PRECISION

REGENERATIVE & FUNCTIONAL MEDICINE

Thank you for choosing Precision Regenerative and Functional Medicine. Please completely fill out this form to ensure the fastest and best service. We may ask you to look over this information from time to time to make sure it stays up–to-date.

Patient name: _____ Date of birth:_____

Address: _____ Sex: ___ Male ___ Female

City, State, Zip: _____ Marital status: M S D W

Preferred language:___english___spanish___other Race:_____Ethnicity:_____

Social security number: _____ Employer:_____

Home number: _____ Work phone:_____

Mobile number: _____ Email address:_____

Emergency contact: _____ Emergency phone number:_____

Insurance company name and policy number **Primary** (see insurance card):

Ins. name: _____

Policy holder: _____

Policy number: _____

Group number: _____

Primary care physician:_____

Insurance company name and policy number **Secondary** (see insurance card):

Ins. name: _____

Policy holder: _____

Policy number:_____

Group number: _____

Referring physician:_____

If you are covered under the policy of a spouse, partner, parent, or legal guardian, please tell us about them:

Name of insured: _____ Social security number:_____

Date of birth: _____ Address:_____

Home phone: _____ Work phone:_____

Mobile phone:_____ Sex: ___ Male ___ Female

Employer:_____

1101 S. Capital of Tx Hwy F-101 Austin,TX 78746 phone 512.892.0490 facsimile 512.892.0589

PRECISION
REGENERATIVE & FUNCTIONAL MEDICINE

Appointment Information

Dear Patient
Your appointment is on date: at:

The attached patient information forms are sent to you to complete at your convenience. Please either email them or fax the completed forms to our office **24 hours** prior to your scheduled appt. Fax: 512-892-0589 email info@austinppc.com. If you are unable to send them please bring them to your office visit. If you are able to complete this paperwork in advance please arrive **15 minutes** prior to your scheduled time. If you would like to complete the paperwork at our office please arrive **45 minutes** prior to your scheduled time.

***Your appointment will be rescheduled if you are not able to complete this paperwork prior to your scheduled time.**

Please note:

* If the patient is a minor, they will need to be accompanied by their legal guardian.
* Be sure to list all drug allergies.
* We will need all guarantor/ responsible party information.
* A complete list of all medications is needed.
* Bring your insurance card(s) and your co-payment.
* Bring any medical records, x-rays, MRIs, CT scans, etc.
* All canceled appointments must be called in at least 24 hours prior to your scheduled appointment.

**** IN THE EVENT YOU FORGET YOUR X-RAYS OR MRI SCANS, THE OFFICE WILL RESCHEDULE YOUR APPOINTMENT****

For additional information please visit our website at **www.austinppc.com**. Should you have any other questions, please call us at (512) 892-0490.

Thank you,

Precision Regenerative and Functional Medicine

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REGENERATIVE & FUNCTIONAL MEDICINE

Financial Policy and Assignment of Benefits

Precision Regenerative and Functional Medicine is dedicated to providing the best possible care and service to you. We regard your understanding of all your financial responsibilities as an essential element of your treatment.

* We have made prior arrangements with many insurers and health plans (HMO & PPO) to accept an assignment of benefits. We will bill those plans and will only require you to pay the authorized copayment, coinsurance and/or deductible at the time of service. **The office policy is to collect this copayment, coinsurance and/or deductible when you arrive for your appointment.** This amount is an estimate and is based on the most recent insurance verification obtained by our office staff.

* If your insurance policy requires a referral for Precision Regenerative and Functional Medicine, please understand we will request this referral from your referring practitioner prior to your appointment, but it is ultimately your responsibility to obtain this referral. If your services are denied because the referral was not received, you will be responsible for the full charged amount.

* **Private pay patients are required to pay in full at the time of service.** A quote will be provided for any and all procedures prior to your appointment.

* We accept VISA, Mastercard, and Discover. Please be advised that there is a $20 service charge on all returned checks.

* Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you, if you assign the benefits to our doctor. If your insurance company does not pay our office within 90 days, you will be responsible for payment. If we later receive a check from your insurer, we will refund any overpayment.

* All health plans are not the same and do not cover the same services. In the event that your health plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

* If you have a medical procedure performed by our physician at a location other than our office you and/or your insurance company will receive two bills, one from our physician for his professional services and one from the facility where the procedure was performed.

* For all services rendered to minor patients, the parent and/or legal guardian will be responsible for payment.

* If you receive a statement from Precision Regenerative and Functional Medicine the balance needs to be paid in full within 30 days of receipt unless prior arrangements have been made. Any remaining balances due after 90 days will be considered delinquent and will be turned over to an outside collection agency. Future appointments will not be scheduled until balances have been paid in full or a written payment plan has been agreed to by our office. Please be sure to update any contact changes with our office staff so you can be reached regarding your balance.

* In order to provide the best possible service and availability to all our patients, please call us as early as possible if you know you will need to reschedule your appointment. Please see the attached cancelation no show polices and fees.

*I hereby assign all medical and surgical benefits, to include major medical benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and other health/medical plan, to issue payment check(s) directly to **Precision Pain Consultants** for medical services rendered to myself and/ or my dependents regardless of my insurance. In the event that the insurance payment is sent directly to me, I realize that I will be billed personally until the balance is paid.

I have read and understand the financial policy and assignment of benefits of the practice and I agree to be bound by its terms. I also understand and agree that the practice may amend such terms from time-to-time.

_____ _____

Patient /responsible party signature Date

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CANCELATION AND NO SHOW POLICIES AND FEES

This is a reminder of our policy regarding missed appointments. When one patient misses their appointment and does not let us know, or when one patient cancels their appointment late (less than 24 hours prior to the appointment), it not only affects our staff, but also other patients.

As you know, our patients are in pain. They like to be seen and treated as soon as possible. We do our best to see and treat everybody as soon as we can, but also allow enough time on our schedule for every patient to be heard and examined, and for questions to be answered. We are respectful of our patients' time, and we ask our patients to be respectful of our time.

When somebody does not call to cancel their appointment and simply just does not show up, or calls and cancels their appointment at the last minute, we cannot schedule another patient on such short notice. We lose time that day and somebody else continues to wait to see us, while suffering in pain.

Charging for missed appointments is not something we like to do. It can be avoided with a minimum of courtesy and good communication. Please help us continue to treat you and everybody else at the standards you deserve.

FOLLOW-UP APPOINTMENTS

NO-SHOW OR MISSED WITHOUT 24 HOURS NOTICE WILL BE CHARGED **$50.00**.

CANCELED WITH LESS THEN 24 HOURS NOTICE WILL BE CHARGED **$25.00**

IF YOU ARRIVE MORE THEN 15 MINUTES LATE FOR A FOLLOW UP APPT,
YOUR APPT MAY BE RESCHEDULED AND YOU WILL BE CHARGED **$25.00**
(this is at the providers discretions)

PROCEDURE APPOINTMENTS

NO-SHOW OR MISSED WITHOUT 24 HOURS NOTICE WILL BE CHARGED **$150.00**

CANCELED WITH LESS THEN 24 HOURS NOTICE WILL BE CHARGED **$50.00**

NEW PATIENT APPOINTMENTS

NO-SHOW OR MISSED WITHOUT 24 HOURS NOTICE WILL BE CHARGED **$50.00**

CANCELED WITH LESS THEN 24 HOURS NOTICE WILL BE CHARGED **$25.00**

FEES NEED TO BE PAID IN FULL BEFORE APPTS WILL BE RESCHEDULED

Patient signature:_____date:_____

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PRECISION

REGENERATIVE & FUNCTIONAL MEDICINE

AUTOMATIC BILLING AUTHORIZATION FORM

Company Name: **Precision Regenerative and Functional Medicine** ID Number: _____

