CAPSTONE
PAIN & SPINE CENTER

PATIENT INFORMATION

Patient's Name (First, Middle, Last): ______________________________

Address: ______________________________

City:______________ State:______ Zip Code: __________ Email: ______________

Main Contact#: ______________ Alternate#:______________ Work#: ______________

Date of Birth: _____/_____/______ Sex: ○ Male ○ Female SS# (optional): ______________

Marital Status: ○Single ○Married ○Divorced ○Widowed Occupation: ______________

Patient Referred By: ______________________ Spouse's Name: ______________

Spouse's Date of Birth: _____/_____/______ Main Contact#: ______________ Alternate#: ______________

Emergency Contact:______________ Relationship: ______________ Phone#: ______________

Primary Care Physician: ______________________ Phone #: ______________

Referring Physician: ______________________ Phone #: ______________

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: ______________(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: ______________Please Specify)

Primary Insurance:______________________ Policy/ID# ______________

Name of Policy Holder:______________ DOB: _____/_____/_____ Group/Acct #:______________

Employer: ______________________ Employer Address: ______________

City: ______________ State: ________ Zip Code: __________ Work #: ______________

Secondary Insurance: ______________________ Policy/ID#: ______________

Name of Policy Holder:______________ DOB: _____/_____/_____ Group/Acct #:______________

Employer: ______________________ Employer Address: ______________

City: ______________ State: ________ Zip Code: __________ Work #: ______________

Father's/Guardian Name: ______________________ Relationship: ______________

Mother's/Guardian Name: ______________________ Relationship: ______________

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GENERAL CONSENT FORM

Patient Name: ____ **Date of Birth:** ______/______/_______

Assignment of Benefits. I authorize Capstone Pain & Spine Center to submit claims on my behalf directly to Medicare/my private health insurance carrier. This means that Capstone Pain & Spine Center will collect payment for supplies and services provided. **I understand that I am financially responsible** to the provider(s) for the charges not paid or payable. I authorize you to release any information necessary to insurance carriers regarding illnesses and or treatment in order to process claims. This assignment will remain in effect until revoked by me in writing.

Patient Initials: ____________

Consent for Treatment. I consent for Capstone Pain & Spine Center to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids(BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, Capstone Pain & Spine Center may have such BBF tested for human immunodeficiency (HIV/AIDS) at Capstone's expense. **Patient Initials:** ____________

Mail/Email/Phone Calls. I certify that I understand the privacy risks of the mail, phone calls and email. I hereby authorize a Capstone Pain & Spine representative or my physician to mail, call and or email me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and diagnostic test results. I understand that I have the right to rescind this authorization at any time by notifying Capstone Pain & Spine Center to that effect in writing. **Patient Initials:** ____________

Lab/X-Ray/Diagnostic Services: I understand that I may receive a separate bill if my medical care should include lab, x-ray and or other services, such as other diagnostic or anesthesia services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by insurance for whatever reason.

Patient Initials: ____________

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GENERAL CONSENT FORM

Involvement of Others in Care. I authorize Capstone Pain & Spine Center to discuss my/the patient's care and medical needs with the following person.

Name	Date of Birth (for identification)	Relationship	Phone

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone#: ____________________
◯ Leave message with contact number only
◯ Leave message with detailed information
◯ Do not leave message

Secondary Phone#: ____________________
◯ Leave message with contact number only
◯ Leave message with detailed information
◯ Do not leave message

Patient Financial Policy
I acknowledge receipt of the "Patient Financial Policy" **Patient Initials:** ________

Notice of Privacy Practice
I acknowledge receipt of the "Notice of Privacy Practice" **Patient Initials:** ________

Medication Policy
I acknowledge receipt of the "Medication Policy" **Patient Initials:** ________

Cancellation/No Show Policy
I acknowledge receipt of the "Cancellation/No Show Policy" **Patient Initials:** ________

____
Print Name of Patient or Personal Representative

____
Signature of Patient or Personal Representative Date

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ALL PATIENTS MUST READ AND SIGN THIS FORM PRIOR TO RECEIVING SERVICES.

