subscriber: (circle) Self/Spouse/Child/Other _____

Party Responsible for Bill: _____ Birth Date: _____

Address: _____ Phone: _____

Occupation: _____ Employer: _____ Employer Phone: _____

In Case of Emergency

Friend/Relative _____ Relationship to Patient: _____ Phone: _____

Please Initial:

___ The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Brock Pain Medicine, or insurance company to release any information required to process my claims.

___ Brock Pain Medicine provides the opportunity for patients to communicate by e-mail. By providing an electronic mail address, the patients acknowledge the medical information may be contained in these communications. E-mail should never be used for emergency problems. Brock Pain Medicine cannot guarantee the security and confidentiality of e-mail communications, and will not be liable for improper disclosure of confidential information that is not caused by Brock Pain Medicine.

PATIENT QUESTIONNAIRE

Name: _____ Date: _____ Referring Physician: _____

Date of Birth: _____ Height: _____ Weight: _____

Brief history of present symptoms: _____

_____

When did your Symptoms Begin:_____

Location of Symptoms: _____

Severity of Symptoms: (circle number): Least 0-1-2-3-4-5-6-7-8-9-10 Worst

Characterize your pain: (Burning, Aching, Numbness, Sharp, Sore, Tingling)

_____

_____

Duration of Symptoms: (constant or intermittent) _____

Modifying Factors: (Worsening) _____ (Lessening) _____

Previous Testing Completed (MRI, X-Rays, CT Scan, Discogram, Nerve-Studies): _____

_____

Is this a work injury? (circle) YES or NO

Are you currently employed? (If not, when were you last employed) _____

Please list any previous treatments you have completed (Physical therapy, injections, massage,

chiropractor, etc.) _____

Past Medical History: _____

_____

Past Surgical History: _____

_____

PATIENT QUESTIONNAIRE PAGE 2

Medications: _____

_____

_____

Allergies: _____

Review of Symptoms: (circle all that apply)

Yes/No Heart Disease _____
Yes/No Hypertension _____
Yes/No Bleeding Problems _____
Yes/No Taking Blood Thinners _____
Yes/No Seizures _____
Yes/No Diabetes/Endocrine Problems_____
Yes/No Lung Problems _____
Yes/No Alcoholism _____
Yes/No Drug Abuse _____
Yes/No Gastro-Intestinal Problems_____
Yes/No Genitourinary _____
Yes/No Bowel/Bladder Difficulty _____
Yes/No Stroke _____
Yes/No Liver Problems _____
Yes/No HIV _____
Yes/No Hepatitis _____
Yes/No Attempting to become pregnant _____
Yes/No Is there a possibility you may be pregnant _____
Yes/No Arm/Leg Numbness Right/Left/Both _____
Yes/No Arm/Leg Pain Right/Left/Both _____
Yes/No Arm/Leg Weakness Right/Left/Both _____

Family History:

Yes/No Heart Disease _____
Yes/No Hypertension _____
Yes/No Diabetes/Endocrine Problems_____
Yes/No Lung Problems _____
Yes/No Gastro-Intestinal Problems_____
Yes/No Stroke _____

Social History:

Yes/No Do you smoke? If yes, packs per day? _____ How long? _____
Yes/No Consume Alcohol? If yes, how much? _____
Yes/No History of Alcohol and/or Substance Abuse? _____
Yes/No Have you ever been in alcohol or drug rehabilitation? _____

NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY

Brock Pain Medicine and Anesthesia, PA, is issuing this Notice of Privacy Practices about your legal rights with respect to your health information.

OUR PLEDGE TO YOU

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of care and services you receive from us. We need this record to provide you with quality care, bill for your care, and comply with legal requirements. This notice applies to all of the records of your care that we maintain, whether made by or staff and authorized trainees, or by your personal doctor. This notice tells you about the ways in which Brock Pain Medicine may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe our obligations regarding the use and disclosure of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Brock Pain Medicine and Anesthesia doctors, nurses, laboratory technicians and other health care professionals may use health information about you to provide you with health treatments or services. We may also disclose health information about you to others who are involved in taking care of you. For example, we may send health information about you to a specialist as part of a referral.

