NORTH TEXAS PAIN
RECOVERY CENTER

PATIENT INFORMATION

DATE:_____

PATIENT NAME:_____AGE:_____BIRTHDAY:_____

ADDRESS:_____CITY:_____STATE:___ZIP:_____

HOME PHONE NUMBER: (___)_____ WORK: (_____)_____

SOCIAL SECURITY #:_____ DRIVER'S LICENSE #:_____

OCCUPATION:_____ EMPLOYER:_____

MARITAL STATUS:_____ REFERRED BY:_____

SPOUSE'S NAME:_____ AGE:____ WORK NUMBER: _____

CHILDREN:_____ AGES:_____

NEAREST RELATIVE NOT LIVING WITH YOU:_____ RELATIONSHIP:_____

ADDRESS:_____ PHONE NUMBER:_____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:_____
_____
_____

ALLERGIES: _____

TREATING PHYSICIAN:_____ PHONE:_____

PHYSICIAN'S ADDRESS:_____ CITY:_____ STATE:_____ZIP:_____

DIAGNOSIS:_____

DATE OF INJURY:_____

INSURANCE INFORMATION: (circle one) Workers' Comp Private LOP Other

INSURANCE COMPANY: _____PHONE:_____

ADDRESS:_____

NAME OF INSURED:_____INSURED DOB:_____

INSURED SS#_____ID#_____

GROUP #_____

ADJUSTOR: _____ PHONE: _____

CLAIM #:_____

ATTORNEY: _____ PHONE: _____

North Texas Pain Recovery Center
Authorization Form

This form when completed and signed by you, authorizes us to release protected information from your clinical record to the person you designate.

I authorize North 'Texas Pain Recovery Center to release *(Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible).*_____

_____

_____

_____

This information should only be released to (name and address of person to whom the information is to be released). _____

_____

I am requesting NTPRC to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.) _____

_____

This authorization shall remain in effect until (fill in expiration date) or until (fill in an event that relates to the individual or the purpose of the use or disclosure). _____

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that North Texas Pain Recovery Center generally may not condition medical or psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

_____

If the authorization is signed by a personal representative of the patient, a description of such Representative's authority to act for the patient must be provided.

North Texas Pain Recovery Center
Authorization Form

This form, when completed and signed by you, authorizes your doctor to release protected information from your clinical record to North Texas Pain Recovery Center.

I authorize _____ to release all of my medical records pertaining to my current illness to North Texas Pain Recovery Center.

This information should only be released to:

North Texas Pain Recovery Center
6702 W. Poly Webb Rd.
Arlington, TX 67016.

I am requesting the abovementioned doctor (clinic) release this information to aid in the treatment of my illness.

This authorization shall remain in effect for 90 days.

I have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that your doctor has taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my doctor generally may not condition medical or psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Signature of Patient Date

_____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

NORTH TEXAS PAIN RECOVERY CENTER

6702 W Poly Webb Rd. Arlington, Texas 76016 Phone 817-478-0095 Fax 817-478-7628

MEDICAL HISTORY

Name: _____ Age: _____ Height: _____ Weight: _____

Please complete entire form.

