PAIN
MANAGEMENT
PARTNERS, LLC

Robert J. Boolbol, MD
David C. Levi, MD

Dear Patient,

Welcome to Pain Management Partners, the practice of Doctors Levi and Boolbol. To help facilitate your care, please complete the attached paperwork, and bring with you to your appointment along with your insurance card(s), pharmacy card and photo ID. If you have had an MRI or CT scan, please bring the CD provided to you by the imaging facility.

Please be advised that we do not prescribe any medications at the first visit. If you are currently prescribed medication(s) by another physician, please notify their office that they will need to provide you with medication for up to 2 weeks after your initial consultation.

If you are scheduled for a procedure, please arrange for a driver to bring you to and from the appointment unless other arrangements have been discussed. If you are scheduled to take Valium for your procedure, please pick up the medication at your pharmacy the day before your appointment. When you arrive, we will advise you when to take the medication when you check in.

Please allow 90-120 minutes for your appointment.

If you have any questions or concerns, please call 203-885-1441.

Thank you!

COVID GUIEDLINES

To maintain a safe environment for all patients and staff, please follow the following guidelines when you come to your appointment:

-All patients must wear a mask at all times while in our office and building.

-Only patients will be allowed in our office. All other guests must wait outside the office.

-If you have any symptoms of COVID, please contact our office to reschedule your appointment.

PATIENT INFORMATION

Patient Name_____ Nickname_____

Marital status_____Previous Name_____

Date of Birth_____Social Security #_____

Sex □ M □ F □ Other Language_____Ethnicity_____

CONTACTS

Emergency Contact Name_____Relationship_____

Emergency Contact Phone _____

Spouse Name_____Caretaker Name_____

Patient home phone_____ Is it OK to leave a detailed message? □ YES □ NO

Patient work phone_____Is it OK to leave a detailed message? □ YES □ NO

Patient cell phone_____ Is it OK to leave a detailed message? □ YES □ NO

Email address_____Would you like enroll in the patient portal? □ YES □ NO

Preferred method to contact you: □ Home □ Work □ Cell □ Email

Home address_____

Seasonal address_____

Employers name_____Occupation_____

INSURANCE INFORMATION

Primary Insurance_____

Policy Holder Name_____Date of Birth_____

Secondary Insurance_____

Policy Holder Name_____Date of Birth_____

WORKERS'COMPENSATION/MOTOR VEHICLE ACCIDENT

Company Name_____

Adjuster Name_____Adjuster Phone_____

Claim #_____Date of Injury_____

Employer (at time of injury if work related)_____

Attorney Name (if you have one)_____

PROVIDERS

Primary Care provider_____Phone_____

Referring physician_____Phone_____

FINANCIAL POLICY

The practitioners and staff of Pain Management Partners LLC are dedicated to providing you with the best possible care and service, and we regard your understanding of our financial policies as an essential element of your care and treatment. Please read the following financial policy and sign. If you have any questions, please ask our staff.

INSURANCE-You, the responsible party, are responsible for providing us with up-to-date insurance information. We will keep a copy of your insurance card(s) on file. Kindly report any changes to your insurance coverage immediately by telephone or upon your arrival to your appointment. If your insurance changes and you do not notify our office, you may be responsible in full for any charges incurred.

REFERRALS- If your insurance plan requires referrals from your PCP to come to our office, YOU are responsible for obtaining the referral. If you do not obtain a referral, you may not be seen or you may be billed for the full amount of services rendered. Please check with your insurance company if you are not sure.

COPAYS-Copays must be paid at time of service. Please come prepared to pay the specialist copay at each visit or you may not be seen.

DEDUCTIBLES and COINSURANCES- We will submit your bills to your insurance carrier(s) for processing. All balances will be billed to you and payment is expected upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office until the balance is settled. If you require a payment plan, please let staff know.

MEDICARE- Medicare patients are responsible for their annual deductible, coinsurance, and any non-covered services in which you agree to pay (advanced Beneficiary Notice). We will bill your secondary insurance as appropriate to be processed in accordance with your plan. Any balances due after insurance processing will be your responsibility and will be due upon receipt. If you fail to pay any balance within 90 days, you may not be seen in the office until said balance is settled.

MOTOR VEHICLE ACCIDENT- If your charges are related to a MVA and you have med pay or PIP coverage, we will bill your auto insurance carrier. Any balances not covered by your carrier are your responsibility. We will not suspend collection of your balance until a third-party claim is settled.

WORKERS' COMPENSATION- If you have a work-related injury, we will submit all claims to your workers' compensation carrier. If your case settles, and you receive a set aside account for medical expenses, you will be billed at the current Connecticut WC rates that will be due at each visit.

PATIENTS WITHOUT INSURANCE- If you do not have insurance, you may be offered a discounted rate. Payments are due upon arrival to your appointment, there are no exceptions.

LATE CANCELLATION/NO SHOW FEES- We require 24 hours for cancelling an appointment. If you no not give adequate notice or fail to show for your appointment, we reserve the right to charge a $75.00 fee for a missed appointment and $200.00 for a missed procedure. The fee must be paid prior to rescheduling the missed appointment.

RETURNED CHECKS- All returned checks are subject to a $35.00 service fee.

PAST DUE ACCOUNTS- We expect that you will pay your account balance in a timely manner. Any account with a balance over 90 days past due will be referred to an outside collection agency and you will be responsible for any related collection costs.

Please contact our billing office if you have any questions.

I have read, understand, and agree to the financial policies of Pain Management Partners, LLC.

Patient Signature: _____Date: _____

Print Name: _____Date of Birth: _____

*If patient is a minor, a parent or guardian must sign

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This notice is effective April 1. 2020. Contact the office manager at your location if you have any questions.

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ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

I acknowledge that I have received a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth Pain Management Partners, LLC privacy practices and my rights regarding privacy of my protected health information.

Patient Signature:_____Date:_____

Print Name:_____Date of Birth:_____

AUDIO/VIDEO ACKNOWLEDGEMENT

Please be advised, that in order to better enable us to assure compliance with HIPAA privacy and security laws an regulations, and in recognition of the legitimate privacy concerns of our patients and staff, the use of any audio or video recording devices in this office by patients or other visitors, including but not limited to cell phones, is strictly prohibited.

We reserve the right to terminate any patient as permitted under State law if the patient or anyone accompanying the patient is found to be in violation of this policy. We appreciate your understanding and cooperation.

Patient Signature:_____Date:_____

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Patient Name_____Date of Birth_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please list the name(s) below of anyone who may need to speak to us regarding your appointments, care and medication. Please include attorneys, care givers and conservators and anyone who may pick up prescriptions on your behalf.

Pain Management Partners, LLC may release my information to the following people:

Name_____Relationship_____

Name_____Relationship_____

The following person(s) are NOT authorized to receive or discuss my health information:

Name_____Relationship_____

Name_____Relationship_____

ADVANCED DIRECTIVE

We are dedicated to providing comprehensive care to patients and following federal guidelines regarding important public health issues.

Please answer the following question.

Are you able to name a surrogate decision maker in the event that you are incapacitated?

If yes, please indicate below.

Name_____Relationshiop_____

Phone number_____

If no, please check the box below.

□ I do not wish or am unable to name a surrogate decision maker.

Patient Signature_____Date_____

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PAIN MANAGEMENT PARTNERS LLC

LABORATORY SERVICES DESIGNATION/FINANCIAL POLICY AND DISCLOSURE

The physicians and practitioners of Pain Management Partners LLC in accordance with their controlled substance compliance policy may ask for random urine drug testing to ensure proper utilization, safety, and compliance of prescribed medications.

Please note, PMP does not participate with the following insurance payers/plans.

- Oxford
- Medicaid
- Anthem plans with the following prefixes (XGT, XGR, XGL, SHP, Z9T, ARY, MTN, XWN, YMW, AWC)

It is the responsibility of the patient to identify if a preferred lab is required by their insurance plan

I understand that I have the right to direct my testing to be done by the following facility (please initial):

____Pain Management Partners LLC Lab

____Other_____

I designate the facility initialed above for urine drug testing. Once I have made this designation, I understand this will not be changed unless I submit a new request for a change of facility.

I understand laboratory testing is part of my compliance program with the prescribing of controlled substances for my chronic pain. Laboratory services will be required for appropriate monitoring of usage of my controlled substance prescriptions. Based on the results of my urine toxicology screenings, additional confirmation testing may be required.

I understand Pain Management Partners will submit a separate bill to my insurance, for toxicology testing performed and I will be responsible for any applicable copayments, coinsurance, and/or deductibles associated with toxicology screening and confirmation testing.

Patient Signature_____Date_____

Print Name_____Date of Birth_____

PAIN MANAGEMENT PARTNERS, LLC

Patient Name:_____**Date of Birth:**_____

Welcome to Pain Management Partners, the practice of Doctors Levi and Boolbol. In order to provide you with the best possible care, it is important that we obtain a thorough medical history and have a good understanding of your pain. Please complete these forms as best as you can. Thank you!

PAST MEDICAL HISTORY

□ Anxiety
□ Asthma
□ Atrial fibrillation
□ Benign prostatic hyperplasia
□ Bipolar disorder
□ Cerebrovascular accident
□ Chronic anemia
□ Chronic obstructive lung disease
□ Chronic pain
□ Coronary arteriosclerosis
□ Deep venous thrombosis
□ Depressive disorder
□ Diabetic on insulin
□ End-stage renal disease
□ Epilepsy
□ Essential hypertension
□ Gastroesophageal reflux disease
□ Hypertension
□ History of primary
□ Hyperparathyroidism
□ History of radiation therapy
□ HIV/AIDS
□ Hypercholesterolemia
□ Hyperlipidemia
□ Hyperthyroidism
□ Hypothyroidism
□ Inflammatory disease of liver
□ Ischemic heart disease
□ Leukemia
□ Malignant lymphoma (clinical)
□ Malignant tumor of lung
□ Malignant tumor of breast
□ Malignant tumor of colon
□ Malignant tumor of prostate
□ Morbid obesity
□ Multiple myeloma
□ Obesity
□ Obstructive sleep apnea syndrome
□ Primary fibromyalgia syndrome
□ Pulmonary embolism
□ Rheumatoid arthritis
□ Type 2 diabetes mellitus
□ Other_____
□ None

PAST SURGICAL HISTORY

□ Abdominoperineal resection
□ Bypass of stomach
□ Cesarean hysterectomy
□ Coronary artery bypass graft
□ Entire transplanted kidney
□ Excision of basal cell carcinoma
□ Excision of melanoma
□ Excision of squamous cell
□ Carcinoma
□ Colostomy
□ Tubal ligation
□ History of appendectomy
□ History of bilateral mastectomy
□ History of cholecystectomy
□ History of colectomy
□ History of liver excision
□ History of percutaneous
□ Transluminal coronary angioplasty
□ History of tissue graft heart valve replacement
□ History of transurethral prostatectomy
□ Hysterectomy
□ Low anterior resection of rectum
□ Lumpectomy of breast
□ Lumpectomy of left breast
□ Lumpectomy of right breast
□ Mastectomy of left breast
□ Mastectomy of right breast
□ Mechanical heart valve replacement
□ Oophorectomy
□ Pancreatectomy
□ Percutaneous extraction of kidney stone with fragmentation procedure
□ Portosystemic shunt operation
□ Prostatectomy
□ Surgical biopsy of skin
□ Tonsillectomy
□ Total hysterectomy
□ Transplantation of heart
□ Transplantation of liver
□ Other _____
□ None

INTERVENTIONAL PAIN HISTORY

□ None
□ Epidural Injection(s) - Cervical
□ Epidural Injection(s) – Thoracic
□ Epidural Injection(s) - Lumbar
□ Facet Injection(s) - Cervical
□ Facet Injection(s) – Thoracic
□ Facet Injection(s) - Lumbar
□ Intrathecal Pump
□ Medial Branch Block - Cervical
□ Medial Branch Block - Thoracic
□ Other_____
□ Medial Branch Block – Lumbar
□ Rhizotomy - Cervical
□ Rhizotomy - Thoracic
□ Rhizotomy - Lumbar
□ Spinal Cord Stimulator

MUSCULOSKELETAL DISEASE HISTORY

□ Acute poliomyelitis
□ Adhesive capsulitis of shoulder
□ Ambidextrous
□ Ankylosing spondylitis
□ Bursitis
□ Carpal tunnel syndrome
□ Chronic low back pain
□ Complex regional pain syndrome
□ Compression fracture of vertebral column
□ Disseminated idiopathic skeletal hyperostosis
□ Epidural steroid injection
□ Fracture at wrist and/or hand level
□ Fracture of ankle
□ Fracture of bone
□ Fracture of distal end of radius
□ Fracture of vertebral column
□ Hip fracture
□ Rheumatoid arthritis
□ History of osteoporosis
□ Idiopathic scoliosis
□ Impingement syndrome of shoulder region
□ Left handed
□ Osteoarthritis
□ Osteopenia
□ Primary gout
□ Prolapsed cervical intervertebral disc
□ Prolapsed lumbar intervertebral disc
□ Psoriasis with arthropathy
□ Rickets
□ Right handed
□ Sarcoma of bone
□ Sarcoma of soft tissue
□ Sciatica
□ Secondary malignant neoplasm of bone
□ Spinal stenosis in cervical region
□ Spinal stenosis of lumbar region
□ Vitamin D deficiency
□ Other_____

MUSCULOSKELETAL SURGICAL HISTORY

□ None
□ Arthroplasty of left shoulder
□ Arthroplasty of right shoulder
□ Arthroplasty of the carpometacarpal joint of the thumb
□ Bilateral replacement of knee joints
□ Decompression of lumbar spine
□ Decompression of median nerve
□ Diagnostic arthroscopy of shoulder joint
□ Excision of bunion
□ Excision of ganglion cyst
□ Exploratory lumbar laminectomy
□ History of arthroplasty of right knee
□ History of arthroscopy of knee joint
□ History of repair of musculotendinous cuff of shoulder
□ Intramedullary nailing of femur
□ Intramedullary nailing of tibia
□ Kyphoplasty of fracture of spine using fluoroscopic guidance
□ Lumbar spinal fusion
□ Open reduction of fracture of radius with internal fixation
□ Osteotomy and discectomy of cervical spine by anterior approach
□ Primary posterior decompression lumbar spine and fusion
□ Prosthetic arthroplasty of bilateral hips
□ Prosthetic arthroplasty of left hip
□ Prosthetic arthroplasty of right hip
□ Prosthetic replacement of cervical intervertebral disc
□ Prosthetic replacement of lumbar intervertebral disc
□ Release of trigger finger
□ Repair of ankle
□ Repair of meniscus
□ Repair of tendon achilles
□ Revision of total hip arthroplasty, both components, with autograft
□ Revision of total knee arthroplasty, all components
□ Revision of total prosthetic replacement of shoulder joint
□ Total reverse shoulder prosthesis
□ Total shoulder replacement
□ Other_____

MUSCULOSKELETAL FAMILY HISTORY

□ None
□ Charcot Marie Tooth Disease
□ Diabetes
□ Hypertension
□ Multiple Hereditary Exostosis
□ Osteoarthritis
□ Osteoporosis
□ Scoliosis
□ Other_____

MUSCOLOSKELETAL PEDIATRIC HISTORY

□ None
□ Breech Position
□ Cerebral Palsy
□ Flatfeet (Pes Planovalgus)
□ Genu Valgum
□ Genu Varum
□ Hip Dysplasia
□ Neonatal Sepsis
□ Pavlik Harness as Infant
□ Spina Bifida
□ Spondylolisthesis
□ other_____

MEDICATIONS Please list all current medications. □ Check here if you are providing a separate list of medications.

Medication name Dosage # of times taken per day

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES Please list all known allergies. □ Check here if you have no known allergies.

Allergy type Describe reactions severity and symptoms

_____
_____
_____
_____
_____

SOCIAL HISTORY

What is your smoking status?
□ Current everyday smoker
□ Current some day smoker
□ Former smoker
□ Never smoker
□ Cigar Smoker

Do you consume alcohol?
□ None
□ Less than one per day
□ 1-2 drinks per day
□ 3 or more drinks per day

Do you use illicit drugs? YES NO

Do you exercise?
□ Several times per day
□ Once per day
□ A few times a week
□ A few times a month
□ Never
□ Other

FAMILY HISTORY

	Alive?	Age	Deceased?	Age at death	Cause of death	Unknown
Father						
Mother						
Maternal Grandfather						
Maternal Grandmother						
Paternal Grandfather						
Paternal Grandmother						

FAMILY HISTORY (Continued)

Please check if any of your immediate family have ever had any of the following conditions, and list who.

□ Cancer_____
□ Heart disease_____
□ Diabetes_____
□ High Blood Pressure_____
□ Stroke/TIA_____
□ Alcohol abuse_____
□ Drug abuse_____
□ Psychiatric illness_____
□ Seizures_____
□ Depression/suicide_____
□ Osteoarthritis_____
□ Osteoporosis_____
□ Scoliosis_____
□ Other_____

Patient Name_____DOB_____

Patient Signature_____Date_____

SOAPP-R FORM

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers. Please feel free to discuss with your provider or add any relative notes to the bottom of this form. Thank you.

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

Comments:_____

SCORE:

_____