Brock Pain Medicine may use and disclose health information about you to obtain payment for the treatment and services you receive from us. For example, we may send billing information to your insurance company or Medicare. We may also tell your insurance company about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Brock Pain Medicine may send you a statement of your account if payment is due from you. We may send the guarantor (responsible party for payment) monthly statements for charges for all patients under the guarantor.

Brock Pain Medicine may use and disclose health information about you to support our health care operations. For example, we may use health information to review the treatment and services and to evaluate the performance of our staff in caring for you. We may combine health information about many patients to decide what additional services we should offer. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

We may disclose information to notify a family member or other person responsible for your care about your condition, status, and location. If you are admitted and unless you tell us otherwise, we may provide your name, location in the hospital, and your general condition (good, fair, etc.) for

information to be included in a patient directory and make this information available to anyone who asks for you by name.

We may use and disclose health information to contact you for an appointment reminder, to tell you about health-related services or recommended possibilities, treatment options or alternatives that may be of interest to you, or to contact you about supporting our fundraising efforts (of which you have the right to opt out).

Subject to certain requirements, we may use or disclose health information about you without your prior authorization for other reasons:

We may give out health information about you for public health purposes; to report abuse or neglect health oversight reviews; in research studies, for funeral arrangements and organ donation; in response to special law enforcement requests, valid judicial or administrative orders, or for authorized national security and intelligence activities; for workers' compensation purposes; to avert a serious threat to your health or safety or those of the public or another person; and when required by law. If you are or were a member of the armed forces, we may release information about you as required by military command authorities or the Department of Veterans Affair. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official.

In any other situation not covered by this notice (i.e. psychotherapy notes, marketing, remuneration), we will ask for your written authorization before using or disclosing your health information. You may revoke this authorization for any subsequent disclosures by notifying us in writing.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the right to request in writing that you inspect and obtain a copy of the health information that we use to make decisions about your care. We may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. If we deny your request to inspect or obtain a copy in certain limited circumstances, you may request that the denial be reviewed. Another licensed health care professional chosen by Brock Pain Medicine will review your request and the denial, and we will comply with the outcome of the review.

If you believe that health information we have about you is incorrect or incomplete, you may make a written request to ask us to amend information. The request should state the reason for the amendment and specific information to be amended. The amendment must be limited to one page. Any amendment we make to your health information will be disclosed to those with who we disclose information as previously stated.

We may deny your request for an amendment if the information to be amended was not created by us, is no longer maintained by us, is not part of the information which you would be permitted to inspect and copy, or is accurate and complete. We will notify you if we deny your request for amendment and you may appeal, in writing, our decision. Any statements of disagreement or rebuttal

will be linked to your health information and made a part of any subsequent disclosure we make of such information.

You have the right to make a written request for a list of disclosure we have made of your health information, except for uses and disclosures for treatment, payment, and health care operations, as previously described, and those for which you have authorized disclosure. Your request must state a time period which may not be longer than six years. We will not charge you for the first list you request within a 12-month period. Additional requests will be charged according to our cost for producing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at the time before any costs are incurred.

You have the right to request a restriction on the health information we use or disclose about you for treatment, payment, or health care operations. There may be risks associated with such restrictions, and we may ask you to acknowledge these risks in writing for certain requests we may make. We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you have paid for a healthcare item or service in full, out-pf-pocket, we must honor your request to restrict the information that is disclosed to a health plan for purposes of payment or operations.

You have the right to request, in writing without requiring you to state a reason, that confidential communications with you be made in an alternative manner or location. We will accommodate all reasonable requests. Your requests must specify how or where you wish to be contacted.

You have the right to be notified of a breach of unsecured PHI in the event that you are affected.

WRITTEN REQUESTS

If you have any questions about the notice, please contact Brock Pain Medicine and Anesthesia, to the attention of the Office Manager: 469-742-9950

COPIES OF NOTICE OF CHANGE

You have the right to obtain a paper copy of this notice at any time.

We reserve the right to change this notice and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future.

COMPLAINTS

If you are concerned that your privacy rights may have been violated or you disagree with a decision we make about your health information, you may contact Brock Pain Medicine and Anesthesia's Office Manager at 4697429950. You may also send a written complaint to the U.S. Department of Health and Human Services. We can provide you with the address.