FROM CREDIT CARD:

I authorize you to charge my bill directly to the credit card(s) listed below:

Primary Card Account	**Secondary Card Account**
Name on credit card (exactly as printed)	Name on credit card (exactly as printed)
Billing Address for credit card (Street, Apt. #)	Billing Address for credit card (Street, Apt. #)
City, State Zip	City, State Zip
Credit card number Expiration Date	Credit card number Expiration Date
Signature Today's Date	Signature Today's Date

☑ Bill all charges to the above card(s). Since the payment amount may vary, I will receive written notification of the amount and date of the next charge prior to each scheduled transaction date.

☑ This authorization is valid until I provide you with written cancellation.

- I authorize the charge of all copays, co-insurance or deductible amounts due for all in office and telemedicine visits.
- I authorize the charge of all No-Show or Missed appointment fees. I have reviewed and signed the Cancelation and No-Show Polices and Fee document.
- I authorize the charge for all clinic lab fees for labs drawn at PRFM.
- I authorize the charge for any peptides, HRT products that are ordered and paid for by PRFM and shipped directly to my home.
- I authorize the charge for any unpaid balances over 30 days old.

Patient signature:_____ Date:_____

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PRECISION
REGENERATIVE & FUNCTIONAL MEDICINE

Authorization for Release and Disclosure of Protected Health Information

In accordance with state law and regulatory agency requirement, the health record is the property of Precision Pain Consultants (PPC). I hereby authorize the PPC/PRFM Medical Records custodian to release information from the medical records of:

Patient name:_____ DOB:_____ SSN:_____

Address:_____ City/State/Zip:_____

Telephone:_____ Alternate contact number:_____

Information may be released to:

Precision Regenerative and Functional Medicine
4613 Bee Caves Rd., Ste 105
Westlake Hills, Texas 78746
(512) 892-0490

Facility or Physician:

Name:_____
Address:_____
City/State/Zip:_____
Phone:_____

Please release the following information:

____Problem list ____X-Ray reports ____Mental health ____Outside report
____Progress notes ____X-Ray films ____Drug/Alcohol ____Immunizations
____EKG reports ____Lab report ____HIV/AIDS test ____Medication list
____History and physical exam finding ____Other reports (specify)_____

This information is necessary for the following:

____Continued patient care ____Personal use ____Attorney/legal ____Insurance

____Other (specify)_____

1. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse.

2. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information that has already been release in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the follow days, event, or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

3. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this in order to assure treatment. I understand that with certain exceptions, I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can contact the Health Information Management Manager at (512) 892-0490.

_____ _____
Signature of patient or legal representative Date

_____ _____
Relationship to patient Date

PRECISION
REGENERATIVE & FUNCTIONAL MEDICINE

Acknowledgement of Receipt of Privacy Notice

I, _____, understand that as part of my health care, Precision Regenerative and Functional Medicine originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, as well as plans for future care. I understand that this information serves as:

* A basis for planning my treatment;
* A means to facilitate communication among the many healthcare professionals who contribute to my care;
* A source of information for applying my diagnosis and surgical information to my bill;
* A means by which a third-party payer can verify that services billed were actually provided;
* A tool for healthcare operations of Precision Pain Consultants such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand that as part of Precision Regenerative and Functional Medicine treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity for the purposes stated above.

I understand I have the right to review a **Notice of Privacy Practices** that provides a more complete description of how Precision Regenerative and Functional Medicine may use and disclose my protected healthcare information. I further understand that Precision Regenerative and Functional Medicine reserves the right to change its **Notice of Privacy Practices**. Should Precision Regenerative and Functional Medicine change its **Notice of Privacy Practices**, an amended copy will be posted in a prominent location in the practice site, or, upon my request, an amended copy will be sent to the address I have provided.

