PAIN MANAGEMENT INSTITUTE

Office 1: 6720A Rockledge Dr, #500 ● Bethesda, MD 20817 ● Tel: (301) 530-7303 ● Fax: (301) 530-7312
Office 2: 2112 F Street, NW #802A ● Washington, DC 20037 ● Tel. (202) 775-7246 ● Fax: (202) 775-2345

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State Code: _____ Zipcode: _____

Referral Dr: _____ Sex (M/F): _____ Marital Status: _____ S M D W

Date of Birth: _____ Social Sec. #: _____-_____-_____

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

Emergency Contact: _____ Emergency Phone: ( ) _____

Is this visit/service related to an **auto accident**? ☐ Yes ☐ No Date of Injury: _____

Is this visit/service related to a **work related accident/injury**? ☐ Yes ☐ No Date of Injury: _____

Are you current on any blood thinner? (e.g. Coumadin, Plavix, Pradaxa, Effient, Xarelto, …) ☐ Yes ☐ No

---

PRIMARY INSURANCE CARRIER

Company: _____

Policy/Claim #: _____

Group Number: _____

SECONDARY INSURANCE CARRIER

Company: _____

Policy/Claim #: _____

Group Number: _____

Claim Adjustor / Attorney (if applicable): _____

Phone Number: ( ) _____ Fax Number: ( ) _____

Mailing address: _____

Patient's Authorization

I authorize PAIN MANAGEMENT INSTITUTE to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to PAIN MANAGEMENT INSTITUTE. I certify that the information I have disclosed above is correct and further authorize the release of any necessary information , including medical information for this or any related claims to the claim carrier(s) I have provided. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

_____ _____

Signature of Subscriber or Beneficiary Date

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NAME: _____ **DATE:** _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Who to call in case of emergency: _____

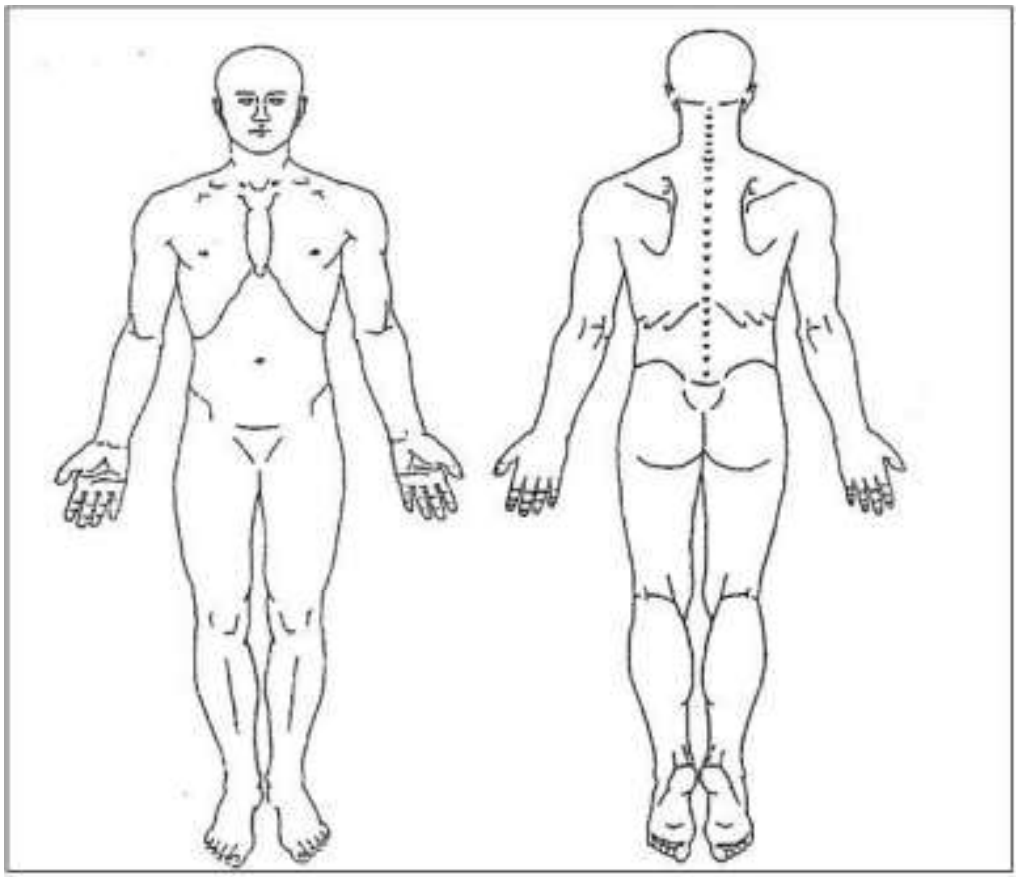
Name of the doctor who has referred you: _____

Name of the doctor(s) who should get this report: _____

REASON FOR VISIT: _____

The worst area(s) of pain: _____

Please mark the areas of pain:



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Please rate your average daily pain: from 0 (no pain) to 10 (worst possible pain): _____/10

Length of time that you have had this pain in this area: _____

Has something or an event started your pain: YES/ NO, If so, what event?

_____

Circle factors that aggravate your pain?

None Standing Exercising Walking Bending Straining Lifting Stress Weather changes Medications Repetitive motions Sitting Head movement Mood swings Light touch Deep breathing Coughing Bearing down Lying down Rolling in bed Other:_____

Circle factors that help your pain?

Nothing Resting Walking Standing Sitting Moving Physical Therapy Massage Heat/Ice packs Medication Lying down Changing positions Other:_____

Circle factors that describe your pain?

Constant Intermittent Burning Sharp Shooting Aching Throbbing Tingling Numbness Other: _____

Circle prior pharmacological treatments:

Anti-inflammatory medications: Ibuprofen, Celebrex, Medrol dose pack
Narcotics: Ultram, Tramadol, Percocet, Oxycodone, Oxycontin, Vicodin, Norco, Hydrocodone, Morphine, Methadone, Dilaudid, Hydromorphone, Duragesic, Buprenorphine, Suboxone
Antidepressants: Elavil, Amitriptylline, Pamelor, Nortrptylline, Trazodone, Desipramine, Cymbalta Antiseizure medication: Neurontin, Gabapentin, Trileptal, Topamax, Gabitril, Lyrica, Pregabalin

Circle prior interventional treatments:

Acupuncture, Magnets, Massage, Chiropractic manipulation, Herbs, Physical therapy, Nerve blocks, Epidural injections, Facet blocks, Other:

_____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

_____

PAST MEDICAL HISTORY: _____

_____

PAST SURGICAL HISTORY: _____

_____

What is your current height?_____ What is your most recent weight?_____

Did you have a flu shot this year? Yes/No Have you had a colonoscopy? Yes/No

Have you had a DXA or Bone Scan? Yes/ No, If so, when?_____

Do you have a history of depression? Yes/No Do you use Tobacco? Yes/No

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FAMILY HISTORY:

RELATIVE	AGE	SIGNIFICANT HEALTH PROBLEM
Mother		
Father		
Brother(s)		
Sister(s)		

SOCIAL HISTORY:

Are you: Single Married Divorced Separated Widowed Partnered
Do you have children? Yes / No. How many? _____
Do you work? Yes / No. If so, describe please _____
Do you smoke? Yes / No. How much? _____
Do you drink? Yes / No. How much? _____
Do you use illicit drugs? Yes / No. How much? _____
Have you ever been addicted to nicotine, alcohol, or illicit drugs? Yes / No
If so, please explain: _____
Are you involved in any unsettled legal issues involving your symptoms? Yes / No
If so, please explain:_____
_____

GENERAL HEALTH QUESTIONS:

Have you had any of the following in the past 2 weeks? Circle all that applies to you:
Fevers Chills Night sweat Unexplained weight loss Eye problems Ear problems
Heart problems Lung problems Stomach problems Bladder/Kidney problems
Skin problems Neurological problems Psychological issues Thyroid problems
Diabetes Bleeding problems

Please explain any of the above:_____
_____
_____

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The Pain Management Institute accepts patient coverage from Medicare, and as such is required under federal law to provide all patients with notice of Patient Rights, information on Advanced Directives, and disclosure of physician interest. Below are details of our standards pertaining to this requirements; patients will be duly informed should there be any changes t these current standing policies.

PATIENT RIGHTS

1. Make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

2. Receive as much information about any proposed treatment or procedure as he/she may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternate course of treatment or non treatment, the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.

3. Have pain assessed and managed as part of the treatment process.

4. Receive information from his/her physician about his/her illness, course of treatment, and prospects for recovery in terms that he/she can understand.

5. Knowledge of the name of the physician who has primary responsibilities for coordinating his/her care and the names and professional relationships of other physicians and non-physicians who will participate in the care. Patient has the right to request physician's credentials.

6. Be treated with consideration, respect,and dignity and the right to be free of all forms of abuse/harassment.

7. Receive service(s) without regard to age, race, color, sex, sexual orientation, marital status, national origin, cultural, economic, educational, religious background, or the source of payment of care.

8. Participate actively in decisions regarding his/her medical treatment including the right to refuse treatment to the extent permitted by law and to be fully informed of the medical consequence of his/her action.

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9. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in their care.

10. Right to receive care in a safe setting.

11. Exercise his/her rights without being subjected to discrimination or reprisal.

12. Receive a copy of his/her account statement upon request.

13. Leave the center even against the advice of physicians.

14. Confidential treatment of all communications and records pertaining to his/her care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with his/her care.

15. Right to contact the Department of Health with any questions or concerns by contacting:

    Ambulatory Care Unit
    Office of Health Care Quality
    Spring Grove Hospital Center
    Bland Bryant Building
    55 Wade Avenue
    Catonsville, MD 21228

    (410) 402-8040

16. Right to contract the Medicare Ombudsman with any questions or concerns:

    http://www.medicare.gov/Ombudsman/resources.asp

17. If a patient is adjudged incompetent under applicable State Health & Safety Laws by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed under state law to act on the patient's behalf.

18. Right to refuse to participate in experimental research.

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PATIENT RESPONSIBILITIES

1. It is the responsibility of all the patients to accept personal financial responsibility for any charges NOT covered by their insurance.

2. To be respectful to all the health care providers, the staff, and other patients in the ASC.

3. Follow the treatment plan prescribed by his/her provider.

4. Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider.

5. Inform his/her provider about any living will, medical power of attorney or other directive that could affect his/her care.

6. Provide to the best of his/her knowledge accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.

7. For his/her actions if he/she refuses treatment or is non-compliant in following a plan of treatment recommended by his.her actions.

8. To know the rules and regulations of the center affecting his care and conduct, and for following the center's rules and regulations.

9. For being considerate of the rights of other patients and the center's personnel, and for assisting in the control of noise and smoking.

10. For being respectful of the property of other persons and of the center.

11. To make sure he/she understands all information regarding the implications of his symptoms, his surgery or procedure (if applicable) and any risks related to having or declining such surgery or procedure, the expected outcomes of the plan of care outlines by his/her physician, and his/her responsibilities with regard to that plan of care.

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ACKNOWLEDGEMENT FORM

I, _____,acknowledge that I have read and understood the above referenced statements by The Pain Management Institute with respect to Patients Rights and Responsibilities, and Ownership of the center.

Signature: _____ Date: _____

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HIPAA Notice 1209

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

Introduction

At Pain Management Institute, we are committed to treating and using your protected health information responsibly. Under federal and state law, your patient health information is protected and confidential. This Notice of Health Information Practices describes the personal health information we collect and how and when we use or disclose that information. It also describes your rights and our responsibilities as they relate to your protected health information.

Understanding your Health Record/Information

Each time you visit the Pain Management Institute, a record of your visit is made. Typically, this record contains your demographic information, medical history, procedure notes, test results, diagnoses, prescription copies, discharge instructions and signed consents. This information, often referred to as your health or medical record, serves as a:

-Basis for planning your care and treatment.
-Means for staff to contact you for follow-up.
-Legal document describing the care you received, and consents you have given.
-Means by which a third-party payer (e.g., your insurance company) can verify who you are, and that services billed were actually provided.
-Source of information for public health officials charged with improving the health of this state and the nation (such as AHCA and FDA).
-Means by which a pathology lab can process and bill for biopsy samples.
-Tool with which we can assess and continually work to improve the care we render at our facility, and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Uses and Disclosures of your Health Information

As described above, your health information is used for a number of different and important purposes. In some circumstances, we may use or disclose your health information without seeking your permission. The following are some examples of ways your information may be used or disclosed:

Treatment: We will use and disclose your health information for medical treatment purposes. For example, your doctors and nurses will update your medical record and use it to determine the best course of care. Additionally, your information may be disclosed to other health care providers involved in your treatment, or to the pharmacist who will be filling your prescriptions.

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Payment: We will use and disclose your health information for payment purposes. For example, we will use your health information to prepare and submit bills and we may need to submit information to your insurance company to obtain authorization prior to providing certain types of treatment.

Health Care Operations: We will use and disclose your health information to conduct our standard internal operations. For example, we may use or disclose your health information to conduct quality assessment and improvement activities and for business management and other general administrative activities.

.Special Uses: We may use your information to contact you with appointment reminders or to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Other Uses or Disclosures: We may use or disclose your health information for the following purposes without your consent and, in some cases, we may be required to do so:

-Required by Law: We may be required to disclose your health information to certain legal authorities if it relates to suspected crimes, abuse, neglect, or similar injuries or events.
-Public Health Activities: We may be required to disclose your health information to public health officials for purposes of collecting vital statistics, information related to disease control, federal regulation of food and drug quality and safety, etc.
-Health Oversight: We may be required to disclose your health information to certain regulatory authorities for purposes of oversight the health care system, government benefits programs, and regulatory compliance investigations or audits.
-Judicial and Administrative Proceedings: We may disclose your health information in response to a lawful subpoena, discovery request, or court order.
-Deaths: We may disclose information relating to deaths to coroners, medical examiners, funeral directors, or organ donation agencies.
-Serious Threat to Health or Safety: We may disclose your health information if necessary to prevent or lessen a serious threat to the health or safety of a person or the public.
-Military and Special Government Forces: If you are a member of the armed forces, we may disclosure your information to appropriate military command authorities at their request. Additionally, we may disclose information to a correctional institution or law enforcement official as required for the care, health and safety of inmates and/or employees of the correctional institution. -Research: In appropriate situations, we may disclose your health information for approved medical research.
-Workers' Compensation: We may disclose your health information in compliance with workers' compensation laws or similar programs.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you decide to authorize the use or disclosure of your health information, you may later revoke such authorization, as provided by 45 CFR § 164.508(b)(5), to prevent the future use or disclosure of your health information in this way.

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Maryland Specific Requirements. In the state of Maryland, you have the following additional rights with respect to your health information:

(1) Your health information may not be disclosed except to the extent that the disclosure is consistent with the authorized purposes for which the information was first obtained. The person or entity to which we disclose your health information may not further disclose that medical information except in accordance with a new written authorization for you, or as specifically required or permitted by law.

(2) If you have requested a restriction on the uses and disclosures of your health information, and we have granted such request, we are required to communicate those restrictions and/or limitations to the person or entity to which we disclose your health information.

Maryland law also limits disclosures of your health information in ways that would otherwise be permitted under federal law. In the situations described below, we will disclose your medical information as follows.

(1) Your health information may be disclosed to other providers of health care, health care service plans, contractors, or other healthcare professionals or facilities for purposes of diagnosis or treatment of the patient. This includes, in an emergency situation, the communication of patient information by radio transmission or other means between emergency medical personnel at the scene of an emergency, or in an emergency medical transport vehicle, and emergency medical personnel at a licensed health facility.

(2) Your health information may be disclosed to an insurer, employer, health care service plan, hospital service plan, employee benefit plan, governmental authority, contractor, or any other person or entity responsible for paying for health care services rendered to you., to the extent necessary to allow responsibility for payment to be determined and payment to be made. If you are, by reason of a comatose or other disabling medical condition, unable to consent to the disclosure of medical information and no other arrangements have been made to pay for the health care services being rendered, your health information may be disclosed to a governmental authority to the extent necessary to determine that your eligible for, and to obtain, payment under a governmental program for health care services provided to the patient

(3) Your health information may be disclosed to a person or entity that provides billing, claims management, medical data processing, or other administrative services for providers or health care or health care service plans. However, any health information so disclosed shall not be further disclosed by the recipient in a way that would violate state law.

(4) Your health information may be disclosed to organized committees and agents of professional societies or of medical staffs of licensed hospitals, licensed health care service plans, professional standards review organizations, independent medical review organizations and their selected reviewers, utilization and quality control peer review organizations, contractors, or persons or organizations insuring, responsible for, or defending professional liability that a provider may incur, if the committees, agents, health care services plans, organizations, reviewers, contractors, or persons are engaged in reviewing the competence or qualifications of healthcare professionals or in reviewing health care services with respect to medical necessity, level of care, quality of care, or justification of charges.

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(5) Your health information may be reviewed reviewed by a private or public body responsible for licensing and/or accrediting our facility. However, no patient-identifying medical information may be removed from our premises except as expressly permitted or required elsewhere by law, nor shall your health information be further disclosed by the recipient in a way that would violate state law.

(6) Unless we are notified in writing of an agreement to the contrary, your health information may be disclosed to a sponsor, insurer, or administrator of a group or individual insured or uninsured plan or policy that you seek coverage by or benefits from, if the health information was created by us as the results of services conducted at the specific prior written request and expense of the sponsor, insurer, or administrator for the purpose of evaluating the application for coverage of benefits.

(7) Your health information may be disclosed to the health care service plans in which we contract for the purpose of administering the health care service plan. Your health information shall not otherwise be disclosed by a health care service plan.

(8) Health information may be disclosed to an organ procurement organization or a tissue bank processing the tissue of a decedent for transplantation into the body of another person, but only with respect to the donating decedent, for the purpose of aiding the transplant.

(9) Your health information may be disclosed to a third party for purposes of encoding, encrypting, or otherwise anonymizing data. However, no health information so disclosed shall be further disclosed by the recipient in a way that would violate state law, including the unauthorized manipulation of coded or encrypted medical information that reveals individually identifiable medical information.

Your Health Information Rights:

Although your health record is the physical property of Pain Management Institute, the information belongs to you. You have the right to:

-Request a restriction on certain uses and disclosures of your health information for treatment, payment, health care operations, or other permitted purposes, as provided by 45 § CFR 164.522(a). Please note, however, that we are not legally required to agree to all requested restrictions.
-Receive confidential communications of your health information, as provided by 45 § CFR 164.522(b).
-Inspect and copy your health record as provided by 45 CFR § 164.524.
-Amend your health record as provided in 45 CFR § 164.526.
-Receive an accounting of disclosures of your health information as provided in 45 CFR § 164.528.
-Obtain a paper copy of this health notice of information practices upon request.

Our Responsibilities

Pain Management Institute is required to:

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-Maintain the privacy of your health information. -Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. -Abide by the terms of the notice of health information practices currently in effect.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided to us.

For More Information or to Report a Problem:

If you believe your privacy right has been violated, you can file a complaint as above with the Office for Civil Rights, U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Patient/Person Authorized to Consent:

_____

Signature Date

_____

Print Name

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PATIENT FINANCIAL TERMS AND CONDITIONS

We are committed to providing you with the best possible care and service. In order to achieve this, we need you to provide us with all relevant insurance information at the time of service. If we are a participating provider with your insurance company, we will be happy to process your insurance claim forms for reimbursement. However, it is your obligation to understand the terms and conditions of your insurance regarding medical procedures and treatments that are covered under your plan, you copay, coinsurance, deductible, and whether a referral form is required for services. If you are a self-paying patient, payment is **DUE** at the time of service in the form of cash or credit card. If we are not a participating provider with your insurance company, it is your responsibility to assure that we are properly and promptly reimbursed for our services. In the event that your insurance company does not cover medical procedures that you have received, you are ultimately responsible for all charges for these services.

PLEASE NOTE, IF WE ARE **NOT** A PARTICIPATING PROVIDER WITH YOUR INSURANCE COMPANY, YOU MUST REALIZE THE FOLLOWING:

1. Your insurance is a contract with you and the insurance company. We are not a party to that contract and therefore not bound by its terms and conditions.
2. We are not bound to the fee payment structure of your insurance company. You are responsible for whatever portion of our charges your insurance does not pay.
3. Not all services are covered benefits in all contracts. Some insurance companies will not cover certain services. These charges are your responsibility.

All accounts are due in 30 days after the insurance companies have paid. Interest in the amount of 1.5% per month will added until the balance is paid. There will be a $40.00 service charge for any check(s) which is/are dishonored by the bank. If your balance is unpaid after 90 days, it will be considered delinquent and will be submitted to our attorney for collections. You would then be responsible for collection cost, interest, court costs, attorney fees, and consequential expenses related to the reporting of the account to the credit bureaus.

Please indicate your understanding and acceptance of this agreement by signing below.

_____ _____

Patient Signature Date

Insurance Authorization and Assignment Form

All professional services rendered are charged to the patient. If we do not accept your insurance plan, the necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees and it is customary to pay when services are rendered unless other arrangements have been made in advance with our facility. You are required to cover your co-insurance and/or deductible when services are rendered. It is the responsibility of the patient to secure the necessary referrals from his/her primary care physician. If you do not have the necessary referral at the time of your visit, the charges for the service rendered will be your responsibility and is expected to be paid at the time of your visit.

Patient Acknowledgement:

I hereby authorize Pain Management Institute to render services related to the visit for which I am scheduled and have consented to, and to furnish all information to the insurance carrier / payor concerning my illness and treatments. I hereby assign all insurance or third-party carrier payments to Pain Management Institute for medical services rendered to myself or my dependents. I understand that I am responsible for any amount that is not a covered service under my insurance.

_____ _____

PATIENT NAME DATE

_____

SIGNATURE

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CONTROLLED SUBSTANCE AGREEMENT

In the event that my consultation/procedure today results in the doctor prescribing any controlled substances. I promise to adhere to the following:

1. I understand that there are risks associated with the use of prescribed medications such as dependence, addiction, personality changes, sleep disorder, constipation, appetite changes, loss of coordination, and changes in sexual desire and performance. I will therefore use the substances only within the parameters given to me by the Pain Management Institute physicians.
2. I will not receive replacements for lost or stolen medications.
3. I will not give these medications to other people under any circumstances.
4. I will receive controlled substances ONLY from the Pain Management Institute unless, arrangements have been made with my other physician and Pain Management Institute is aware of these arrangements. Any violation of this rule will result in the discontinuation of treatment.
5. I will not expect to receive additional medication before my next scheduled refill, even if my prescription runs out.
6. If it appears to the physician that my daily functioning and quality of life are not benefiting from treatment with the controlled substance, I will gradually taper off my medication as directed by the physician. I will not hold any member of the Pain Management Institute group liable for problems caused by the discontinuance of controlled substances.
7. I agree to submit to urine, oral, and/or blood screening to detect the use of non-prescribed medications at any time. Medication interactions can increase the risk associated with narcotics.
8. I will review and follow the instructions provided with my medication and by my pharmacist. I understand that my medication may impair my abilities to perform certain activities, such as driving and operating equipment, and that I should avoid such activities, if impaired.
9. I recognize that my chronic pain represents a complex problem that may benefit from physical therapy, psychotherapy, and behavioral medicine strategies. I also recognize that my participation in the management of pain is extremely important. I agree to actively participate in all aspects of the Pain Management Program to maximize my level of functioning and to increase my ability to cope with my condition.
10. Under no circumstance will there be any altering of any prescription.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

Name: _____ Date: _____

Date of Birth: _____

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.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

Nombre: _____ Fecha: _____

Fecha De Nacimiento: _____

SOAPP®-R

Las siguientes son algunas preguntas hechas a pacientes. Algunos de estos pacientes toman medicamentos para el dolor. Otros aún no toman medicamentos para el dolor, pero estamos considerando dárselos. Responda cada pregunta con la mayor sinceridad posible. No hay respuestas correctas ni incorrectas.

	Nunca	Rara vez	A veces	A menudo	Muy a menudo
	0	1	2	3	4
1. ¿Con qué frecuencia le cambia el estado de ánimo?	○	○	○	○	○
2. ¿Con qué frecuencia ha sentido necesidad de tomar dosis mayores de medicamento para tratar el dolor?	○	○	○	○	○
3. ¿Con qué frecuencia se ha sentido impaciente con sus médicos?	○	○	○	○	○
4. ¿Con qué frecuencia se ha sentido tan presionado por distintas cosas que no puede manejarlas?	○	○	○	○	○
5. ¿Con qué frecuencia hay tensión en su casa?	○	○	○	○	○
6. ¿Con qué frecuencia ha contado sus pastillas para el dolor para ver cuántas le quedan?	○	○	○	○	○
7. ¿Con qué frecuencia se ha sentido preocupado de que la gente lo juzgue por tomar medicamentos para el dolor?	○	○	○	○	○
8. ¿Con qué frecuencia se siente aburrido?	○	○	○	○	○
9. ¿Con qué frecuencia ha tomado más medicamentos para el dolor de los que debía tomar?	○	○	○	○	○
10. ¿Con qué frecuencia le ha preocupado que lo dejen solo?	○	○	○	○	○
11. ¿Con qué frecuencia ha sentido ansias de tomar medicación?	○	○	○	○	○

	Nunca	Rara vez	A veces	A menudo	Muy a menudo
	0	1	2	3	4
12. ¿Con qué frecuencia otras personas se han mostrado preocupadas por el uso que usted hace de la medicación?	○	○	○	○	○
13. ¿Con qué frecuencia alguno de sus amigos cercanos ha tenido problemas de alcoholismo o drogadicción?	○	○	○	○	○
14. ¿Con qué frecuencia otras personas le dijeron que tenía mal genio?	○	○	○	○	○
15. ¿Con qué frecuencia se ha sentido dominado por la necesidad de conseguir medicamentos para el dolor?	○	○	○	○	○
16. ¿Con qué frecuencia se ha quedado sin medicamentos para el dolor antes de tiempo?	○	○	○	○	○
17. ¿Con qué frecuencia otras personas le han impedido conseguir lo que usted merece?	○	○	○	○	○
18. ¿Con qué frecuencia, en su vida, ha tenido problemas legales o ha sido arrestado?	○	○	○	○	○
19. ¿Con qué frecuencia ha asistido a reuniones de alcohólicos anónimos o narcóticos anónimos?	○	○	○	○	○
20. ¿Con qué frecuencia ha tenido una discusión tan fuera de control que alguien resultó herido?	○	○	○	○	○
21. ¿Con qué frecuencia ha sido abusado sexualmente?	○	○	○	○	○
22. ¿Con qué frecuencia otras personas han sugerido que tiene un problema de drogadicción o alcoholismo?	○	○	○	○	○
23. ¿Con qué frecuencia ha tenido que pedir prestados medicamentos para el dolor a sus familiares o amigos?	○	○	○	○	○