CAPSTONE PAIN & SPINE CENTER, recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to **avoid** any misunderstanding concerning protected health information and payment for professional services.

- **PAYMENT: Payment is expected at the time of service.** If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. **Even though insurance will be filed, you are responsible for any balance after insurance processes your claim.** All charges for treatment become due and payable **sixty (60) days** after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. If not paid within 60 days, CAPSTONE PAIN & SPINE CENTER will begin various collection activities including, but not limited by submitting the past due account to a **collection agency.** If payment is not made at the time of your appointment, you may be asked to reschedule your appointment. Also, if payment is not made at time of service, you may be given only one month of your medication and asked to return in 30 days for a follow up appointment. If balance and copayment are not paid at next appointment, you may be subject to dismissal from the practice.

- **SELF PAYMENT (PRIVATE, CASH PAYMENT):** If you have no insurance coverage we ask that you coordinate your care with our practice manager prior to your surgery. We require an advance payment for professional services.

- **MANAGED CARE: All managed care (HMO, PPO, etc.) co-payment amounts are due at the time of service.** If your insurance plan requires a referral authorization from a primary care physician please present this at your initial visit. If you request an office visit or surgery without a referral authorization your insurance plan may deem this as **"out of network" or "non covered" treatment**, and you will be responsible for a larger amount or all of the charges. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non covered or not authorized by the plan.

- **MEDICARE:** CAPSTONE PAIN & SPINE CENTER, are participating providers with the Medicare program and accept as payment, the Medicare allowable, patient deductible and/ or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card and any forms your insurance company may require. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

- **AUTOMOBILE ACCIDENT PATIENTS:** We do NOT treat automobile accident patients.

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SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information as outlined below. Patient agrees to notify provider in the future immediately of any additions, changes or deletions in primary or secondary insurance coverage. Initial/complete as applicable.

______ **I have no secondary insurance coverage.**

______ **I have secondary insurance coverage as described on the attached Patient Demographic form.**

- **If you have Medicaid coverage of any kind, you must notify us prior to your visit.** This is part of your agreement with Medicaid, and failure to notify us of Medicaid coverage will result in full financial responsibility for services rendered and or dismissal from the practice.

- Before receiving services, **you** must verify that we are participating providers for your insurance company. If your insurance requires a referral from you primary care provider, it is the responsibility of the patient to make sure that there is a referral on file. **Failure to do so, may result in full financial responsibility for services rendered. Payment, however, is due in full at the time of service**.

- We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30-days after receipt of the initial statement. You can call **877-910-3272**

- **Dallas Office DOES NOT ACCEPT CHECKS**

  Failure to keep your account balance current may require us to cancel/reschedule your appointment and or you may be subject to dismissal from the practice.

CAPSTONE PAIN & SPINE CENTER, firmly believes that a good patient/physician relationship is based upon understanding and open communications. It is our hope that the above policies will allow us to provide the highest quality care to our patients. If you have any questions or need clarification regarding these policies please discuss with the Practice Manager

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MEDICATION POLICY

1. Please come to your appointment with a full list of all medications or the actual prescription bottles that you are currently taking. We will then review your medications during each individual office visit. The prescriptions that are prescribed during each office visit, should last you until your next appointment with our office. It is the responsibility of the patient to remind your provider of the medications that you need refilled.

2. If you have a change in your pain level, we ask that you make an appointment with our office. You will then receive an individual consultation.

3. There are some medications that can only be prescribed on a monthly basis. (Schedule II Narcotics such as Duragesic, Oxycontin, Methadone or Hydrocodone); for these prescriptions you will need to make an appointment for each two months.

4. If you have any questions or are experiencing any side effects from the medications that we have prescribed to you, it is very important that you notify our office immediately.

5. We **DO NOT** replace "lost or stolen" narcotic prescriptions. It is the responsibility of the patient to ensure the safety of all prescriptions. **There are NO exceptions to this policy.**

6. It is very important that all prescriptions be filled as closely to the "Earliest Fill Date" as possible, with NO EARLY FILL. Controlled prescriptions have a "21 day" window and will be considered EXPIRED on the 22nd day ***after*** the date or earliest fill date written. We DO NOT replace expired prescriptions. We require 48-72 hours for all refill requests.