I agree that Precision Regenerative and Functional Medicine may do the following unless I specifically give direction prohibiting such activity:

* Send visit reminders and test results to the address I have provided.
* Send routine correspondence, such as billing statements, to the address I have provided.
* Leave messages on answering machine or voicemail associated with the telephone numbers I have provided to either confirm appointments or to request that I call the practice for medical or billing matters.
* Speak to or leave message with the familly members/friends listed below:

Name:_____Relationship to patient:_____Contact number:_____

Name:_____Relationship to patient:_____Contact number:_____

_____ _____

Patient's signature or signature of personal representative Date

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REGENERATIVE & FUNCTIONAL MEDICINE

I. PATIENT PROFILE:

Your first visit & medical history

Today date:____/____/____ Patient name:_____

Your birth date:____/____/ ____ Age:_____

Height: _____ Weight:_____

II. CHIEF COMPLAINT:

Indicate your primary complaint: (neck, back, extremity, etc.)

_____

III. HISTORY:

A. PRESENT ILLNESS:

When did this pain begin? _____

What were the circumstances that started the pain that you are being seen for today?

_____

_____

Is your pain the result of a ...
____Fall ____Auto accident ___Injury on the job ____Other

C. RED FLAGS (RISK FACTORS)

1. Tumor/cancer	_____Yes	_____No
2. Infection	_____Yes	_____No
3. Fracture	_____Yes	_____No
4. Progressive focal neurologic deficits	_____Yes	_____No
5. Bowel/bladder incontinence	_____Yes	_____No
6. Saddle anesthesia	_____Yes	_____No
7. Medical cause of low back pain	_____Yes	_____No

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REGENERATIVE & FUNCTIONAL MEDICINE

Patient:_____

OFFICE USE ONLY (DO NOT WRITE ON THIS PAGE)

B. COMPLAINTS:

Dominant Pain:

Site:

Character:

Aggravating factors:

Alleviating factors:

Secondary Pain:

Site:

Character:

Aggravating factors:

Alleviating factors:

C. RED FLAGS (RISK FACTORS)

D. PAIN/PAIN BEHAVIOR:

1. VAS scale: Now _____ Range _____
2. NPDS / Roland Morris: _____
3. MSPQ:_____
4. Zung:_____
5. DRAM:_____
6. DAST:_____SOAPP-R_____
7. PRFM Hormone score:_____
8. Pain medication:

E. PAST MEDICAL HISTORY:

1. List any **ALLERGIES** you have to medications, foods, etc.

_____

Have you ever had a reaction to?

_____Iodine / Seafood/ IV Contrast
_____Marcaine / Lidocaine
_____Steroids
_____Versed
_____Other

2. Medical Illnesses:

a. Current illnesses: in the last month, have you...

Been on antibiotics	_____No	_____Yes
Had any invasive procedures	_____No	_____Yes
Had a GI infection	_____No	_____Yes
Had a lung infection	_____No	_____Yes

b.Chronic illnesses: do you have a CHRONIC ILLNESS?
Describe. _____

c. Do you have any of the following medical conditions?

AIDS/HIV	_____No	_____Yes
Arthritis or joint pain	_____No	_____Yes
Bleeding disorders	_____No	_____Yes
Cancer (type if known)	_____No	_____Yes
Diabetes (type)	_____No	_____Yes
Epilepsy/seizures.	_____No	_____Yes
Heart problems (CAD, MI, arrhythmia).	_____No	_____Yes
Hypertension	_____No	_____Yes
Liver problems (hepatitis, etc.)	_____No	_____Yes
GI problems (ulcers, diarrhea, constipation	_____No	_____Yes
Kidney problems	_____No	_____Yes
Hormonal problems (thyroid, etc.)	_____No	_____Yes
Muscle diseases	_____No	_____Yes
Migraines/headaches	_____No	_____Yes
Neurologic disorders (MS, Alzheimer's etc.	_____No	_____Yes
Mental health (addiction, depression, anxiety)	_____No	_____Yes

3. Surgeries (give dates and names of surgeon):

Non-spinal:

Spinal:

Patient:_____

F. REVIEW OF SYSTEMS

Recently, have you had?