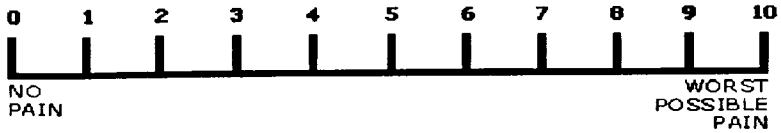
Yes	No		If yes, please explain
☐	☐	Heart attack, angina, irregular heartbeat	_____
☐	☐	Mitral Valve prolapse / rheumatic fever Last time an EKG done? _____ Where? _____	_____
☐	☐	Do you have sleep apnea or use a CPAP?	_____
☐	☐	High blood pressure	_____
☐	☐	Epilepsy, seizures, fainting spells	_____
☐	☐	Paralysis or stroke	_____
☐	☐	Diabetes	_____
☐	☐	Thyroid problems	_____
☐	☐	Asthma, bronchitis, emphysema	_____
☐	☐	Do you smoke? _____ ppd _____ years Last chest x-ray date? _____ Where? _____	
☐	☐	Hepatitis, jaundice	_____
☐	☐	Alcohol consumption? _____	How much? _____
☐	☐	Reflux, heartburn	_____
☐	☐	Kidney or bladder problems	_____
☐	☐	Neck or back trouble	_____
☐	☐	Arthritis	_____
☐	☐	Bleeding tendency or clotting problems	_____
☐	☐	Could you possibly be pregnant? LMP	_____
☐	☐	**Any other medical problems not listed**	_____
☐	☐	**Are you taking any medications, Rx diet pills, herbs, vitamins?**	_____
☐	☐	**Are you allergic to any medications, fish, eggs, soy products, latex, iodine contrast (e.g. IVP Dye)? Please list:**	_____
☐	☐	Previous surgeries	_____
☐	☐	Problems with anesthesia	_____
☐	☐	Family history problems with anesthesia	_____
☐	☐	Dentures, partial plates, caps, crowns, bridges, braces?	_____
☐	☐	Blood tests done in the last month? Where?	_____
☐	☐	Do you have any body piercing(s)? Where?	_____

Check all that apply:

Quality: Sharp _____ Constant _____ Aching _____ Intermittent _____ Pressure/Tightness _____

Sensation: Normal _____ Decreased _____

Specific location and level of pain: _____



I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge.
I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law.

_____ Signature

_____ Date

CONSENT FOR TREATMENT
PHYSICAL THERAPY

This document represents an agreement between myself, _____, and North Texas Pain Recovery Center for a treatment program designed to help me restore my level of functioning.

1. I understand that the total cost of my treatment at North Texas Pain Recovery Center will be billed to Workers' Compensation or my private insurance. I also understand I am responsible for any co-pay or deductible required by my insurance.

2. All therapies prescribed by North Texas Pain Recovery Center are considered necessary and important. I understand and agree that I am expected to take part in all therapy sessions as scheduled.

3. I understand that I am not permitted to carry alcoholic beverages, illegal drugs or drugs not specifically prescribed for my use onto the Center property and I may not come to scheduled therapy sessions in an intoxicated state. Doing so will constitute grounds for dismissal from therapy.

4. I have been informed and understand that some of the therapy I will be required to participate in may be uncomfortable at first. I have been informed and understand the significance of completing these therapies. However, I understand I can discuss, and should discuss any new concerns with my physical therapist at North Texas Pain Recovery Center at any time.

5. I understand that it is necessary for me to carry through with exercise, activities and relaxation practice at home, and agree to do this as a necessary and important part of my rehabilitation.

6. I understand and agree to abide by the Attendance Policy of the North Texas Pain Recovery Center.

7. I consent to be evaluated by the physical therapist as prescribed by my doctor.

8. I consent to the treatment planned by the physical therapist and as prescribed by my doctor.

I agree to follow the therapy program as described above, including activities scheduled at home. I understand I can speak with any North Texas Pain Recovery Center staff member whenever I have questions about treatment. I understand also that my progress depends on my practice and strict adherence to the program.

By signing below I acknowledge that: I have read and understand the information outlined on this form; I have had the opportunity to ask questions; I have received all the information I need to make a decision; and, I give my consent to undergo treatment at North Texas Pain Recovery Center.

_____ _____
Patient Date

_____ _____
Staff Member Date

Rev. 12/02

POOL CONSENT FORM

Do you have Diabetes?	___ Yes	___ No	
Have you ever had seizures?	___ Yes	___ No	
Do you have high blood pressure?	___ Yes	___ No	
Do you take heart medication?	___ Yes	___ No	
Can you swim?	___ Yes	___ No	
If yes, what level?	___Beginner	___Intermediate	___Advanced
Are you afraid of the water?	___ Yes	___ No	
Is your balance in the water	___ Good	___ Fair	___ Poor

1. Come prepared to get in the pool. Bring your bathing suit or shorts, shirt and towel.

2. Make sure you have eaten food and drank liquids at least 1 hour to 1½ hours prior to coming to the pool. Due to the heat in the pool, it is easy to get dehydrated. If you have a headache, make sure you drink more water prior to exercise.