Under no circumstances will we ever ask you to waive your rights under this notice or retaliate against you in any manner for filling a complaint.

Please sign the attached acknowledgment that you have received our Notice of Privacy Practices, effective April 15, 2020.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
BROCK PAIN MEDICINE

I received a copy of the Notice of Privacy Practices from the above noted entities:

Signature: _____ Date: _____

Print Name: _____

Personal Representative: _____

If personal representative, please note relationship to patient: _____

Prescription Pick-Up Authorization

Name: _____ Relationship: _____

Signature: _____
(Authorized Representative must present valid photo ID upon pick up)

Name: _____ Relationship: _____

Signature: _____
(Authorized Representative must present valid photo ID upon pick up)

ADVANCED PRACTICE NURSE / NURSE PRACTITIONER CONSENT

Dr. Brock wants you to know that he employs Advanced Practice Nurses (also known as Nurse Practitioners) to assist him in a "team approach" to his high-quality delivery of medical care.

An Advanced Practice Nurse (APN)/Nurse Practitioner (NP) is a Registered Nurse who has received advanced education and training in the provision of health care. Advanced Practice Nurse/Nurse Practitioners are not doctors. APN's/NP's of Brock Pain Medicine can diagnose, treat, and monitor routine and complex pain disorders. If you are seen by an APN/NP, your doctor will review your care with the APN/NP as part of the care plan.

I have read the above and understand that in this practice a "team approach" is used, with my unique problems and/or needs presented and discussed with one or more physicians in the development of my care plan. I also understand that typically one MD will direct my overall care, but that from time to time I may be seen by any or all the practitioners in this practice, including a Nurse Practitioner.

I hereby consent to the services of a Nurse Practitioner for my health care needs.

I understand that I can refuse to see the Nurse Practitioner, and request to see a Physician. I understand that this may require my appointment to be re-scheduled.

Please SIGN to acknowledge that you have read and accept the above.

Signature: _____ Date: _____

WARNING REGARDING PHYSICAL DEPENDENCE
OF CONTROLLED SUBSTANCE

Physical dependence and/or tolerance can occur with the use of controlled substances such as opioids/narcotics.

Physical dependence means that if the controlled substance is abruptly stopped or not taken as directed, a withdrawal symptom can occur. This is a normal physiological response. The withdrawal syndrome could include, but is not limited to, sweating, nervousness, abdominal cramps, diarrhea, goose bumps, and alternations in one's mood.

It should be noted that physical dependence does not equal addiction. For example, one can be dependent on insulin to treat diabetes or dependent on prednisone (steroids) to treat asthma, but one is not addicted to the insulin or prednisone.

Addiction is a primary, chronic neurologic-disease with genetic, psychosocial, and environmental factors influencing its development and manifestation. It is characterized by behavior that includes one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and cravings. This means the drug decreases one's quality of life.

Tolerance means a state of adaptation in which exposure to the drug induces changes that result in diminution of one or more of the drug's effect over time. The dose of the controlled substance may have to be titrated up or down to a dose that produces maximum function and a realistic decrease of the patient's pain.

It may be deemed necessary by your doctor that you see an addiction medicine specialist at any time while receiving controlled substance medications. Understand that if you do not attend such an appointment, your medication may be discontinued or may not be refilled beyond a tapering dose to completion. If the specialist feels that you are at risk for addiction or psychological dependence, medications will no longer be refilled.

Side effects for opiate/narcotic medication may include:

- Drowsiness, sedation and/or disorientation resulting in falls and resulting in significant injury.
- Constipation and bowel obstruction, possibly requiring surgical intervention and potentially resulting in ischemic (dead) bowel, sepsis, and death.
- Allergic and/or anaphylactic reactions to the medications resulting in hypotension (low blood pressure), tachycardia (fast heart rate), arrhythmia (irregular heart rhythm), respiratory or cardiac arrest, and death.
- Respiratory depression resulting in respiratory arrest and/or death, as well as resultant cardiac arrest and/or death.
- Tolerance to the medication may develop after long-term use, which means that ultimately this medication may become less effective.

- Physical dependency, psychological dependency, and addiction are possible with all narcotic medications. These situations may result in discontinuation of the pain medication by your doctor.
- Withdrawal phenomenon may occur with abrupt discontinuation of the pain medication. This may cause significant side effects such as heart palpitations, diaphoresis (swelling), anxiety, nausea, vomiting, elevated pulse, and elevated blood pressure. Do not abruptly discontinue this medication. Your health care provider will guide you on how to stop narcotics using a slow weaning process.

Precautions while taking Opiate medications:

- Patients taking anticoagulants (blood thinners) are at particularly high risk of any kind of trauma (falls, etc.) as a resultant life-threatening hemorrhage, intracranial bleeding, or death may occur.
- The elderly may exhibit marketed or dramatic side effects from narcotic medications, even in low doses.
- Patients with other significant medical problems (including heart or lung disease) are at a high risk for complications related to the use of narcotic medications.
- Patients taking sedative medications or central nervous system depressants should use narcotics sparingly and in reduced doses due to addictive and/or synergistic interactions and greater than expected or enhanced side effects.
- Narcotic analgesics should not be used during pregnancy.

Take precautions with the following activities while taking Opiate Medications:

- Any kind of activity where judgement is required (i.e. driving; signing important documents; caring for the sick, the elderly, or the very young).
- Narcotic medications may affect the ability to drive or operate machinery.
- Avoid working on high-risk areas (i.e. construction sites, elevated work sites, working with power tools, etc.)
- If you experience the side effects such as sedation with opiate use, do not participate in the above activities.

If you have questions regarding these items, please ask your physician or nurse practitioner during your visit.

PAIN MANAGEMENT CONTRACT AND PROGRAM RULES

OFFICE COPY

I have agreed to use controlled medications as part of my treatment for pain. I understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by local, state and federal government. Because my physician is prescribing me such medication(s) to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of the contract, and at the sole discretion of my physician, may result in termination of our physician-patient relationship.

1. I will receive controlled medications only from the Pain Medicine Physician Dr. Lee A. Brock of Brock Pain Medicine. If I receive controlled medications prescribed by other physicians, my treatment will be stopped.
2. I will use the medication(s) only as prescribed by the Pain Medicine Physician Dr. Lee A. Brock of Brock Pain Medicine.
3. I understand that combining other medications with controlled medications may cause drowsiness, intoxication, or death. Some of these medications are tranquilizers (downers), stimulants (uppers), diet pills, sleeping pills, alcohol, or other street drugs.
4. I understand if I use more medications than prescribed, sell or let other people use them, or obtain/use other medications not authorized by my physician, he/she may refuse to continue prescribing these medications. A referral to an Addiction Treatment Specialist may be made.
5. I will select one pharmacy to fill my medication and inform my physician of any changes.
6. I understand that refills will be made on a scheduled basis as determined by my physician. Refills may be obtained at the time of a scheduled appointment.
7. If my medication(s) is/are stolen, I will report this to my local police department and obtain a stolen item report. Replacement prescriptions will be given at the sole discretion of my physicians.
8. I understand that I must be seen by my physician regularly. This requires a scheduled visit. Refills will not be made if I do not keep this appointment. My response to treatment using these medications will be evaluated at each visit.
9. I understand that other modalities of pain management may be incorporated as deemed necessary. These include psychological evaluation, physician therapy, behavioral and biofeedback therapy, and stress management.
10. I understand that I may have to submit to blood or urine tests to check if I am following the rules.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

PAIN MANAGEMENT CONTRACT AND PROGRAM RULES

PATIENT COPY

I have agreed to use controlled medications as part of my treatment for pain. I understand that these drugs are very useful, but have a potential for misuse and are therefore closely controlled by local, state and federal government. Because my physician is prescribing me such medication(s) to help manage my pain, I agree to the following conditions. I am aware that failure to abide by any of these conditions will be considered a breach of the contract, and at the sole discretion of my physician, may result in termination of our physician-patient relationship.

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10. I understand that I may have to submit to blood or urine tests to check if I am following the rules.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

BROCK PAIN MEDICINE
CANCELLATION POLICY/NO SHOW POLICY
FOR DOCTOR APPOINTMENTS AND SURGERY PROCEDURES

1. **Cancellation/No show Policy for Doctor Appointment**
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work of family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
   If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.
2. **Scheduled Appointments**
   We understand that delays can happen however we must try to keep the other patients and doctors on time.
   If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.
3. **Cancellations/No Show Policy for Procedures**
   Due to the scheduled block of time needed for procedures, last minute cancellations can cause problems and added expenses for the surgery center.
   If surgery is not cancelled at least 72 hours in advance you will be charged a hundred and fifty-dollar ($150) fee; this will not be covered by your insurance company.
4. **Account balances**
   We will require that patients with balances pay their account balances to zero prior to receiving further services by our practices.
   Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.
   Patients with balances over $100 must make payment arrangements prior to future appointments being made.

_____ _____ ___/___/_____
Printed Patient Name Signature of Patient/Guardian Date

BROCK PAIN MEDICINE

BROCK PAIN MEDICINE

Prescription Medications

Dr. Brock signs all prescriptions electronically by noon the following day, whether your appointment was with Dr. Brock or one of the NP's or PA. Please wait to call the office about a prescription until after that timeframe.

Please contact your pharmacy prior to contacting our office to ask if prescription has been sent and when you can pick up your medications.

Refills on narcotics and other controlled substances will not be filled prior to 28 days after the previous prescription.

Follow Up Appointments

Follow up appointments are scheduled for 4 weeks after the previous appointment.
Follow up appointments are primarily with the Nurse Practitioners or Physician Assistant. They are fully equipped to assist you and manage your medical care.

Our front desk coordinators will call you to make your follow up, however, please call the office if you have not heard from them within a week after your previous appointment to schedule your next appointment.

Accepted Insurance Plans

Please verify covered benefits with your insurance carrier as our in-network plans vary with each specific plan.

*Our contracted insurance companies are listed, but are not limited to the ones below. Please call the office if you do not see the company you are with to check benefits and eligibility.

- Aetna
- Aetna Medicare
- Blue Cross Blue Shield
- Humana
- Cigna PPO
- First Health
- Health Smart
- United Healthcare
- TriCare

SOAP Questionnaire

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

1. How often do you have mood swings?
   0 1 2 3 4

2. How often have you felt a need for higher doses of medication to treat your pain?
   0 1 2 3 4

3. How often have you felt impatient with your doctors?
   0 1 2 3 4

4. How often have you felt that things are just too overwhelming that you can't handle them?
   0 1 2 3 4

5. How often is there tension in the home?
   0 1 2 3 4

6. How often have you counted pain pills to see how many are remaining?
   0 1 2 3 4

7. How often have you been concerned that people will judge you for taking pain medication?
   0 1 2 3 4

8. How often do you feel bored?
   0 1 2 3 4

9. How often have you taken more pain medication that you were supposed to?
   0 1 2 3 4

10. How often have you been worried about being left alone?
    0 1 2 3 4

11. How often have you felt a craving for medication?
    0 1 2 3 4

12. How often have others expressed a concern over your use of medication?
    0 1 2 3 4

13. How often have any of your close friends had a problem with alcohol or drugs?
    0 1 2 3 4

14. How often have others told you that you had a bad temper?
0 1 2 3 4

15. How often have you felt consumed by the need to get pain medication?
0 1 2 3 4

16. How often have you run out of pain medication early?
0 1 2 3 4

17. How often have others kept you from getting what you deserve?
0 1 2 3 4

18. How often, in your lifetime, have you had legal problems or been arrested?
0 1 2 3 4

19. How often have you attended an AA or NA meeting?
0 1 2 3 4

20. How often have you been in an argument that was so out of control that someone got hurt?
0 1 2 3 4

21. How often have you been sexually abused?
0 1 2 3 4

22. How often have others suggested that you have a drug or alcohol problem?
0 1 2 3 4

23. How often have you had to borrow pain medication from your family or friend?
0 1 2 3 4

24. How often have you been treated for an alcohol or drug problem?
0 1 2 3 4

Part Two Patient Health Questionnaire

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

1. Little interest or pleasure in doing this: 0 1 2 3 4

2. Feeling down, depressed, or hopeless: 0 1 2 3 4