Change in sleeping pattern	_____No	_____Yes
Constitutional symptoms (fever, weight loss)	_____No	_____Yes
Eye problems	_____No	_____Yes
Ears/Nose/Mouth/Throat problems	_____No	_____Yes
Cardiovascular (chest pain, arrhythmia)	_____No	_____Yes
Respiratory (shortness of breath)	_____No	_____Yes
GI (nausea/vomiting/diarrhea/constipation)	_____No	_____Yes
Genitourinary	_____No	_____Yes
Musculoskeletal	_____No	_____Yes
Skin	_____No	_____Yes
Neurologic	_____No	_____Yes
Psychiatric	_____No	_____Yes
Hematologic/Lymphatic	_____No	_____Yes
Allergic/immunologic	_____No	_____Yes

F. SOCIAL HISTORY:

1. Do you smoke? _____No _____Yes…how many packs a day? _____

2. Do you drink alcohol? _____No _____Yes…how many drinks a week? _____

3. Marital status:

4. Employment:

G. FAMILY HISTORY:

1. Do you have a family history of musculoskeletal or joint disease? _____No _____Yes
2. Do you have a family history of spinal disease or spinal surgery? _____No _____Yes
3. Do you have a family history of any chronic disease or condition? _____No _____Yes

Describe_____

VITALS:

Blood Pressure
Pulse
Resp
Temp
Weight
Height

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REGENERATIVE & FUNCTIONAL MEDICINE

Patient name:_____ DOB:_____

Medication Chart

We will have you update this list every time you visit.

	Name of medication	Dose(mg)	Frequency(how may times a day?)	Date and time of last dose
1.	_____	_____	_____	_____am pm
2.	_____	_____	_____	_____am pm
3.	_____	_____	_____	_____am pm
4.	_____	_____	_____	_____am pm
5.	_____	_____	_____	_____am pm
6.	_____	_____	_____	_____am pm
7.	_____	_____	_____	_____am pm
8.	_____	_____	_____	_____am pm
9.	_____	_____	_____	_____am pm
10.	_____	_____	_____	_____am pm

Allergies_____

Main reason for today's visit:

Other concerns I would like to discuss if there is time:

Please check all that apply:

_____I have prescriptions that need to be refilled _____I need a school or work excuse

_____I need a referral for my insurance company _____I need the attached forms filled out

Name of pharmacy for prescriptions: _____

Phone # of pharmacy:_____ Clinician initials:_____

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Medication Agreement and Instruction

You are expected to use your medication appropriately. Do not share, sell or otherwise permit others access to your medication. Take your medication only as directed on the bottle or explained to you by the physicians or physician's assistants. Store your medication in a safe place. Count your medication at the pharmacy when receiving it.

Only one provider (physician/physician assistant) should prescribe and maintain your medication.

If you find your medication is not effective, do not increase your medication dosages yourself. Please email info@austinppc.com or call 512.892.0490 to speak with a medical assistant. While we try to answer everybody promptly, you must allow at most 48 hours for response to your email or call. We may schedule a follow-up appointment to discuss some issues.

Please do not contact our office for refills. Please request your prescription refills at least 48 hours prior to medications running out, not counting Saturdays, Sundays, or holidays. This allows for proper review of your history or time for prior authorization required by insurance companies.

In case of lost, stolen, self-increased medication or any other unexplained discrepancies, early refills will not be provided. Non-opioid medication or withdrawal medication may be offered.

Maintain a primary care physician that you see for general or other medical care, lab testing for other acute or chronic health conditions that may require annual or routine monitoring and care.

Provide a list of other medical conditions, medications, and other physicians and notify our office of any changes that may occur.