3. Realize that the pool is heated to approximately 94 °- 98 ° and you may feel extremely tired following exercise. We will adapt your exercise program as you tolerate more activity. A whirlpool is available and the temperature is approximately 102 °- 106 °.

4. If you have a rash, scabs, open sores, any type of bleeding, infectious or communicable diseases, you will not be allowed in the pool due to health reasons.

5. Please keep the therapist and technician informed of any changes in your medical status. Also, let us know if you are fearful of water, prone to dizziness, have seizures, etc.

6. Please keep the therapist informed of any cardiac or respiratory conditions.

7. If you are running a temperature or if you are ill, please do not attend the pool exercises.

8. Be sure and read rules posted in the pool area.

9. We will encourage you to have fun while you exercise, but horseplay will not be tolerated.

10. No diving allowed. No running allowed. No food allowed in pool area.

11. Do not get in pool without supervision of a therapist / tech.

I understand and agree to the above statements.

_____ _____
Patient Date

_____ _____
Witness Date

6702 W. Poly Webb
Arlington, Texas 76016
Phone (817) 478-0095
Fax (817) 478-7628

NORTH TEXAS PAIN
RECOVERY CENTER

PAIN MANAGEMENT
WORK HARDENING

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to: **North Texas Pain Recovery Center**. I instruct and direct payment by check made out to:

North Texas Pain Recovery Center
6702 W. Poly Webb Rd.
Arlington, Texas 76016

If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

c/o North Texas Pain Recovery Center
6702 W. Poly Webb Rd.
Arlington, Texas 76016

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the profession services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed by indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Signature _____ Date _____

Witness _____

6702 W Poly Webb Arlington, Texas 76016 Phone 817-478-0095 Fax 817-478-7628

I have received the "Notice of North Texas pain Recovery Center's Policies and Practices to Protect the Privacy of Your Health Care Information."

_____
Signature

_____
Printed Name

_____
Date

Notice of North Texas Pain Recovery Center's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MEDICAL AND PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician, surgeon, psychologist, or chiropractor.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within our clinic such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our clinic such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when We am asked for information for purposes outside of treatment, payment and health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy or counseling notes. "*Psychotherapy or counseling notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, we must make a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, the Texas Youth Commission, or to any local or state law enforcement agency.

- **Adult and Domestic Abuse:** If we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, we must immediately report such to the Department of Protective and Regulatory Services.

- **Health Oversight:** If a complaint is filed against us with one of our state regulatory boards they have the authority to subpoena confidential medical or mental health information from us relevant to that complaint.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and we will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.

- **Worker's Compensation:** If you file a worker's compensation claim, we may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are getting treatment. Upon your request, we will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you

for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, We will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

North Texas Pain Recovery Center's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we am required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will provide an updated policy during your next visit or will mail a copy to your home address.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Michael R. Walker, Administrative Director (817-478-0095).

If you believe that your privacy rights have been violated and wish to file a complaint with our clinic, you may send your written complaint to Dr. Michael R. Walker, Administrative Director, 6705 W. Poly Webb Rd., Arlington, TX 76016 or they can be emailed to mwalker@painrecovery.net

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2004.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will either hand deliver the revised notice or will mail it to you.