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Cancellation Policy/No Show Policy
For Doctor Appointments and Procedures

1. ***Cancellation/No Show Policy for Doctor Appointment***

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book. **Excessive late cancellations/No Show can result in dismissal from the practice.**

   If an appointment is not cancelled at least 24 hours in advance you will be charged a twenty five ($25) fee; this will not be covered by your insurance company.

2. ***Scheduled Appointments***

   We understand that delays can happen however, we must try to keep the other patients and doctors on time. **If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment.**

3. ***Cancellation/No Show Policy for Procedures***

   Due to large block of time needed for procedures, last minute cancellations cause problems and added expenses for the office. **If the procedure is not cancelled at least 24 hours in advance you will be charged a one hundred dollar ($100) fee; this will not be covered by your insurance company.**

4. ***Account Balances***

   We will require that patients pay their account balances to zero (0) prior to receiving further services by our practice.

   Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to the Practice Manager with whom they can review their account and concerns.

   Patients with balances over $100 must make payment arrangements prior to future appointments being made.

______________________________ ________________________________ _____/_____/_____

Print Patient Name **Signature Patient/Guardian** **Date**

Patient Account# ______________________
(Office Use Only)

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PATIENT MEDICAL HISTORY

CHARACTERISTICS OF PAIN:

What is the main problem for which you are seeking treatment?

____

How long have you had your current pain problem?

__________ Years_________ Months

Currently my pain level is _____/10 At best my pain level is ____/10 At worst my pain level is ____/10

ONSET OF PAIN: How did your current problem start?

Injury at work
Injury, not at work
Motor Vehicle Accident
Illness, Non-Injurt
Treatment caused (e.g. radiation, surgery, etc)
Undetermined
If there was another cause not mentioned, what is it? ____

SEVERITY OF PAIN: In general, over the past month, the intensity of my pain has been:

Mild Moderate Moderate-Severe Severe

TIMING OF PAIN: How often do you have your pain (please check one)?

___ Constantly (100% of the time)
___ Nearly constantly (60 to 95% of the time)
___ Intermittently (30 to 60% of the time)
___ Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst (please check one)?

___ Morning
___ Afternoon
___ Evening
___ Night
___ No typical pattern

PAIN/SYMPTOM QUALITY: How would you describe your pain (please check all that apply; if there is a dominant quality to your pain, please circle the appropriate term)

___Burning ___sharp ___cutting ___throbbing ___cramping ___dull/aching

___Pressure ___shooting ___other (describe)____________

Associated with pain, I feel the following (please check all appropriate terms)

___Numbness I feel these sensations in the ___same ___different area than the pain
___Pins and Needles I feel these sensations in the ___same ___different area than the pain

I have had weakness in my: Upper Extremities ____ yes Dropping objects? ____yes
Lower Extremities ____ yes Falling? ____yes

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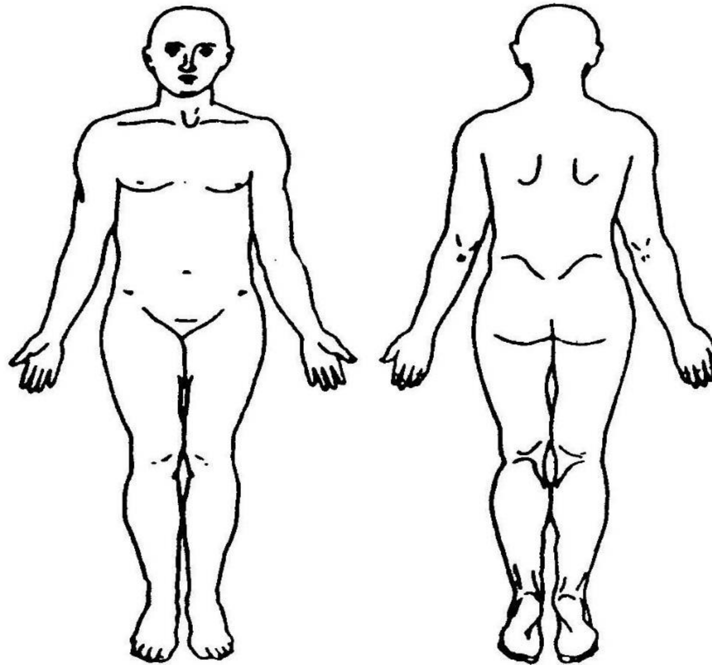
PAIN LOCATION: please mark the location(s) of your pain on the diagrams above with an "X". If whole areas are painful, please shade in the areas.



RELIEVING AND AGGRAVATING FACTORS:

How do the following affect your pain (please check one for each item)

	DECREASE	NO CHANGE	INCREASE
LYING DOWN			
STANDING			
SITTING			
WALKING			
EXERCISE			
RELAXATION			
COUGHING/SNEEZING			
URINATION			
BOWEL MOVEMENTS			

I have ___ had ___ or not had ___ a recent change in bowel or bladder habits.

Please describe recent changes ____

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ACTIVITIES AND YOUR PAIN:

How many blocks can you walk? ___ less than a block ___ blocks (how many?)

How many minutes or hours can you sit? ___ minutes (how many?) ___ hours (how many?)

How many minutes or hours can you stand? ___ minutes (how many?) ___ hours (how many?)
How often during the day do you lie down because of pain?

___ never ___ seldom ___ sometimes ___ often ___ constantly

To assist walking, I use a: ___ Cane ___ Walker ___ Wheelchair ___ No assistance device

Are you NOT able to perform any of the following activities of daily living? (mark all that apply)

___ Going to work ___ Performing household chores ___ Doing yard work or shopping

___ Socializing with friends ___ participating in recreational activities ___ Exercising

PAIN TREAMTENTS: Please check your response to all the treatments that you have tried

TREATMENT	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
SURGERY			
TRACTION			
NERVE BLOCK/INJECTION			
PHYSICAL THERAPY			
EXERCISE			
TENS			
HEAT TREATMENT			
ICE TREATMENT			
PSYCHOTHERAPY			
ACUPUNCTURE			
HYPNOSIS			
BIOFEEDBACK			
CHIROPRACTIC MANIPULATION			

PAST MEDICAL HISTORY:
Have you had any of the following health problems (please check all that apply)?

___ Hypertension ___ Coronary Artery Disease ___ Angina or chest pain
___ Heart Attack ___ Diabetes ___ Asthma or wheezing
___ Emphysema ___ Kidney Disease ___ Liver Disease
___ Stroke ___ Seizure or epilepsy ___ Bleeding Problem
___ Depression ___ Anxiety ___ Thyroid Disease
___ Arthritis- Specify location ____________________ ___ Cancer- Specify location ___________
___ Other- specify ____

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PAST SURGICAL HISTORY:

DATE (APPROXIMATE)	TYPE OF SURGERY

CURRENT MEDICATIONS FOR PAIN:

NAME	DOSE	FREQUENCY

CURRENT MEDICATIONS (OTHER THAN ANALGESICS)

NAME	DOSE	FREQUENCY

My pain medications provide relief:
___ None of the time
___ Some of the time
___ Most of the time
___ All of the time

Side-effects from these medications include:
___ Nausea
___ Vomiting
___ Constipation
___ Stomach Upset
___ Sedation
___ Other (please specify)

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PRIOR PAIN TREATMENTS: Please check all medications you have used in the past for treatment of pain. These are listed by class of medication.

Opioids
___ Hydrocodone (Vicodin)
___ Propoxyphene (Darvocet)
___Codeine
___ Fentanyl (Fentora/Duragesic)
___ Hydromorphone (Dilaudid)
___ Morphine/MSContin
___ Demerol
___ Levodromoran
___ Methadone
___ Oxycodone (Percocet)
___ Oxycontin
___ Oxymorphone (Opana)
___ Stadol
___ Talwin
___ Tramadol (Ultram)

NSAIDs/Tylenol
___ Tylenol
___ Aspirin
___ Motrin
___ Naproxen
___ Daypro
___ Salsalate/Trilisate
___ Feldene
___ Indocin
___ Lodine
___ Orudis
___ Relafen
___ Celebrex
___ Toradol

Muscle Relaxants
___Soma
___ Parafon Forte
___Flexeril
___ Baclofen
___ Zanaflex
___ Robaxin
___ Skelaxin
___ Valium

Antidepressants
___Elavil (amitryptilin)
___ Pamelor (nortriptyline)
___ Desipramine
___ Imipramine
___ Zoloft
___ Paxil
___ Prozac
___ Serzone
___ Cymbalta

Other
___ Neruontin
___ Lyrica
___ Dilantin
___ Depakote
___ Klonopin
___Xanax/Ativan/Valium
___ Tegretol
___Mexilitine
___ Imitrex
___ Ergotamine

Allergies: Please indicate the names of any medications to which you are allergic:
____

What type of reaction did you have? ____
I am allergic to contrast dye used for X-rays ___ yes ___ no

Review of Systems: please check all items you feel are applicable to you:

___ Recent significant weight gain: _____ pounds over ______ weeks/months/years
___ Recent significant weight loss: _____ pounds over ______ weeks/months/years
___ Fever
___ Dizziness
___ Difficulty Swallowing
___ Double or Blurry Vision
___ Nausea
___ Vomiting
___ Constipation
___ Diarrhea
___ Difficulty initiating urine stream
___ Genital Pain
___ Chest Pain
___ Heart Palpitations
___ Shortness of breath
___ Wheezing
___ Memory Loss
___ Loss of consciousness
___ Seizures
___ Easy or Excessive Bruising
___ Easy or Excessive Bleeding
___ Rash
___ Diabetes
___ Adrenal Disease
___ Hypothyroidism
___ Hyperthyroidism
___ Joint Stiffness
___ Decreased range of motion
___ Pain in extremity (specify) ____________
___ Swelling (specify) ___________________
___ Difficulty walking
___ Muscle Weakness

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SOCIAL HISTORY:

EDUCATION: Your highest education level achieved:
___ Graduate or professional training
___ College graduate
___ Partial College graduate
___ High School graduate
___ GED or trade technical school graduate
___ Partial high school (10th grade through partial 12th)
___ Partial junior high school (7th grade through 9th)
___ Elementary school

EMPLOYMENT: Your current or most recent occupation:
___ Semi-skilled or unskilled (eg. Waitress, assembler)
___ Skilled trade or clerical (eg. Carpenter, electrician, truck driver, secretary)
___ Business executive or Managerial
___ Professional (eg. Lawyer, teacher, nurse, physician, psychologist)
___ Homemaker
___ Other: please specify: ____

CURRENT EMPLOYMENT STATUS: Please check one:
___ Employed Full-Time
___ Employed Part-Time
___ Unemployed
___ Retired
___ Student
___ Homemaker
If you are unemployed or employed part-time, is this due to your present pain condition?
___ yes ___ no
Past Employment: _________________________

If you are currently unemployed, indicate how long you have been off work: _______________

Legal Issues: Please indicate any of the following claims you may have filed related to your pain problem:
___ Worker's Compensation
___ Personal Injury/Liability
___ Social Security Disability Insurance (SSDI)
___ Other Insurance

Sleep Disturbance:
Do you have any difficulty falling asleep? ___ yes ___ no
Do you have difficulty remaining asleep? ___ yes ___ no
Are you ever awakened by pain? ___ yes ___ no

If you use any sleep-aids, please specify.____

Family Life: Please specify living arrangements:
___ Living alone
___ Living with spouse/partner
___ Living with spouse/partner and children
___ Living with children
___ Living with friends
___ Living with other

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Psychological Treatment:
Have you ever had psychiatric, psychological, or social work evaluation or treatments for any problem, including your current pain?
___ yes ___ no

For what diagnosis were you treated?____

When?____

Please list current or last therapist's ____

Have you ever considered suicide? ____ yes ____ no When? _______________
Have you ever planned suicide? ____ yes ____ no When? _______________
Have you ever attempted suicide? ____ yes ____ no When? _______________

Substance Abuse:

Have you ever been a smoker? ___ yes –Current ___ yes- in past ___ no- never
If you smoke, how many packs per day? ____ packs per day
For how many years did you smoke? ____ Years

Do you have a history of alcoholism? ___ yes ___ no ___ current problem
Have you ever abused prescription analgesics? ___ yes ___ no ___ current problem
Cocaine or intravenous substance abuse? ___ yes ___ no ___ current problem

How many years has it been since you abused alcohol or drugs? _____ years

If you have a history of alcoholism, have you ever been enrolled in Alcoholics Anonymous?

____ yes ____ no ____ When?

If you have a history of substance abuse, have you ever been in a detoxification program?

____ yes ____ no ____ When?

Family History: Please specify any medical or psychiatric conditions common in your family and who suffers with these ailments:

Condition: ______________________ Specific family member(s): ___________________________
Condition: ______________________ Specific family member(s): ___________________________
Condition: ______________________ Specific family member(s): ___________________________
Condition: ______________________ Specific family member(s): ___________________________

Physical Examination

How much do you weigh? _________ lbs.
How tall are you? _________ feet _________ inches

Name: ____ **Date:** _____________________________

Please read carefully: This questionnaire is designed to enable us to understand how much your low back has affected your ability to manage your everyday activities. Please circle the LETTER that most closely describes your situation.

1. Pain Intensity

A. The pain comes and goes and is very mild
B. The pain is mild and does not vary much
C. The pain comes and goes and is moderate
D. The pain is moderate and does not vary much
E. The pain comes and goes and is severe
F. The pain is severe and does not vary much

2. Personal Care

A. I do not have to change my way of washing or dressing in order to avoid pain
B. I do not normally change my way of washing or dressing even though it causes some pain
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it
E. Because of pain, I am unable to do ***some*** washing and dressing without help
F. Because of pain, I am unable to do ***any*** washing or dressing without help

3. Lifting

A. I can lift heavy weights without any help
B. I can lift heavy weights but it gives me extra pain
C. Pain prevents me from lifting heavy weights off the floor
D. Pain prevents me from lifting heavy weights, but I can manage if they are conveniently positioned, e.g. on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift light weights, at the most

4. Walking

A. Pain does not prevent me from walking any distance
B. Pain prevents me from walking more than 1 mile
C. Pain prevents me from walking more than ½ mile
D. Pain prevents me from walking more than ¼ mile
E. I can only walk using a cane or crutches
F. I am in bed most of the time and have to crawl to the toilet

5. Sitting

A. I can sit in any chair as long as I like, without pain
B. I can only sit iin my favorite chair as long as I like
C. Pain prevents me from sitting more than 1 hour
D. Pain prevents me from sitting more than ½ hour
E. Pain prevents me from sitting more than 10 minutes
F. Pain prevents me from sitting at all

6. Standing

A. I can stand as long as I want without pain
B. I have some pain while standing, but it does not increase with time
C. I cannot stand for longer than 1 hour without increasing pain
D. I cannot stand for longer than ½ hour without increasing pain
E. I cannot stand for longer than 10 minutes without increasing pain
F. I avoid standing because it increases pain right away

7. Sleeping

A. I get no pain in bed
B. I get pain in bed, but it does not prevent me from sleeping well
C. Because of pain, my normal night's sleep is reduced by less than one-quarter
D. Because of pain, my normal night's sleep is reduced by less than one-half
E. Because of pain, my normal night's sleep is reduced by less than three-quarters
F. Pain prevents me from sleeping at all

8. Social Life

A. My social life is normal and gives me not pain
B. My social life is normal, but increases the degree of my pain
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc
D. Pain has restricted my social life and I do not go out very often
E. Pain has restricted my social life to my home
F. I rarely have a social life because of pain

9. Traveling

A. I get no pain while traveling
B. I get some pain while traveling, but none of my usual forms of travel make it any worse
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel
D. I get extra pain while traveling which compels me to seek alternative forms of travel
E. Pain restricts all forms of travel
F. Pan prevents all forms of travel except that done lying down

10. Changing degree of Pain

A. My pain is rapidly getting better
B. My pain fluctuates, but overall is definitely getting better
C. My pain seems to be getting better, but improvement is slow at present
D. My pain is neither getting better nor worse
E. My pain is gradually worsening
F. My pain is rapidly worsening

Examiner: ____