Allow periodic medication monitoring by urine drug screens (UDS) and other lab testing if necessary as part of your treatment plan. In case of inconsistencies on your UDS, you will be dismissed from our care and offered one month's worth of medication and instructions on how to taper it. Do not use alcohol or take any other mind altering substances while using pain medications. Chronic opioid analgesic therapy may cause dependence, addiction or re-addiction, and tolerance.

Please initial and sign:

_____ I have read and had the opportunity to discuss the information in this MEDICATION AGREEMENT between myself, my physician or physician assistant.

_____ I understand that for my safety, failure to follow the instructions detailed in this agreement may result in non- narcotic pain management treatments only, and possible dismissal from services through Precision Pain Consultants.

_____ _____

Patient name (printed) Date

_____ _____

Patient signature Witness

PRECISION
REGENERATIVE & FUNCTIONAL MEDICINE

Patient name:_____ Date:_____

Modified Somatic Perception Questionnaire

Please describe how you have felt during the past week by checking the appropriate box. Please answer all questions. Do NOT think before answering.

	Not at all	A little, slightly	A great deal, quite a bit	Extremely, could not have been worse
1. Heart rate increase				
2. Feeling hot all over	0	1	2	
3. Sweating all over	0	1	2	3
4. Sweating in a particular part of the body				
5. Pulse in the neck				
6. Pounding in head				
7. Dizziness	0	1	2	3
8. Blurring of vision	0	1	2	3
9. Feeling faint	0	1	2	3
10.Everything appearing normal				
11. Nausea	0	1	2	3
12. Butterflies				
13. Pain or ache in stomach	0	1	2	3
14. Stomach churning	0	1	2	3
15. Desire to pass water				
16. Mouth becoming dry	0	1	2	3
17. Difficulty swallowing				
18. Muscle in neck aching	0	1	2	3
19. Legs feeling weak	0	1	2	3
20. Muscles twitching or jumping	0	1	2	3
21. Tense feeling across forehead	0	1	2	3
22. Tense feeling in jaw muscles	0	1	2	3

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REGENERATIVE & FUNCTIONAL MEDICINE

Patient name:_____ Date:_____

Modified ZUNG Depression Index

Please indicate for each of these questions which answers best describe how you have been feeling recently.

	Rarely or none of the time (less than 1 day per week)	Some or little of the time (1-2 days per week)	A moderate amount of time (3-4 days per week)	Most of the time (5-7 days per week)
1. I feel downhearted and sad.	0	1	2	3
2. Morning is when I feel best.	3	2	1	0
3. I have crying spells or feel like it.	0	1	2	3
4. I have trouble getting to sleep at night.	0	1	2	3
5. I feel that nobody cares.	0	1	2	3
6. I eat as much as I used to.	3	2	1	0
7. I still enjoy sex.	3	2	1	0
8. I noticed I am losing weight.	0	1	2	3
9. I have trouble with constipation.	0	1	2	3
10. My heart beats faster than usual.	0	1	2	3
11. I get tired for no reason.	0	1	2	3
12. My mind is as clear as it used to be.	3	2	1	0
13. I tend to wake up too early.	0	1	2	3
14. I find it easy to do the things I used to.	3	2	1	0
15. I am restless and can't keep still.	0	1	2	3
16. I feel hopeful about the future.	3	2	1	0
17. I am more irritable than usual.	0	1	2	3
18. I find it easy to make a decision.	3			
19. I feel quite guilty.	0	1	2	3
20. I feel I am useful and needed.	3	2	1	0
21. My life is pretty full.	3	2	1	0
22. I feel that others would be better off if I were dead.	0	1	2	3
23. I am still able to enjoy the things I used to.	3	2	1	0

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Patient name:_____ Date:_____

Health Status Questionnaire Form (Roland Questionnaire)

When your back or leg hurts you may find it to difficult to do some of the things you normally do. This list contains some sentences that people have used to describe themselves when they have back pain or sciatica. When you read them, you may find that some stand out because they describe you today. As you read the list, think of yourself today. When you read a sentence that describes you today, put a check in the YES column. If the sentence does not describe you, check the NO column.