NORTH TEXAS PAIN RECOVERY CENTER

PAIN MANAGEMENT
WORK HARDENING

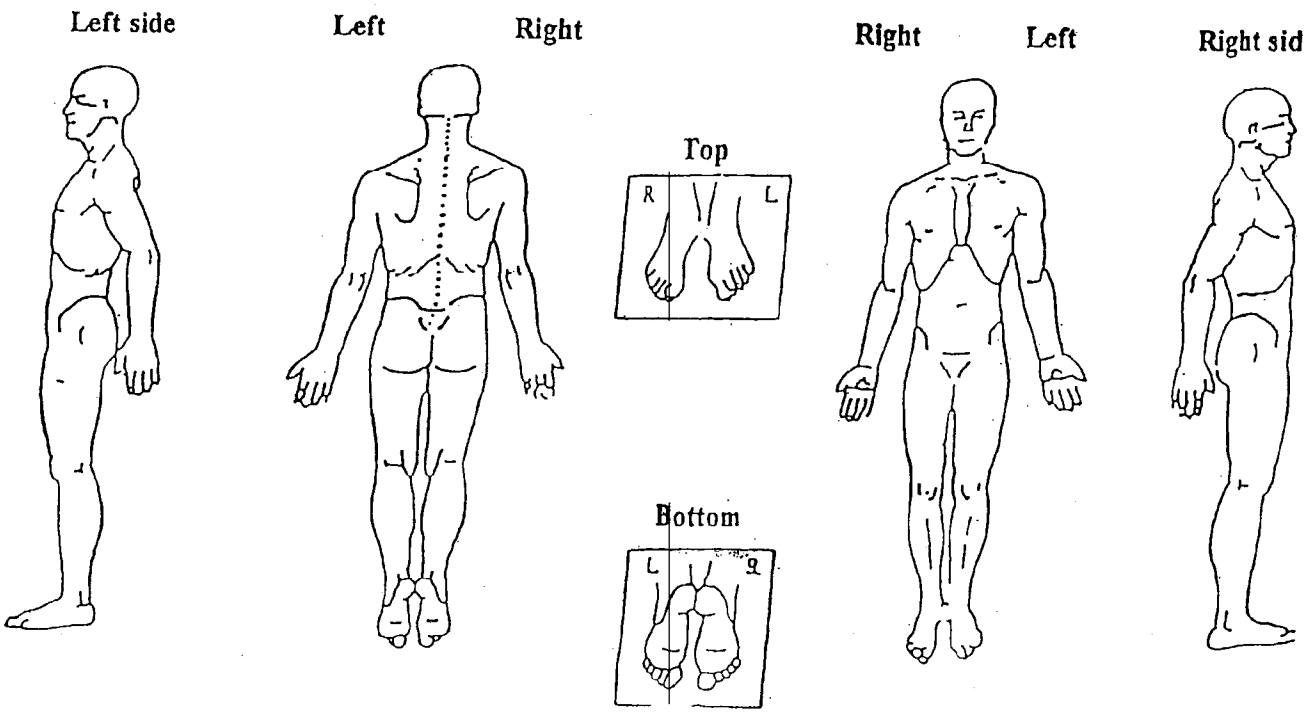
VISUAL ANALOG PAIN SCALE

Name:_____ Date:_____

I do not have any pain ——— I have mild pain ——— I have moderate pain ——— I have severe pain ——— My pain could not be worse

None ——— 1 2 3 4 5 6 7 8 9 10 ——— Severe

Mark on the chart below the places you hurt, with the following key:
D= Dull X= Sharp B= Burning T= Tingling N= Numbness



North Texas Pain Recovery Center

Pain Management Work Hardening

Program Accreditations:
The Rehabilitation Accreditation Commission (CARF) American Academy of Pain Management (AAPM)

Name: _____ Date: _____

Instructions: Please check the *one* appropriate response for each of the 10 sections below. Please answer according to how you feel *this* week.

Section 1 – Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pail killers give little relief from pain.
- ☐ Pain killers have no effect on pain and I do not use them.

Section 2 – Personal Care (Washing, dressing, etc.)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self care.
- ☐ I do not get dressed. I wash with difficulty and stay in bed.

Section 3 – Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example, on a table.
- ☐ Pain prevents me from lifting heavy weights, b I can manage light to medium weights if they are positioned conveniently.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than 1/2 mile.
- ☐ Pain prevents me walking more than 1/4 mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me sitting more than 1/2 hour.
- ☐ Pain prevents me sitting more than 10 minutes.
- ☐ Pain prevents me sitting at all.

Section 6 – Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain
- ☐ Pain prevents me standing for more than 1 hour.
- ☐ Pain prevents me standing for more than 1/2 hour.
- ☐ Pain prevents me standing for more than 10 minutes.
- ☐ Pain prevents me standing at all.

Section 7 – Sleeping
- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Sex Life
- ☐ My sex life is normal and causes no extra pain.
- ☐ My sex life is normal and causes some extra pain.
- ☐ My sex life is nearly normal is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9 - Social Life
- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests (for example, dancing).
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 10 – Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short, necessary, journeys of under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

6702 W. Poly Webb
Arlington, Texas 76016

Phone (817) 478-0095
Fax (817) 478-7628

Patient Name

Beck Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much	Moderately- it wasn't pleasant at times	Severely- it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst	0	1	2	3
happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

North Texas Pain Recovery Center

Pain Management Work Hardening

Program Accreditations:
The Rehabilitation Accreditation Commission (CARF) **American Academy of Pain Management (AAPM)**

PROGRESS SURVEY

NAME: _____ DATE: _____

In answering the following questions, please keep in mind that we are interested in knowing about changes that have occurred **over the past week**.

1. Use the following rating scale to indicate what your level of pain has been **over the past week** (circle the appropriate number). In other words, **your average** pain level over the past week.

   No pain 0----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 Worst pain imaginable

2. Use the following rating scale to indicate how well you have been coping with your pain **over the past week** (circle the appropriate number).

   Totally unable to deal with it 0 --- 1 ---2 --- 3 --- 4 --- 5 --- 6 --- 7 --- 8 --- 9 --- 10 Dealing with it great

3. Over the past week, count the number of times you have taken part in any social and/or recreational activity. **Indicate the number of times you have done the following activities by placing a number on the line.** If you have done an activity other than what is listed, please use the other category.

__ church	__ shopping	__ visiting	__ walking	__ movie
__ sports events	__ park	__ fun parks	__ groceries	__ bank
__ yard work	__ post office	__ shopping mall	__ traveling	__ outside hobby
__ out to eat	__ Laundromat	__ dancing	__ concert	__ other

_____

(you may list the "other" activities on this line, if you wish)

4. Use the following rating scale to indicate how well you feel you have been getting along with family members (spouse, children, parents, etc.).

   Many bad feelings and arguments 0 -- 1 -- 2 -- 3 -- 4 -- 5 -- 6 -- 7 -- 8 -- 9 -- 10 Getting along great

Rev. 02/03

6702 W. Poly Webb
Arlington, Texas 76016

Phone (817) 478-0095
Fax (817) 478-7628

North Texas Pain Recovery Center

Pain Management Work Hardening

Program Accreditations:

The Rehabilitation Accreditation Commission (CARF) American Academy of Pain Management (AAPM)

DALLAS PAIN QUESTIONAIRE
(DPQ)

NAME: _____ DATE: _____

PLEASE READ: This questionnaire has been designed to give your doctor information as to how your pain has affected your life. Be sure that these are your answers. Do not ask someone else to fill out the questionnaire for you. Please mark an "X" along the line that expresses your thoughts from 0 to 100 in each section.

Section I: Pain Intensity

To what degree do you rely on pain medications or pain relieving substances for you to be comfortable?

None Some All the time

0% (_____:_____:_____:_____:_____:_____) 100%

Section II: Personal Care

How much does pain interfere with your personal care (getting out of bed, teeth brushing, dressing, etc.)?

None (no pain) Some (I cannot get out of bed)

0% (_____:_____:_____:_____:_____:_____) 100%

Section III: Lifting

How much limitation do you notice in lifting?

None (I can lift as I did) Some (I cannot lift anything)

0% (_____:_____:_____:_____:_____:_____) 100%

Section IV: Walking

Compare to how far you could walk before your injury or back trouble, how much does pain restrict your walking now?

None (I can walk the same) Almost the Very little (I cannot walk)

0% (_____:_____:_____:_____:_____:_____) 100%

North Texas Pain Recovery Center

Pain Management Work Hardening

Program Accreditations:

The Rehabilitation Accreditation Commission (CARF) **American Academy of Pain Management (AAPM)**

Section V: Sitting

Back pain limits my sitting in a chair to:

None (Pain, same as before) Some (I cannot sit at all)

0% (_____:_____:_____:_____:_____:_____) 100%

Section VI: Standing

How much does your pain interfere with your tolerance to stand for long periods?

None (same as before) Some (I cannot stand)

0% (_____:_____:_____:_____:_____:_____) 100%

Section VII: Sleeping

How much does pain interfere with your sleeping?

None (Sleep, same as before) Some (I cannot sleep at all)

0% (_____:_____:_____:_____:_____) 100%

(Sum X 3 = _____% (Daily Activities Interference)

Section VIII: Social Life

How much does pain interfere with your social life (dancing, games, going out, eating **with friends, etc.)?**

None (same as before) Some (No activities total loss)

0% (_____:_____:_____:_____:_____:_____:_____:_____) 100%

Section IX: Traveling

How much does pain interfere with traveling in a car?

None (Same as before) Some (I cannot travel)

0% (_____:_____:_____:_____:_____:_____:_____) 100%

Section X: Vocational

How much does pain interfere with your work and/or daily activities?

None (No interference) Some (all of the time)

0% (_____:_____:_____:_____:_____:_____:_____:_____) 100%

Sum X 5 = _____% (Work / Leisure Activities Interference)

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Section XI: Anxiety / Mood
How much control do you feel that you have over demands made on you?

Total (No change) 100% (_____:_____:_____:_____:_____:_____:_____:_____) 0% Some (None)

Section XII: Emotional Control
How much control do you feel you have over your emotions?

(No change) Total 100% (_____:_____:_____:_____:_____:_____:_____:_____) 0% Some (None)

Section XIII: Depression
How depressed have you been since the onset of pain?

No depressed significantly 0% (_____:_____:_____:_____:_____:_____:_____:_____) 100% **Overwhelmed** by depression

Sum X 5 = _____% Anxiety / Depression Interference

Section: XIV: Interpersonal Relationships
How much do you think your pain has changed your relationships with others?

Not Changed 0% (_____:_____:_____:_____;_____:_____:_____:_____) 100% **Drastically** changed

Section XV: Social Support
How much support do you need from others to help you during this onset of pain (taking over chores, fixing meals, etc.)?

None needed 0% (_____:_____:_____:_____:_____:_____:_____) 100% Some All the time

Section XVI: Punishing Response
How much do you think others express irritation, frustration, or anger toward you because of your pain?

None 0% (_____:_____:_____:_____:_____:_____:_____:_____) 100% Some All the time

Sum X 5 = _____% (Social Interest Interference)

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Personal Inventory

Please circle the item in each group of statements which best describes your feelings over the past week.

1. 0 - I do not feel sad
   1 - I feel sad
   2 - I feel sad all of the time and I can't stand 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 failure
   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 guilty most of the time
   3 – I feel guilty all of the time

6. 0 – I don't feel I may be 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 off than anybody else
   1 – I am critical of myself for my weaknesses and 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

10. 0 I don't cry any more than usual
    1 – I cry more now than I used to
    2 – I used to be able to cry, but now I can't even though I want to
    3 – I cry all the time now

11. 0 – I am no more irritated by things now than I ever am
    1 – I am slightly more irritated now than usual
    2 – I am quite annoyed or irritated a good deal of the time
    3 – I feel irritated all the time now

12. 0 – I have not lost interest in other people
    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 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 that I look any worse than I used to
    1 – I am worried that I am looking old and 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 extra effort to get started at doing something
    2 – I have to push myself very hard to do anything
    3 – I can't do my work at all

16. 0 – I can sleep as well as I used to
    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 and cannot get back to sleep

17. 0 – I don't get more tired than usual
    1 – I get tired more easily that I used to
    2 – I get tired from doing almost anything
    3 – I am to 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
    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 my physical problems such as aches & pains, or 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 physical problems that I can't think about anything else

21. 0 – I have not noticed any recent change in my interest in sex
    1 – I am less interested in sex than I used to be
    2 – I am much less interested in sex
    3 – I have lost interest in sex completely

pop Pain Outcomes Profile

Patient Name _____

Patient ID # _____

1. Enter today's date: _____ / _____ / _____ *(MM/DD/YY)*

2. Enter your date of birth: _____ / _____ / _____ *(MM/DD/YY)*

3. How long have you had the pain for which you are now seeking treatment?

_____ Years _____ Months

4. On a scale of 0 to 10, with 0 being no pain at all and 10 being the worst possible pain, how would you rate your pain ***right now***?

0	1	2	3	4	5	6	7	8	9	10
no pain at all										*worst possible pain*

5. How would you rate your pain on the ***average*** during the ***last week*** ?

0	1	2	3	4	5	6	7	8	9	10
no pain at all										*worst possible pain*

6. Does your pain affect your self-esteem or self-worth?

0	1	2	3	4	5	6	7	8	9	10
not at all										*all the time*

7. Does your pain interfere with your ability to walk?

0	1	2	3	4	5	6	7	8	9	10
not at all										*all the time*

8. Does your pain interfere with your ability to bathe yourself?

0	1	2	3	4	5	6	7	8	9	10
not at all										*all the time*

9. How would you rate your physical activity?

0	1	2	3	4	5	6	7	8	9	10
significant limitation in basic activities										*can perform vigorous activities without limitation*

10. How would you rate your feelings of depression ***today***?

0	1	2	3	4	5	6	7	8	9	10
not depressed at all										*extremely depressed*

please turn over →

pop

11. Does your pain interfere with your ability to carry/handle everyday objects such as a bag of groceries or books?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

12. Does your pain interfere with your ability to dress yourself?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

13. How would you rate your overall energy?

0 (*totally worn out*) 1 2 3 4 5 6 7 8 9 10 (*most energy ever*)

14. How much do you worry about re-injuring yourself if you are more active?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

15. How would you rate your feelings of anxiety ***today***?

0 (*not anxious at all*) 1 2 3 4 5 6 7 8 9 10 (*extremely anxious*)

16. Does your pain interfere with your ability to climb stairs?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

17. Does your pain interfere with your ability to use the bathroom?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

18. How would you rate your strength and endurance ***today***?

0 (*very poor strength and endurance*) 1 2 3 4 5 6 7 8 9 10 (*very high strength and endurance*)

19. Do you have problems concentrating on things ***today***?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

20. Does your pain require you to use a cane, walker, wheelchair or other devices?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

21. Does your pain interfere with your ability to manage your personal grooming? (for example combing your hair, brushing your teeth, etc)

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

22. How often do you feel tense?

0 (*not at all*) 1 2 3 4 5 6 7 8 9 10 (*all the time*)

23. How safe do you think it is for you to exercise?

0 (*not safe at all*) 1 2 3 4 5 6 7 8 9 10 (*extremely safe*)

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Pain Outcomes Profile +

Patient Name:_____ Date:_____

	Yes	No
1) Are you concerned that you should cut down or cut back on your use of alcohol, medications, or other substances?	_____	_____
2) Have you ever been annoyed by people trying to talk to you about your use of alcohol, medication, or other substances?	_____	_____
3) Have you ever felt guilty about your use of alcohol, medication, or other substances?	_____	_____
4) Have you ever needed an eye-opener (use of alcohol, medication, or other substances) just to start your day?	_____	_____