Advanced Pain Management Institute

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Welcome to Advanced Pain Management Institute**.** Thank you for choosing us to assist you in the management of your unique pain problems. We appreciate your trust in us and look forward to the opportunity to work with you and your referring physician.

In order to provide the best possible care for you, it is essential to keep your medical information current. We have enclosed a Patient Health History and Pain Questionnaire that will need to be completed prior to your first visit. Although the questionnaire is quite lengthy, we request you that you take time to be thorough and complete, since all the information is important in the management of your care. Please read and answer each question carefully. Please print all the answers clearly. If you feel the need to add more information than the space given can accommodate, feel free to use additional sheets of paper. You may also fax in the filled out form for the doctor to review prior to your visit.

Please remember to bring your photo ID, all your medical records, MRIs, X-rays, & most importantly **medications in their original packaging**. It is important to keep your insurance information current. Please keep us informed of any changes in your insurance status. Please bring your insurance information with you to your first visit to our office (insurance cards(s), forms, authorization, and/or referral forms) so that we can properly process your paperwork with your insurance company or the responsible party. We show that your current insurance is :

Please notify us immediately of any changes to our insurance coverage. Review your plan participation requirements carefully because you are financially liable for all deductibles, copayments, products and services not covered by your insurance plan.

We have **24 hour CANCELLATION POLICY**. A $50.00 charge will be applied to your account in case of late cancellation or missed office appointment and $100.00 for missed procedures/injections. **Please acknowledge below**.
I acknowledge that I have been informed that any advance directive will be suspended during my procedure at APMI. I understand that it is not the responsibility of APMI to advise each provider of care (emergency responders, emergency room, acute care facility, etc.) of my Advance Directive and that I should keep a copy of my Advance Directive with me and my designated health care proxy should also have a copy of the form.

Signature: _____ Date: _____

If you have any questions or concerns regarding your upcoming appointment, please feel free to call our office at **(707) 359-2255 in Vacaville** or **(916)334-1100 in Sacramento.** Our office hours are Monday through Friday 8:00 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m.
We look forward to meeting you.

YOUR APPOINTMENT DATE/TIME:

CREDIT CARD POLICY(does not apply to LIEN cases)

We are a paperless office and do not mail statements. For your convenience, we offer an option to use your credit/debit card to cover co-pays and deductibles. Your credit card information is kept confidential & secure, and payments are processed ONLY after your insurance instructs us on the amount due from you.	**I hereby authorize APMI to charge my credit/debit card for balance due for services that my insurance company identifies as my financial responsibility.** Cardholder signature: _____ Date: _____ To cancel this authorization, I must give a 60-day written notice and have my account in good standing.
_VISA _MC _AmEx _DISC _Debit card Name on card: Card Number: Exp Date:	

CREDIT CARD ON FILE POLICY

We are using paperless office now, and are transitioning away from mailing statements. As a convenient method of payment for the portion of services that your insurance applies to your co-pays or deductible, we offer an option of keeping your credit or debit card on file. Your credit card information is kept confidential and secure and payments to your card are processed **ONLY after the claim has been filed and processed by your insurer**, and the insurance portion of the claim has paid and posted to the account.

If you decline, a paper fee of $5.00 will be added to your account for any balances that we must attempt to collect through mailing monthly statement. Furthermore, an "outstanding balance" charge of 1% of the total bill will be charged for each month that the bill remains unpaid.

I understand and agree:

Patient Name: _____

DOB: _____

Patient Signature: _____ Date: _____

CREDIT CARD CHARGE AUTHORIZATION

I, the undersigned, hereby authorize to charge the portion of the bill that is my financial responsibility for payment of fees and costs owned to the Advanced Pain Management Institute, pursuant to Explanation of Payment from my insurance carrier against the below indicated credit card account.

Check One: **Visa** ☐ **MasterCard** ☐ **Am EX** ☐ **Discover** ☐

Cardholder Name: _____

Credit Card #: _____

Expiration Date: _____

Cardholder Billing Address: _____

City, State, Zip: _____

I hereby authorize and request APMI to charge my credit card for balances due monthly, until my balance is cleared, for services rendered that my insurance company identifies as my financial responsibility.
This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to APMI in writing and the account must be in good standing.

Cardholder Signature: _____ Date: _____

Provider Name: Valery D. Tarasenko, M.D.
Email: billing@paininstitute.org
Phone #: 707-359-2255 ext. 106

NEW PATIENT QUESTIONNAIRE

Patient Information

Today's Date: ___ / _____ / _____

Name (first) _____ (last) _____ DOB: _____ Age _____

Sex: _____ Height: _____ Weight _____

Home Address: _____

City/State/Zip _____

Home Phone:_____ Cell:_____Work:_____
Preferred: □ Home, □ Mobile, □ Work

Email:_____

Race: □African American □Asian □Hispanic □Middle Eastern □Native American □Pacific Islander □White □Other: _____

Ethnicity: □Arab □Armenian □European □Filipino □Hispanic □Non-Hispanic □Russian □Vietnamese □Refused to Report
□Other _____

Marital Status: □ Divorced □ Married □ Separated □ Single □ Unknown □ Widowed

Education: □College graduate □ Partial college □ Elementary school □ High School □ Post-graduate □ MD □ JD □ MBA

Employment: □Employed □ Unemployed □ Disability

Primary Doctor: _____ Preferred Pharmacy : _____ Address _____
_____

Language**:** □ English □ Spanish □ Russian □ Other: _____

Referred by: □ Physician: _____□APMI Website □ Other _____

Primary Insurance: _____Secondary Insurance: _____

□ Attorney: _____ □Family/Friend: _____Other: _____

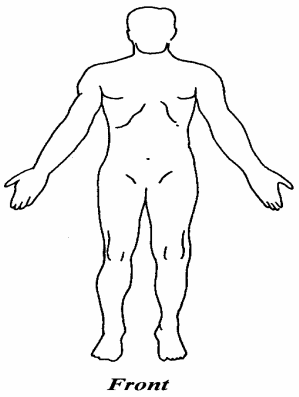
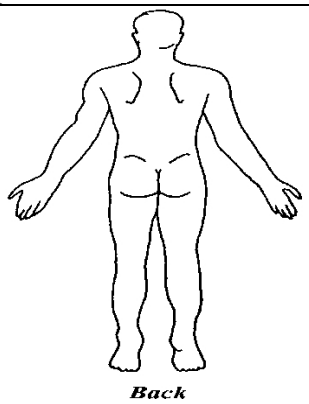
Emergency Contact Name: _____ Phone: _____ Relationship: _____

ALLERGIES Do you have any known drug allergies, including Latex, X-ray dye, Iodine, shellfish, tape? □No □Yes

Name	**Allergic Reaction Type**

□ Right Handed □ Left Handed
□ Are you pregnant? □ N/A □ NO □ Not Sure □ YES _____weeks__

CURRENT SYMPTOMS Please mark the location(s) of your pain with an "X" and show where it goes with an arrow.
If whole areas are painful, shade in the painful area. Circle the words which best describe you pain.

sharp throbbing stabbing cutting dull, aching pressure cramping	 *Front* right left	shooting electric-like pins and needles weakness numbness	 *Back* left right	burning skin sensitivity to light touch, cold abnormal swelling, hair/nail growth abnormal sweating abnormal skin color changes abnormal skin temperature limited movement

Please list your complaints in order of importance.

Complaint #1: _____

The pain is □constant (90-100% of the time), □frequent (75%), □intermittent (50%), □occasional (25%)

Pain Intensity: Circle your pain intensity with "0" representing no pain and "10" the most severe pain imaginable	Current	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	7 day average	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	Least pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	Worst pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe

What increases or decreases your pain?

Increase		Decrease
	Bending forward	
	Bending backwards	
	Sitting	
	Standing	
	Walking	
	Exercise	

Increase		Decrease
	Coughing or Straining	
	Bowel movements	
	Lying down	
	Pushing shopping cart	
	Relaxation	
	Medications (give names)	

Complaint #2: _____

The pain is □constant (90-100% of the time), □frequent (75%), □intermittent (50%), □occasional (25%)

It's worse with _____

It's better with _____

Pain Scale: current ___/10, 7 day average ___/10, 7 day least ___/10, 7 day worst ___/10

Complaint #3: _____

The pain is ( ) constant (90-100% of the time) ( ) frequent (75%) ( ) intermittent (50%) ( ) occasional (25%)

It's worse with _____

It's better with _____

Pain Scale: current ___/10, 7 day average ___/10, 7 day least ___/10, 7 day worst ___/10

If you have both back and leg pain: back is ____% of entire pain leg is _____ % of entire pain

If you have both neck and arm pain: neck is ____% of entire pain arm is _____% of entire pain

How many blocks can you walk before having to stop because of pain? _____ Blocks

HISTORY OF PRESENT ILLNESS. When did you first start having the pain?
_____ / _____ / _____ (mm/dd/yyyy) □At age of _____ □ ____years ago □ _____ months ago

How did your symptoms start? □ Suddenly □Gradually □Over what period of time? _____

Are your symptoms related to an i**njury**? □No □Yes If yes: Date of Injury ____ / _____ / _____ (mm/dd/yyyy)

Where did your injury occur? (Address or description of location): _____
_____

The injury was: □Lifting □Falling □Twisting □Whiplash □Repetitive Strain Injury

Describe how your injury occurred: _____
_____
_____

When did you realize that you were injured? _____

The injury was □Not Work Related □Work Related □Auto Accident
Please list the injured body parts, as a result of your injury: _____
_____

Have you ever experienced the same or similar symptoms before this injury? □Yes □ No If "Yes", please explain:
_____

Claim # _____Claim status: □Active □Settled Were you awarded Future Medical Benefits: □No □Yes
Permanent & Stationary: □No □Yes If yes, when? ____ / ___ / _____ (mm/dd/yyyy)

Diagnostic Tests and Imaging

MRI of the _____ Date: _____ Facility _____
CT scan _____ Date: _____ Facility _____
X-ray of the _____ Date: _____ Facility _____
EMG _____ Date: _____ Facility _____
Other diagnostic testing: _____

ð I have not had any diagnostic tests

Pain Treatment History

□Physical Therapy Date _____ For how long? Where How often Did it help?
□Chiropractic Date Where How often How did it help?
□Psychological Therapy _____
□Surgery: _____ Date _____ Done by _____Result_
□Epidural Steroid Injection: Cervical/Thoracic/Lumbar Date _____ Done by _____Result_
_□Joint Injection: _____ Date _____ Done by _____Result_
□Medial Branch Blocks: _____ Date _____ Done by _____Result_
□Nerve Block: _____ Date _____ Done by _____Result_
□Spinal Cord Stimulator - Trial/Permanent Implantation: Date _____ Done by _____Result_
□Trigger Point Injection Date _____ Done by _____Result_
□Vertebroplasty □Kyphoplasty: Date _____ Done by _____Result_
Other: _____
□I have not had any prior treatments for my current pain complaints

Are your symptoms related to a MOTOR VEHICLE ACCIDENT (MVA)? YES NO **If "No", please skip this page.**

Date of accident? _____ Time of day _____ am pm

Were you the: driver; passenger front seat, back seat (on driver side in the middle on passenger side)

Were you wearing a seat belt? No Yes

Your vehicle was struck from: behind front driver side passenger side

Area(s) of vehicle damaged? rear front driver side passenger side

The car rolled over did not roll over How many vehicles were involved in the accident? _____

Damage to your vehicle? Mild Moderate Significant Totaled

The accident occurred when ☐other vehicle lost control ☐patient's vehicle lost control ☐vehicle hit the patient

Did airbags deploy? No Yes

Location of the accident: ☐highway ☐red light ☐stop sign ☐parking lot ☐street road_____

_____

Estimate how fast your vehicle was traveling: _____mph

Estimate how fast the other vehicle was traveling: _____ mph

At the time of the accident were you looking? straight ahead to the right to the left up down

Was your body turned? NO Yes to the left Yes to the right

Direction you were headed? North South East West Direction of other vehicle? North South East West

Were you aware of the impending collision? No Yes Did you prepare yourself for the collision? No Yes

How many people were in your vehicle? _____ . Besides you, was anyone else injured? No Yes

Describe how the accident occurred (please be specific): _____

_____

_____

What were the year, make and model of the vehicle you were in? Year _____ Make _____ Model _____

What were the year, make and model of the other vehicle? Year _____ Make _____ Model _____

Did your vehicle collide with anything? No Yes If yes, what? _____

Did any of your body parts hit the interior of the car? No Yes If yes, explain: _____

HISTORY OF TREATMENT

If injured, were you treated at the scene? NO YES If yes, how? _____

_____

Did you go to a hospital? NO YES If yes, when? _____
City? _____ Name of hospital? _____
If yes, did you get hospitalized? NO YES If yes, how long? _____
Name of the doctor who treated you? _____
Describe treatment and/or diagnostic testing: _____

_____

What did that doctor say was wrong with you? _____

_____

Please list all the doctors seen for this injury, other than at a hospital. List in the order seen:

Name of doctor #1: _____ Type of doctor? _____ City? _____

Describe treatment, tests, or referrals: _____

_____

What did the doctor say was wrong with you? _____

_____

Results of treatment? _____
Date of first treatment? _____ Last treatment? _____ Number of treatments? _____
Length of treatments? _____ Still being treated? NO YES If yes, how often? _____

Name of doctor #2: _____ Type of doctor? _____ City? _____
Describe treatment, tests, or referrals: _____

_____

_____

What did the doctor say was wrong with you? _____

_____

Results of treatment? _____
Date of first treatment? _____ Last treatment? _____ Number of treatments? _____
Length of treatments? _____ Still being treated? NO YES If yes, how often? _____

Name of doctor #3: _____ Type of doctor? _____ City? _____
Describe treatment, tests, or referrals: _____

_____

_____

What did the doctor say was wrong with you? _____

_____

Results of treatment? _____
Date of first treatment? _____ Last treatment? _____ Number of treatments? _____
Length of treatments? _____ Still being treated? ( )no, ( )yes If yes, how often? _____

Any other treatment, tests, therapy or examinations that have not been described? NO YES
If yes, explain: _____

_____

Were you treated by any of these providers before? NO YES If yes, explain: _____

_____

Do you treat your condition at home? NO YES If yes, explain: _____

_____

Are you using ( ) brace, ( ) cane, ( ) crutches, ( ) wheelchair?
Has there been a recommendation of testing or treatment which you have not received? NO YES
What treatment(s) offer you the most relief? _____

_____

CURRENT MEDICATIONS Please check the medications that you are currently on. Indicate the dosage and number of pills you are taking per day.
Cross out medications that you have tried in the past, indicate the reason for stopping.

OPIOIDS	**MUSCLE RELAXANTS**	**ANTIDEPRESSANTS**
buprenorphine (Suboxone)	baclofen	bupropion (Wellbutrin)
Butrans	carisoprodol (Soma)	citalopram (Celexa)
fentanyl	cyclobenzaprine (Flexeril)	desipramine (Norpramin)
hydrocodone (Norco)	metaxalone (Skelaxin)	duloxetine (Cymbalta)
hydromorphone (Dilaudid)	tizanidine (Zanaflex)	escitalopram (Lexapro)
methadone	**MIGRAINE**	fluoxetine (Prozac)
morphine (MS Contin)	amitriptyline (Elavil)	nefazodone (Serxone)
oxycodone (Oxycontin)	nortriptyline (Pamelor)	paroxetine (Paxil)
oxymorphone (Opana)	atenolol (Tenormin)	sertraline (Zoloft)
Percocet	metoprolol (Lopressor)	trazodone
tapentadol (Nucynta)	propranolol (Inderal)	venlafaxine (Effexor)
tramadol	topiramate (Topamax)	
Tylenol with codeine	valproic acid (Depakote)	**SLEEPING meds**
	Botox, Xeomin	zolpidem (Ambien)
ANTI-INFLAMMATORIES (NSAIDS)	eletriptan (Relpax)	eszopiclone (Lunesta)
celecoxib (Celebrex)	rizatriptan (Maxalt)	**BLOOD THINNERS**
diclofenac (Voltaren)	sumatriptan (Imitrex)	Aspirin
etodolac	zolmitriptan (Zomig)	Coumadin
Ibuprofen (Motrin)	**ANTIANXIETY**	Plavix
indomethacin (Indocin)	alprazolam (Xanax)	**OTHERS**
ketorolac (Toradol)	buspirone	carbamazepine (Tegretol)
meloxicam (Mobic)	clonazepam (Klonopin)	gabapentin (Neurontin)
nabumetone (Relafen)	diazepam (Valium)	lamotrigine (Lamictal)
naproxen (Aleve)	lorazepam (Ativan)	phenytoin (Dilantin)
piroxicam (Feldene)	temazepam (Restoril)	pregabalin (Lyrica)
Tylenol	triazolam (Halcion)	Lidoderm

OTHER MEDICATIONS	Dose	How many at a time	How many times a day	Benefits/ side effects	First Intake?	Last intake?	Refill needed?

Review of Systems (Circle all that apply).

General	Chills Fatigue Fever Weakness Unplanned weight gain/loss
Eyes	Double/blurred vision Glaucoma Recent visual changes
Nose:	Congestion Bleeding Runny nose Sinusitis
Throat:	Difficulty swallowing Hoarseness Sore throat
Cardiovascular:	Chest pain High blood pressure Irregular heartbeat Palpitation Previous heart attack
Respiratory:	Cough Pulmonary embolism Shortness of breath Tuberculosis Wheezing
Gastrointestinal:	Abdominal pain Constipation Dark stools Diarrhea Heartburn Hepatitis Nausea Vomiting
GU:	Flank pain Hematuria Incontinence Kidney stones Urinary retention
Musculoskeletal:	Arthritis Gout Knee pain Muscle pain Restricted movement Shoulder pain Stiffness
Skin	Easy bruising Hair loss Hives Itching Lesions Lumps Rash
Neurological:	Problems controlling bowel/ bladder Dizziness Drowsines Headache Seizures Trouble walking Weakness
Psychiatric:	Anxiety Depression Memory loss Mood swings Panic episodes Poor concentration Suicidal thoughts/planning
Endocrine:	Cold /heat intolerance Diabetes Thyroid disorder
Hematology:	Anemia Bleeding Enlarged lymph nodes Low platelet count

DISABILITY: Has this illness affected your work performance? □No □Yes If yes, how? _____

_____

Before developing this condition, how would you describe your health? □Excellent □Good □Fair □Poor
If fair or poor, explain: _____

Activities you avoid because of pain: □going to work □performing household chores □doing yard work or shopping □driving □socializing □participating in recreation □having sexual relations □exercising □caring for self

Have you missed work or been placed on modified duty due to this condition? □No □YES If yes, explain: _____

_____

PRIOR WORK INJURIES: List in chronological order.

	Date	Injured body part(s)	Claim#	Status of the claim	Employer
1					
2					
3					

PRIOR NON-WORK RELATED INJURIES: List in chronological order.

	Date	Injured body part(s)	Claim#	Status of the claim	Employer
1					
2					
3					

Have you experienced the same or similar symptoms before the onset of this condition? □No □Yes. If yes, explain: __

_____

_____

Have you received a **prior** disability award? □No □Yes If yes, explain: _____

_____

Have you served in the military? □No □Yes If yes, did you receive a medical discharge? □No □Yes
If yes, explain: _____

_____

Have you suffered any new injuries to the body parts which were injured in the accident? □NO □Yes
If yes, explain: _____

PAST MEDICAL HISTORY: Have you ever had any of the following health problems?

Diabetes Type I II	Arthritis	Bleeding	Hepatitis A B C
High blood pressure	Fibromyalgia	Cancer	HIV/ AIDS
Chest pain, heart attack	Lupus	Kidney disease	Syphilis
Asthma, COPD	Stroke (TIA)	Seizure or epilepsy	TB

Other medical problems:

1	5
2	6
3	7

List all surgeries (date and type of operation):

1. Laminectomy?	5.
2. Fusion?	6.
3.	7.

Have you ever had any problems with anesthesia/sedation? □No □Yes (Please describe) _____

_____

FAMILY HISTORY List all health problems in your family ☐ none

Mother ☐Alcohol addiction ☐Drug addiction ☐Back pain ☐Fibromyalgia ☐Migraine headaches ☐Psychiatric illnesses ☐Suicide

Father ☐Alcohol addiction ☐Drug addiction ☐Back pain ☐Fibromyalgia ☐Migraine headaches ☐Psychiatric illnesses ☐Suicide

Present Physician(s) Name & City _____

_____

Past Physician(s) Name & City _____

_____

JOB DESCRIPTION

Who is your employer? _____ What is your job title? _____

What is the nature of your work? _____

When did you start working for this employer? _____

Employed ( ) Full-time ( ) Part-time ____ hrs/day, ____ days/week

( ) Temporarily disabled ( ) Permanently disabled ( ) Retired

How many rest periods do you have per day? _____ How long are the rest periods? _____

How many hours per work day do you? Sit ___ stoop ___ walk ___ stand ___ kneel ___ squat ___ climb ___ bend ___ twist _

Please list your job duties/activities at work

WORK HISTORY Please list all previous employers before this accident. (Dates/ Employer/ Job Title/ Duties)

1. _____
2. _____
3. _____

SOCIAL HISTORY

Are you? ☐single ☐married ☐widowed ☐separated ☐divorced

Are you currently living? ☐alone ☐with spouse ☐partner (name?) ☐with parents ☐with friends ☐other _____

How many children do you have (names? ages?) _____

_____

Years married/ in long-term relationship _____ Times Married _____ Times Divorced _____

Education. How many years of schooling have you had? _____

Please list any degrees which you have: PhD MD JD RN MBA BA BS GED Other ___

☐partial college training

☐high school graduate

☐trade-technical school graduate

☐partial high school (10th grade through 12th)

☐partial junior high school (7th grade through 9th)

☐elementary school (6th grade or less)

Do you exercise? ☐No ☐Yes If yes _____ average min/day, _____times/week

Describe your exercises and frequency _____

_____

If no, why not? _____

_____

Do you have hobbies? ☐No ☐Yes Please describe your hobbies and frequency: _____

_____

SUBSTANCE USE HISTORY. Please check all that apply**.**

	Currently	In The past	Never	Date/Time of most recent use	Method of use	How Often?	How Much?	How many years?
Alcohol								
Anti-anxiety								
Cocaine								
Crystal Meth								
Heroin								
Inhalants								
LSD								
Marijuana								
Methadone								
Pain Killers								
PCP								
Stimulants (pills)								
Other								

Do you use tobacco? ☐No ☐Yes _____ packs of cigarettes per day for _____ years.
Quit smoking _____ years ago. Used to smoke _____ packs of cigarettes per day for _____ years.

Have you ever abused alcohol? ☐No ☐Yes Attended AA? ☐No ☐Yes If yes, when? _____

Have you ever abused drugs? ☐No ☐Yes Attended NA? ☐No ☐Yes If yes, when? _____

Did you ever stop using any of the above because of dependence? ☐No ☐Yes If yes, please list _____

What was your longest period of abstinence? _____

Would you like to learn about our opioid detox program? ☐Yes ☐No

Have you ever been arrested or convicted? ☐No ☐Yes **Drug-related:** ☐No ☐Yes **DUI**: ☐No ☐Yes How Many?

Domestic violence ☐No ☐Yes Other _____

Have you ever been abused? ☐No ☐Yes ☐Physically ☐Verbally ☐Emotionally ☐Sexually

Have you ever had psychiatric, psychological, or social work evaluations or treatments? ☐No ☐Yes

If yes, explain _____

THE OSWESTRY DISABILITY INDEX

Date: ____/_____/_____

This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life activities. We realize that you may consider more than one statement in a section applicable to you but please mark the one box that most closely describes your present day situation.

1: Pain Intensity
- ☐ 0. My pain is mild to moderate. I do not need painkillers.
- ☐ 1. The pain is bad but I manage without taking painkillers.
- ☐ 2. Painkillers give complete relief from pain.
- ☐ 3. Painkillers give moderate relief from pain.
- ☐ 4. Painkillers give very little relief from pain.
- ☐ 5. Painkillers have no effect on the pain.

2 Personal Care
- ☐ 0. I can look after myself normally without causing pain.
- ☐ 1. I can look after myself normally but it causes extra pain.
- ☐ 2. It is painful to look after myself and I am slow and careful.
- ☐ 3. I need some help but manage most of my personal care.
- ☐ 4. I need help every day in most aspects of self-care.
- ☐ 5. I do not get dressed; I wash with difficulty and stay in bed.

3 Lifting
- ☐ 0. I can lift heavy weights without causing extra pain.
- ☐ 1. I can lift heavy weights but it causes extra pain.
- ☐ 2. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (i.e. on a table)
- ☐ 3. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ 4. I can lift very light weights.
- ☐ 5. I cannot lift or carry anything at all.

4 Walking
- ☐ 0. I can walk as far as I wish.
- ☐ 1. Pain prevents me from walking more than 1 mile.
- ☐ 2. Pain prevents me from walking more than ½ mile.
- ☐ 3. Pain prevents me from walking more than ¼ mile.
- ☐ 4. I can walk only if I use a cane or crutches.
- ☐ 5. I am in bed or in a chair for most of every day.

5. Sitting
- ☐ 0. I can sit in any chair for as long as I like.
- ☐ 1. I can sit in my favorite chair only, but for as long as I like.
- ☐ 2. Pain prevents me from sitting for more than 1 hour.
- ☐ 3. Pain prevents me from sitting for more than ½ hour.
- ☐ 4. Pain prevents me from sitting for more than 10 minutes.
- ☐ 5. Pain prevents me from sitting at all.

6. Standing
- ☐ 0. I can stand as long as I want without extra pain.
- ☐ 1. I can stand as long as I want but it gives me extra pain.
- ☐ 2. Pain prevents me from standing for more than 1 hour.
- ☐ 3. Pain prevents me from standing for more than ½ hour.
- ☐ 4. Pain prevents me from standing for more than 10 min.
- ☐ 5. Pain prevents me from standing at all.

7. Sleeping
- ☐ 0. Pain does not prevent me from sleeping well.
- ☐ 1. I sleep well but only when taking medicine.
- ☐ 2. Even when I take medication, I sleep less than 6 hours.
- ☐ 3. Even when I take medication, I sleep less than 4 hours.
- ☐ 4. Even when I take medication, I sleep less than 2 hours.
- ☐ 5. Pain prevents me from sleeping at all.

8. Social Life
- ☐ 0. My social life is normal and causes me no extra pain.
- ☐ 1. My social life is normal but increased the degree of pain.
- ☐ 2. Pain affects my social life by limiting only my more energetic interests such as dancing, sports, etc.
- ☐ 3. Pain has restricted my social life and I do not go out as often.
- ☐ 4. Pain has restricted my social life to my home.
- ☐ 5. I have no social life because of pain.

9. Sexual Activity
- ☐ 0. My sexual activity is normal and causes no extra pain.
- ☐ 1. My sexual activity is normal but causes some extra pain.
- ☐ 2. My sexual activity is nearly normal but is very painful.
- ☐ 3. My sexual activity is severely restricted by pain.
- ☐ 4. My sexual activity is nearly absent because of pain.
- ☐ 5. Pain prevents any sexual activity at all.

10. Traveling
- ☐ 0. I can travel anywhere without extra pain.
- ☐ 1. I can travel anywhere but it gives me extra pain.
- ☐ 2. Pain is bad but I manage journeys over 2 hours.
- ☐ 3. Pain restricts me to journeys of less than 1 hour.
- ☐ 4. Pain restricts me to necessary journeys under ½ hour.
- ☐ 5. Pain prevents traveling except to the doctor/hospital

BECK DEPRESSION INVENTORY

Date: ____/_____/_____

On this questionnaire are groups of statements. Please read each group of statements carefully then pick out the statement in each group that best describes the way you have been feeling the past week including today. Circle the number next to the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1	0	I do not feel sad
	1	I feel sad
	2	I am sad all the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2	0	I am not particularly discouraged about the future
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to
	3	I feel that the future is hopeless and that things cannot improve.
3	0	I do not feel like a failure.
	1	I feel I have failed more than the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4	0	I get as much satisfaction out of things as I used to
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5	0	I don't feel particularly guilty
	1	I feel guilty a good part of the time
	2	I feel quite guilty most of the time
	3	I feel guilty all of the time.
6	0	I don't' feel I am being punished
	1	I feel I may be punished
	2	I expect to be punished
	3	I feel I am being punished
7	0	I don't feel disappointed in myself
	1	I am disappointed in myself
	2	I am disgusted with myself.
	3	I hate myself
8	0	I don't feel I am any worse than anybody else.
	1	I am critical of myself for my weaknesses or mistakes
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens
9	0	I don't have any thoughts of killing myself
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself
	3	I would kill myself if I had the chance
	0	I don't cry any more than usual.
10	1	I cry more now than I used to
	2	I cry all the time now
	3	I used to be able to cry but now I can't cry even though I want to.
	0	I am no more irritated now than I ever am.
11	1	I get annoyed or irritated more easily than I used to.
	2	I feel irritated all the time now.
	3	I don't get irritated at all by the things that used to irritate me.
12	0	I have not lost interest in other people.
	1	1 I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.
13	0	I make decisions about as well as I ever could.
	1	I put off making decisions more than I used to.
	2	I have greater difficulty in making decisions than before.
	3	I can't make decisions at all anymore.
14	0	I don't feel I look any worse than I used to.
	1	I am worried that I am looking old or unattractive.
	2	I feel that there are permanent changes in my appearance that make me look unattractive.
	3	I believe that I look ugly.
15	0	I can work about as well as before.
	1	It takes an extra effort to get started at doing something.
	2	I have to push myself very hard to do anything.
	3	I can't do any work at all.
16	0	I can sleep as well as usual.
	1	I don't sleep as well as I used to.
	2	I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	I wake up several hours earlier than I used to and cannot get back to sleep.
17	0	I don't get more tired than usual.
	1	I get tired more easily than I used to.
	2	I get tired for doing almost anything.
	3	I am too tired to do anything.
18	0	My appetite is no worse than usual.
	1	My appetite is not as good as it used to be.
	2	My appetite is much worse now.
	3	I have no appetite at all anymore.
19	0	I haven't lost much weight, if any, lately.
	1	I have lost more than 5 pounds. I am purposely trying to lose weight by eating less.
	2	I have lost more than 10 pounds.
	3	I have lost more than 15 pounds.
20	0	I am no more worried about my health than usual.
	1	I am worried about physical problems such as aches and pains, upset stomach or constipation.
	2	I am very worried about physical problems and it's hard to think of much else.
	3	I am so worried about my physical problems that I cannot think about anything else.
21	0	I have not noticed any recent change in my interest in sex.
	1	1 I am less interested in sex than I used to be.
	2	I am much less interested in sex now.
	3	I have lost interest in sex completely.

Signature: _____ Printed Name:_____ Date: _____