	YES	NO
1. I stay at home most of the time because of my back problem or leg pain (sciatica).		
2. I change position frequently to try to get my back or leg comfortable.		
3. I walk more slowly than usual because of my back problem or leg pain (sciatica).		
4. Because of my back problem I am not doing any of the jobs that I usually do around the house.		
5. Because of my back problem, I use a handrail to get upstairs.		
6. Because of my back problem, I have to hold on to something to get out of an easy chair.		
7. I get dressed more slowly than usually because of my back problem or leg pain (sciatica).		
8. I only stand for short periods of time because of my back problem or leg pain (sciatica).		
9. Because of my back problem, I try not to bend or kneel down.		
10. I find it difficult to turn over in bed because of my back problem or leg pain (sciatica).		
11. My back or leg is painful almost all of the time.		
12. I find it difficult to get out of a chair because of my back problem or leg pain (sciatica).		
13. I have trouble putting on my socks/stockings because of the pain in my back or leg.		
14. I only walk short distances because of my back or leg pain (sciatica).		
15. I sleep less well because of my back problem.		
16. I avoid heavy jobs around the house because of my back problem.		
17. Because of my back problem I am more irritable and bad tempered with people than usual.		
18. Because of my back problem, I go upstairs more slowly than usual.		
19. I stay in bed most of the time because of my back or leg pain (sciatica).		
20. Because of my back problem, my sexual activity is decreased.		
21. I keep rubbing or holding areas of my body that hurt or are uncomfortable.		
22. Because of my back problem, I am doing less of the daily work around the house than I would usually do.		
23. I often express concern to other people over what might be happening to my health		

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The Drug Abuse Screening Test (DAST)

Directions: the following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or "over-the-counter" drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

		YES	NO
1.	Have you used drugs other than those required for medical reasons?	____	____
2.	Have you abused prescription drugs?	____	____
3.	Do you abuse more than one drug at a time?	____	____
4.	Can you get through the week without using drugs? (other than those required for medical reasons)?	____	____
5.	Are you always able to stop using drugs when you want to?	____	____
6.	Do you abuse drugs on a continuous basis?	____	____
7.	Do you try to limit your drug use to certain situations?	____	____
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	____	____
9.	Do you ever feel bad about your drug abuse?	____	____
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	____	____
11.	Do your friends or relatives know or suspect you abuse drugs?	____	____
12.	Has drug abuse ever created problems between you and your spouse?	____	____
13.	Has any family member ever sought help for problems related to your drug use?	____	____
14.	Have you ever lost friends because of your use of drugs?	____	____
15.	Have you ever neglected your family or missed work because of your use of drugs?	____	____
16.	Have you ever been in trouble at work because of drug abuse?	____	____
17.	Have you ever lost a job because of drug abuse?	____	____
18.	Have you gotten into fights when under the influence of drugs?	____	____
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?		
20.	Have you ever been arrested for driving while under the influence of drugs?	____	____
21.	Have you engaged in illegal activities in order to obtain drugs?	____	____
22.	Have you ever been arrested for possession of illegal drugs?	____	____
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	____	____
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc)?	____	____
25.	Have you ever gone to anyone for help for a drug problem?	____	____
26.	Have you ever been in a hospital for medical problems related to your drug use?	____	____
27.	Have you ever been involved in a treatment program specifically related to drug use?	____	____
28.	Have you been treated as an outpatient for problems related to drug abuse?	____	____

Patient signature:_____ Date:_____

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PRECISION
REGENERATIVE & FUNCTIONAL MEDICINE

SOAPP-R

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.

SOAPP®-R	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 dose 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 over-whelming 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 other 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 do you run out of pain medication early?	o	o	o	o	o

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SOAPP®-R	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
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

Please include any additional information you wish about the above answers: