MIND + BODY MEDICINE

10400 N Central Expressway, Dallas, Tx 75231
p. (214) 972-2427 | F. (415) 795-4434

IMPORTANT - PLEASE READ

We want to make sure your visit is a success! ☺
Please read the following instructions.
If you have any questions, call us immediately at 214.972.2427.

► Be prepared to pay your co-pay, co-insurance or deductible for the doctor's visit on the date of service. If you arrive and are unable to pay, you will be re-scheduled. Credit Card and Cash are accepted methods of payment.

► Bring your license/ID and insurance card(s).

► If you need to cancel, you must do **so 24 hours BEFORE** your appointment.

► You will receive a reminder call from our office 48 hours before your appointment.

Any questions, please call (214) 972-2427

AFTER YOU COMPLETE ALL FORMS,
PLEASE SAVE YOUR EDITS AND EMAIL THE FORM PACKET TO:

LAmico@stat-management.net

Rev. 5-15-2025

MIND + BODY MEDICINE

BASIC INFORMATION FORM

Patient Name: _____ Today's Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Email address: _____
Home Phone: (_____)_____ Cell Phone: (_____)_____
DOB: _____ /_____ /_____ Gender: ☐ M ☐ F
Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Dr. License #_____ SS Number # : _____-_____-_____
Pharmacy: _____ Phone: (_____)_____
Employer Name: _____ Phone: (_____)_____
Address: _____ City: _____ State: _____ Zip: _____
Emergency Contact Name: _____ Phone: (_____)_____

Do you have insurance?: ☐ Yes ☐ No
If no, how will you be paying today? : ☐ Cash Check ☐ Credit Card
Whom should we thank for referring you? _____

PRIMARY INSURANCE (Insurance companies require the below information for billing purposes)
Name of Insured: _____ Relationship to Pt: _____
Insured's Social Security#_____-_____-_____ Insured's DOB: _____ /_____ /_____
Insurance Co. Name: _____ Phone: (_____)_____
Address: _____ City: _____ State: _____ Zip: _____
Policy #: _____ Group ID: _____

SECONDARY INSURANCE
Name of Insured: _____ Relationship to Pt: _____
Insured's Social Security#_____-_____-_____ Insured's DOB: _____ /_____ /_____
Insurance Co. Name: _____ Phone: (_____)_____

I authorize Howard Cohen, MD and/or staff involved with my care to discuss medical and/or billing with the following individual:

Name: _____ Relationship to Pt: _____
I authorize the release of any information concerning my healthcare, to expedite insurance payment. I also hereby authorize payment of insurance and understand that I am responsible for all charges, regardless of insurance coverage.

_____ _____
Signature of patient, parent, or legal guardian Date

MIND + BODY MEDICINE

Privacy Statement

In order to be able to treat you effectively, we will need to ask you in depth questions about your medical and personal history. This information is confidential and cannot be released without your consent. Please let us know if there is anything you don't feel comfortable about putting down on paper.

Name: _____ **Date:** _____

What brings you to the office?

_____

_____

_____

_____

Please check all medical problems:

☐ BIH ☐ POTS ☐ Mast Cell Activation ☐ Other

☐ Obesity ☐ PBA ☐ Ehlers Danlos Syndrome

- ☐ Glasses / Contacts
- ☐ Hearing problems / Tinnitus
- ☐ Sinus infections
- ☐ Glaucoma / Cataracts / Mac. Degen.
- ☐ Asthma / COPD I Lung Disease / TB
- ☐ Mitral valve prolapse / Murmur
- ☐ Hypertension / MI / Cardiovascular
- ☐ Ulcers/gastritis / Esophagitis / IBS
- ☐ Crohn's disease/ Ulcerative colitis
- ☐ Liver disease / Hepatitis / Gallbladder
- ☐ Pancreatitis
- ☐ Kidney stones / Disease / Cystitis
- ☐ Prostate disease
- ☐ Gynecological problems / Pelvic pain
- ☐ Sexual problems or difficulties
- ☐ Fibromyalgia / Muscle Pain / Spasm
- ☐ Knee / Foot disorder
- ☐ Back / Thoracic disorder
- ☐ Neck / Shoulder disorder
- ☐ TMJ / Facial Pain
- ☐ AIDS / HIV / Immune disorder
- ☐ Rheumatic Disorders / Lupus skin disorder
- ☐ Chronic infections
- ☐ Chronic Regional Pain Syndrome (CRPS)
- ☐ Osteoarthritis / Degenerative joints
- ☐ Serious childhood disease
- ☐ PMS
- ☐ Anemia or blood disorder
- ☐ Cancers / Benign tumors / Type:_____
- ☐ Genetic / Metabolic disorder
- ☐ Diabetes / Endocrine / Hormonal
- ☐ Attention deficit disorder (ADHD)
- ☐ Borderline personality disorder
- ☐ Alcohol / Drug problems
- ☐ Neuorpathy/Phantom pain
- ☐ Sciatica/Neuralgia
- ☐ Severe allergies
- ☐ Headaches / Migraines / Cluster
- ☐ Stroke / TIA / Aneurysm
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Neurologic disorder
- ☐ Head injury / Concussion
- ☐ Dementia / Alzheimer's
- ☐ Seizures / FND
- ☐ Depression / Bipolar disorder
- ☐ Panic / OCD / Anxiety
- ☐ Developmental / Autism
- ☐ Sleep Apnea / Disorders
- ☐ Schizophrenia / Schizoaffective

MIND + BODY MEDICINE

Please list your current medications (& herbs, and supplements), including dose and frequency:

_____

_____

3. Please check/ circle if you are having any of the following symptoms:

- ☐ Visual changes
- ☐ Ringing in ears
- ☐ Loss of ability to smell / taste
- ☐ Hearing changes
- ☐ Trouble swallowing
- ☐ Shortness of breath / cough
- ☐ Coughing up blood
- ☐ Constipation / Diarrhea
- ☐ Bloody or black stools
- ☐ Rashes
- ☐ Muscle aches / spasms
- ☐ Frequent colds / infections
- ☐ Tremors
- ☐ Excessive thirst / urination
- ☐ Difficulty with urination
- ☐ Palpitations
- ☐ Weakness / Dizziness
- ☐ Swelling of extremities
- ☐ Chest Pain
- ☐ Abdominal pain / Cramps
- ☐ Bloating / Gas
- ☐ Forgetfulness
- ☐ Balance problems
- ☐ Personality change
- ☐ Blackouts / Fainting spells
- ☐ Fever / Chills / Night sweats
- ☐ Weight Loss / Gain

4. Food Allergies:

Medication allergies: _____

Medication side effects: _____

5. If female, are you pregnant? _____ Previous number of times pregnant?: _____

☐ Abortions/stillbirths? ☐ Live Births ☐ Postpartum depression?

6. List prior surgeries:

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

Surgery: _____ Date: _____

MIND + BODY MEDICINE

7. List any hospitalizations, reason and years:

Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____
Reason: _____ Date: _____

8. List your current medical doctors (full name) and their specialties;

Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____
Name: _____ Specialty: _____

9. Where were you born? _____ Raised By whom? _____

10. Please list your family members, their ages, and what kind of significant medical, psychological, or alcohol/drug problems, they may have had.

	Name (Optional)	Age	Medical Problems	Psychological Problems	Alcohol/Drug Problems	If deceased, Cause of Death
Biological Father						
Biological Mother						
Brothers						
Sisters						
Kids						

11. Do you have any other close relatives with significant medical, psychological or genetic illnesses?

_____
_____

12. What is your highest level of education? Degree? School?
Any other training or schooling? Military service?

_____
_____

13. Please indicate your marital history - single, married, separated, divorced, widowed, significant other?
How long? Any children? If single, are you currently in a relationship?

_____
_____

14. Are you currently employed? How long? What are your previous jobs/careers? Are you disabled?

_____
_____

15. Do you currently have any legal problems such as lawsuits, charges pending, probation? Past felony convictions or time served?

_____
_____

16. What type of exercise do you get?

_____

17. How many times a day do you eat? Please describe your diet.

_____
_____
_

18. What do you like to do in your free time? Please list hobbies/interests.

_____
_____

19. How would you describe your personality?

_____

MIND + BODY MEDICINE

20. Briefly describe your childhood. Were you ever the victim of abuse , neglect or trauma as a child or later in life?

_____

_____

_____

_____

21. Please check treatments and tests you have received:

- ☐ EEG
- ☐ Spinal Tap
- ☐ ECT
- ☐ Transcranial Magnetic Stimulation
- ☐ 72/96 hr EEG
- ☐ QEEG Brain Mapping
- ☐ Genetic Testing
- ☐ EMG/Nerve conduction PET/SPECT
- ☐ Sleep study
- ☐ MRI/CT of _____

- ☐ Acupuncture
- ☐ Biofeedback / Hypnosis
- ☐ Research Trial
- ☐ Massage Therapy
- ☐ Ketamine Therapy
- ☐ TENS Unit / Muscle stimulation
- ☐ Physical Therapy
- ☐ Stress Management
- ☐ Aquatherapy
- ☐ Pain pump or trial
- ☐ Chiropractic / ice
- ☐ Trigger point injections
- ☐ Epidural / Nerve blocks
- ☐ Implanted nerve stimulator
- ☐ Chinese herbs
- ☐ Psychotherapy

22. Current Stressors - check all that apply.

- ☐ Pain
- ☐ Medical / health problems
- ☐ Conflicts with spouse / significant other
- ☐ Financial Problems
- ☐ Problems with job / employer / career
- ☐ Legal problems
- ☐ Problems with children
- ☐ Illness of family members
- ☐ Problems with parents
- ☐ Grief issues

23. Please check/circle if you currently use or have used any of the following:

	Currently Use Amount / Frequency	**Past Use / Experimentation**
☐ Alcohol		
☐ Tobacco		
☐ Caffeine (coffee, soft drinks, tea)		
☐ Marijuana / Salvia		
☐ Methamphetamine / Khat		
☐ Heroin/Kratom/Rx Opiate abuse		
☐ Ecstasy / GHB		
☐ PCP / Ketamine		
☐ LSD / Mushrooms		
☐ Cocaine / Crack		

MIND + BODY MEDICINE

Check all that apply:

- [ ] Do you feel sad, blue, or irritable?
- [ ] Have you had a change in appetite or weight loss? Weight gain?
- [ ] Do you have problems going to sleep, staying asleep, or sleeping too much?
- [ ] Do you find you're not as interested in activities you used to enjoy?
- [ ] Do you have problems concentrating?
- [ ] Have you noticed problems with your memory?
- [ ] Do you have feelings of being worthless/useless?
- [ ] Do you have problems with excessive worry?
- [ ] Have you had thoughts that life is not worth living?
- [ ] Have you experienced panic attacks or feelings of losing control?
- [ ] Have you been increasing your alcohol or recreational drug use?
- [ ] Have you been experiencing problems with physical or mental fatigue?
- [ ] Have you experienced a loss of zest for life or an inability to experience pleasure?
- [ ] Have you noticed a change in your sex drive?
- [ ] Have you had thoughts about killing yourself or not caring if you are alive?
- [ ] Have you been experiencing sleep paralysis or sleepwalking?
- [ ] Do you startle easily, feel jumpy, or have recurrent nightmares?
- [ ] Have you felt so full of energy that you do not need to sleep? Spending too much money?
- [ ] Are you bothered by repetitive thoughts about the same things that won't stop?
- [ ] Have you noticed excessive hand washing, checking on things, or counting rituals?
- [ ] Have you experienced periods of increased energy with racing thoughts or rapid speech?
- [ ] Have you had episodes of hearing voices or seeing things that others don't seem to experience?
- [ ] Have you felt as if you are being followed or that someone is watching you?

25. Anything else that concerns you or you wish to discuss?

_____

_____

_____

_____

MIND + BODY MEDICINE

PAIN MEDICATION HISTORY

(Please check boxes of any medications you have ever taken)

_____ Date:_____

ANTIDEPRESSANTS / PAIN

- ☐ Emsam / Selegiline
- ☐ Vibryd
- ☐ Pristiq / Effexor (venlafaxine)
- ☐ Savella / Fetzima
- ☐ Cymbalta (duloxetine)
- ☐ Anafranil (clomipramine)
- ☐ Trimipramine
- ☐ Celexa (citalopram)
- ☐ Vivacitil (protriptyline)
- ☐ Trintellix/Brintellix
- ☐ Elavil (amitriptyline)/nortriptyline
- ☐ Lexapro (escitalopram)
- ☐ Luvox (fluvoxamine)
- ☐ Nardil (phenelzine)/ Parnate
- ☐ Desipramine /imipramine
- ☐ Zoloft (sertraline) / Paxil (paroxtine)
- ☐ Prozac (fluoxetine)
- ☐ Remeron (mirtazapine)
- ☐ Serzone (nefazodone)/ Trazodone
- ☐ Doxepin
- ☐ Lithium
- ☐ Wellbutrin (bupropion)
- ☐ Ketamine/Spravato
- ☐ Auvelity / Gepirone

ANTI-ANXIETY

- ☐ Ativan (lorazepam)
- ☐ Klonopin (clonazapam)
- ☐ Librium (chlordiazepoxide)/Librax
- ☐ Serax (oxazepam)
- ☐ Valium (diazepam)
- ☐ Xanax (alprazolam)
- ☐ Tranxene (chlorazepate)
- ☐ Buspar (buspirone)
- ☐ Valerian/Kava/Lavender
- ☐ Phenobarbital
- ☐ Vistaril (Hydroxyzine)
- ☐ Gabapentin

MOOD STABILIZERS

- ☐ Abilify(aripiprazole)
- ☐ Geodon (ziprasidone)
- ☐ Risperdal (risperidone)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa/ Lybalvi (olanzapine)
- ☐ Clozaril
- ☐ Haldol (haloperidol)
- ☐ Caplyta
- ☐ Moban (molindone)
- ☐ Thorazine (chlorpromazine)
- ☐ Invega (palloperidone)
- ☐ Saphris
- ☐ Latuda
- ☐ Fanapt
- ☐ Rexulti
- ☐ Vraylar
- ☐ Lithium/lamotrigine/Vimpat
- ☐ Caplyta
- ☐ Cobenfy

ANTI-NAUSEANTS

- ☐ Vistaril/(hydroxyzine)
- ☐ Zofran (ondansetron)
- ☐ Phenergan (promethazine)
- ☐ Marinol (dronabinol)
- ☐ Compazine
- ☐ Reglan (metoclopramide)
- ☐ Emend
- ☐ Scopolamine patch

TOPICALS

- ☐ Lidoderm /lidocaine
- ☐ Doxepin/Amitriptyline
- ☐ Ketamine gel/cream
- ☐ Biofreeze/ Ted's Pain
- ☐ Voltaren gel/Flector patch

OPIOIDS

- ☐ Nucynta (tapendatol)
- ☐ Tylenol with codeine , #3 ,#4
- ☐ Duragesic Patch (fentanyl)
- ☐ Actiq Lozenge / Subsys
- ☐ Hydrocodone
- ☐ Trezix (dihydrocodeine)
- ☐ Opana (oxymorphone)
- ☐ Dilaudid (hydromorphone) / Exalgo
- ☐ Levorphanol
- ☐ Demerol/Mepergan (meperidine)
- ☐ Methadone
- ☐ MS-Contin, (Morphine)
- ☐ Oxycontin / Xtampza / Oxycodone
- ☐ Suboxone/Subutex/Bunavail/Zubsolv
- ☐ Butrans patch/ Belbuca (buprenorphine)
- ☐ Nubain (nalbuphine)
- ☐ Stadol (butorphanol)
- ☐ Talwin NX (pentazocine/naltrexone)
- ☐ Ultram (Tramadol)
- ☐ Low Dose Naltrexone

MUSCLE RELAXERS

- ☐ Lorzone/Parafon (chlorzoxazone)
- ☐ Flexeril (cyclobenzaprine)
- ☐ Baclofen
- ☐ Norflex (orphenadrine)
- ☐ Valium suppository
- ☐ Robaxin (methocarbamol)
- ☐ Skelaxin (metaxalone)
- ☐ Soma (carisoprodol)/
- ☐ Zanaflex (tizanidine)
- ☐ Botox

MIND + BODY MEDICINE

ANTICONVULSANTS/ NERVE PAIN

- ☐ Lidocaine
- ☐ Tegretol (carbamazepine)
- ☐ Gabitril (tiagabine) / Keppra
- ☐ Klonopin (clonazepam)
- ☐ Lamictal (lamotrigine)
- ☐ Keppra (levotiracetam)
- ☐ Depakote (valproate)
- ☐ Neurontin / Gralise / (gabapentin)
- ☐ Lyrica (pregabalin)
- ☐ Topamax (topiramate)/Quedexy
- ☐ Trileptal (oxcarbazepine)/Oxtellar
- ☐ Aptiom
- ☐ Zonegran (zonisamide)
- ☐ Ketamine/Nuedexta/Namenda
- ☐ Vimpat (lacosamide)
- ☐ Medical Cannabis

ADDICTION MEDICATIONS

- ☐ Acamprosate
- ☐ Revia / Vivitrol (naltrexone)
- ☐ Catapres (clonidine)/ Lucemyra
- ☐ Antabuse (disulfuram)
- ☐ Methadone
- ☐ Suboxone/Subutex/Bunavail/ Zubsolv (buprenorphine)
- ☐ Campral (acamprosate)
- ☐ Chantix

CNS

- ☐ Amantadine
- ☐ Cogentin (benztropine)
- ☐ Selegiline
- ☐ Sinemet (levodopa /carbidopa)
- ☐ Mirapex (pramipexole)
- ☐ Requip (ropinerole)
- ☐ Mysoline
- ☐ Prazosin / Dibenzyline
- ☐ Clonidine
- ☐ Nuedexta / Namenda
- ☐ Ketamine oral / intranasal

OBESITY

- ☐ Adipex / Lomaira / Phentermine
- ☐ Topiramate , T3 / Synthroid
- ☐ Contrave
- ☐ Qsymia
- ☐ Weygovy / Zepbound

STIMULANTS

- ☐ Ritalin, Concerta, (methylphenidate)
- ☐ Cylert (pemoline)
- ☐ Adderall, desoxyn, dexedrine
- ☐ Sunosi
- ☐ Provigil (modafanil)/ Nuvigil (armodafanil)
- ☐ Phentermine/phendimetrazine
- ☐ Strattera (atomoxetine)/Qelbree
- ☐ Vyvanse/Mydayis
- ☐ Xelstrym

HEADACHE MEDICATIONS

- ☐ Relpax/Amerge/Axert/Maxalt
- ☐ Zomig/Frova
- ☐ Imitrex tablet/injection/spray (sumatriptan)
- ☐ Onzetra/Zembrace
- ☐ Bellergal (ergotamine tartrate, belladonna alkaloids, Phenobarbital)
- ☐ Cafergot, (ergotamine tartrate, caffeine)
- ☐ D. H. E. 45 (dihydroergotamine mesylate)
- ☐ Migranal nasal spray
- ☐ Trudhesa (dihydroergotamine)
- ☐ Midrin (isometheptene)
- ☐ Periactin (cyproheptadine)
- ☐ Sansert (methysergide) /methergine
- ☐ Esgic, Fioiricet/Fioricet (butalbital)
- ☐ Calan (verapamil)
- ☐ Inderal (propranolol)/Atenolol
- ☐ Botox
- ☐ Aimovig/Ajovy/ Emgality/Vyepti
- ☐ Magnesium/Coenzyme Q10/Riboflavin
- ☐ Butterbur
- ☐ Lidocaine drops/spray
- ☐ Cambia/Celcoxcib liquid
- ☐ Namenda/Nuedexta
- ☐ Ubrelvy/Nurtec/Qulipta
- ☐ Reyvow

COGNITIVE ENHANCERS

- ☐ Namenda(memantine)
- ☐ Hydergine (ergoloid mesylates) Aricept (donepezil)
- ☐ Exelon (rivastigmine)
- ☐ Piracetam /Aniracetam
- ☐ Centrophenoxine
- ☐ Vinpocetine
- ☐ Razadyne (galantamine)
- ☐ Ginko Biloba
- ☐ Eldepryl/Deprenyl (selegiline)
- ☐ DMAE/Choline/Phosphatadiylcholine

HYPNOTICS/SLEEP

- ☐ Ambien (zolpidem)
- ☐ Dalmane (flurazepam)
- ☐ Halcion (triazolam)
- ☐ Restoril (temazepam)
- ☐ Sonata (zaleplon)
- ☐ Melatonin
- ☐ Xywav/Xyrem/Lumryz (GHB)
- ☐ Lunesta (eszopiclone)
- ☐ Rozerem (ramelteon)
- ☐ Belsomra/Dayvigo
- ☐ Benadryl
- ☐ Trazodone
- ☐ Seroquel
- ☐ Hydroxyzine
- ☐ Mirtazapine
- ☐ Doxepin/Silenor
- ☐ Dayvigo

NON-OPIOID PAINKILLERS

- ☐ Tylenol (acetaminophen)
- ☐ Advil, Motrin/(ibuprofen)
- ☐ Aleve, Naprosyn (naproxen)
- ☐ Arthrotec (diclofenac/ misoprostol)
- ☐ Aspirin (acetylsalicylic acid)
- ☐ Voltaren (diclofenac)/Zipsor/
- ☐ Celebrex (celecoxib)
- ☐ Clinoril (sulindac)
- ☐ Daypro (oxaprozine)
- ☐ Dolobid (diflunisal)
- ☐ Feldene (piroxicam)
- ☐ Indocin (indomethacin)
- ☐ Lodine (etodolac)
- ☐ Mobic (meloxicam)
- ☐ Nalfon (fenoprofen)
- ☐ Orudis, Oruvail (ketoprofen)
- ☐ Relafen (nabumetone)
- ☐ Toradol (ketorolac)
- ☐ Plaquenil/methotrexate
- ☐ Biologics for rheumatic disorders
- ☐ Prialt (ziconotide)
- ☐ Ketamine IV/ troches/intranasal
- ☐ DXM
- ☐ Oxytocin
- ☐ Journavx

MIND + BODY MEDICINE

PATIENT HEALTH QUESTIONNAIRE AND GENERAL ANXIETY DISORDER (PHQ-9 AND GAD-7)

Patient Name:_____ DOB: ____ /____ / ____ Date:_____

PHQ-9 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**	**0** Not at all	**1** Several days	**2** More than half the days	**3** Nearly every day
A. Little interest or pleasure in doing things.	☐	☐	☐	☐
B. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
C. Trouble falling or staying asleep, or sleeping too much.	☐	☐	☐	☐
D. Feeling tired or having little energy.	☐	☐	☐	☐
E. Poor appetite or overeating.	☐	☐	☐	☐
F. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
H. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
I. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐	☐	☐	☐

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? **(check one)**

☐ Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely Difficult

GAD-7 **Over the last <u>two weeks</u> how often have you been bothered by the following problems?**	0 Not at all	1 Several days	2 Over half the days	3 Nearly every day
Feeling nervous, anxious, or on edge.	☐	☐	☐	☐
Not being able to stop or control worrying.	☐	☐	☐	☐
Worrying too much about different things.	☐	☐	☐	☐
Trouble relaxing.	☐	☐	☐	☐
Being so restless that it's hard to sit still.	☐	☐	☐	☐
Becoming easily annoyed or irritable.	☐	☐	☐	☐
Feeling afraid as if something awful might happen.	☐	☐	☐	☐

Total Score (add your column scores):_____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? **(Check one)**

☐ Not difficult at all ☐ Somewhat difficult ☐ Very Difficult ☐ Extremely Difficult

MIND + BODY MEDICINE

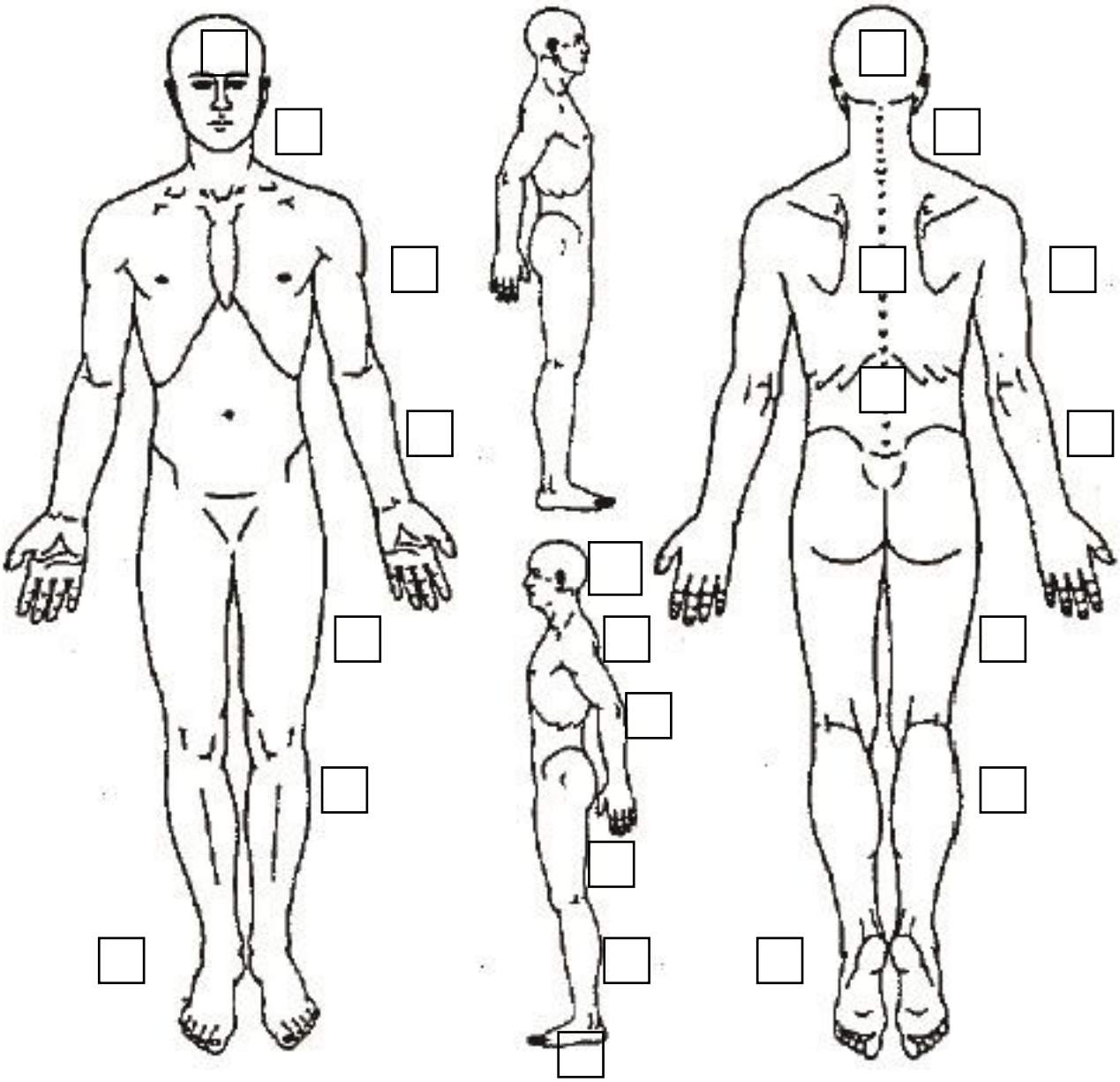
PAIN DIAGRAM

Patient Name: _____ Date: _____

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

KEY

A: Ache B: Burning N: Numbness P: Pin & Needles S: Stabbing O: Other



MIND + BODY MEDICINE

Central Sensitization Inventory: Part A

Patient Name: _____ Date: _____

Please check the best response to the right of each statement.

	Never	Rarely	Sometimes	Often	Always
1) I feel unrefreshed when I wake up in the morning.	☐	☐	☐	☐	☐
2) My muscles feel stiff and achy.	☐	☐	☐	☐	☐
3) I have anxiety attacks.	☐	☐	☐	☐	☐
4) I grind or clench my teeth.	☐	☐	☐	☐	☐
5) I have problems with diarrhea and/or constipation.	☐	☐	☐	☐	☐
6) I need help in performing my daily activities.	☐	☐	☐	☐	☐
7) I am sensitive to bright lights.	☐	☐	☐	☐	☐
8) I get tired very easily when I am physically active.	☐	☐	☐	☐	☐
9) I feel pain all over my body.	☐	☐	☐	☐	☐
10) I have headaches.	☐	☐	☐	☐	☐
11) I feel discomfort in my bladder and/or burning when peeing.	☐	☐	☐	☐	☐
12) I do not sleep well.	☐	☐	☐	☐	☐
13) I have difficulty concentrating.	☐	☐	☐	☐	☐
14) I have skin problems such as dryness, itchiness or rashes.	☐	☐	☐	☐	☐
15) Stress makes my physical symptoms get worse.	☐	☐	☐	☐	☐
16) I feel sad or depressed.	☐	☐	☐	☐	☐
17) I have low energy.	☐	☐	☐	☐	☐
18) I have muscle tension in my neck and shoulders.	☐	☐	☐	☐	☐
19) I have pain in my jaw.	☐	☐	☐	☐	☐
20) Certain smells, such as perfumes, make me feel dizzy and nauseated.	☐	☐	☐	☐	☐
21) I have to urinate frequently.	☐	☐	☐	☐	☐
22) My legs feel uncomfortable and restless when I am trying to go to sleep at night.	☐	☐	☐	☐	☐
23) I have difficulty remembering things.	☐	☐	☐	☐	☐
24) I suffered trauma as a child.	☐	☐	☐	☐	☐
25) I have pain in my pelvic area.	☐	☐	☐	☐	☐

MIND + BODY MEDICINE

Central Sensitization Inventory: Part B

Have you been diagnosed by a doctor with any of the following disorders?

Please check the box to the right for each diagnosis and write the year of the diagnosis.

	NO	YES	YEAR DIAGNOSED
1. Restless Leg Syndrome			
2. Chronic Fatigue Syndrome			
3. Fibromyalgia			
4. Temporomandibular Joint Disorder (TMJ)			
5. Migraine or tension headaches			
6. Irritable Bowel Syndrome			
7. Multiple Chemical Sensitivities			
8. Neck Injury (including whiplash)			
9. Anxiety or Panic Attacks			
10. Depression			

MIND + BODY MEDICINE

Insomnia Severity Guide

Patient Name: _____ Date: _____

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please Check the box that best describes your answer
Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
1. Difficulty falling asleep	☐	☐	☐	☐	☐
2. Difficulty staying	☐	☐	☐	☐	☐
3. Problems waking up too early	☐	☐	☐	☐	☐

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

☐ Very Satisfied 0 ☐ Satisfied 1 ☐ Moderately Satisfied 2 ☐ Dissatisfied 3 ☐ Very Dissatisfied 4

5. How NOTICABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

☐ Not at all Noticeable 0 ☐ A Little 1 ☐ Somewhat 2 ☐ Much 3 ☐ Very Much Noticeable 4

6. How WORRIED/DISTRESSED are you about your current problem?

☐ Not at all Noticeable 0 ☐ A Little 1 ☐ Somewhat 2 ☐ Much 3 ☐ Very Much Worried 4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

☐ Not at all Interfering 0 ☐ A Little 1 ☐ Somewhat 2 ☐ Much 3 ☐ Very Much Interfering 4

Guidelines for Scoring/Interpretation:
Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 + 6 + 7) = _____ your total score

Total score categories:
0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

MIND + BODY MEDICINE

Back Depression Inventory

Patient Name: _____ Date: _____

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Check the box/number beside the statement you have picked. If several statements in the group seem to apply equally well, check the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness
- ☐ 0 I do not feel sad.
- ☐ 1 I feel sad much of the time.
- ☐ 2 I am sad all the time.
- ☐ 3 I am so sad and unhappy that I can't stand it.

2. Pessimism
- ☐ 0 I am not discouraged about my future.
- ☐ 1 I feel more discouraged about my future than I used to be.
- ☐ 2 I do not expect things to work out for me.
- ☐ 3 I feel my future is hopeless and will only get worse.

3. Past Failure
- ☐ 0 I do not feel like a failure.
- ☐ 1 I have failed more than I should have.
- ☐ 2 As I look back, I see a lot of failures.
- ☐ 3 I feel I am a total failure as a person.

4. Loss of Pleasure
- ☐ 0 I get as much pleasure as I ever did from the things I enjoy.
- ☐ 1 I don't enjoy things as much as I used to.
- ☐ 2 I get very little pleasure from the things I used to enjoy.
- ☐ 3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings
- ☐ 0 I don't feel particularly guilty.
- ☐ 1 I feel guilty over many things I have done or should have done.
- ☐ 2 I feel quite guilty most of the time.
- ☐ 3 I feel guilty all of the time.

6. Punishment Feelings
- ☐ 0 I don't feel I am being punished.
- ☐ 1 I feel I may be punished.
- ☐ 2 I expect to be punished.
- ☐ 3 I feel I am being punished.

7. Self-Dislike
- ☐ 0 I feel the same about myself as ever.
- ☐ 1 I have lost confidence in myself.
- ☐ 2 I am disappointed in myself.
- ☐ 3 I dislike myself.

8. Self-Criticalness
- ☐ 0 I don't criticize or blame myself more than usual.
- ☐ 1 I am more critical of myself than I used to be.
- ☐ 2 I criticize myself for all of my faults.
- ☐ 3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
- ☐ 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. Crying
- ☐ 0 I don't cry anymore than I used to.
- ☐ 1 I cry more than I used to.
- ☐ 2 I cry over every little thing.
- ☐ 3 I feel like crying, but I can't.

MIND + BODY MEDICINE

11. Agitation

- ☐ 0 I am no more restless or wound up than usual.
- ☐ 1 I feel more restless or wound up than usual.
- ☐ 2 I am so restless or agitated that it's hard to stay still.
- ☐ 3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

- ☐ 0 I have not lost interest in other people or activities.
- ☐ 1 I am less interested in other people or things than before.
- ☐ 2 I have lost most of my interest in other people or things.
- ☐ 3 It's hard to get interested in anything.

13. Indecisiveness

- ☐ 0 I make decisions about as well as ever.
- ☐ 1 I find it more difficult to make decisions than usual.
- ☐ 2 I have much greater difficulty in making decisions than I used to.
- ☐ 3 I have trouble making any decisions.

14. Worthlessness

- ☐ 0 I do not feel I am worthless.
- ☐ 1 I don't consider myself as worthwhile and useful as I used to.
- ☐ 2 I feel more worthless as compared to other people.
- ☐ 3 I feel utterly worthless.

15. Loss of Energy

- ☐ 0 I have as much energy as ever.
- ☐ 1 I have less energy than I used to have.
- ☐ 2 2 I don't have enough energy to do very much.
- ☐ 3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

- ☐ 0 I have not experienced any change in my sleeping pattern.

- ☐ 1a I sleep somewhat more than usual.
- ☐ 1b I sleep somewhat less than usual.

- ☐ 2a I sleep a lot more than usual.
- ☐ 2b I sleep a lot less than usual.

- ☐ 3a I sleep most of the day.
- ☐ 3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

- ☐ 0 I am no more irritable than usual.
- ☐ 1 I am more irritable than usual.
- ☐ 2 I am much more irritable than usual.
- ☐ 3 I am irritable all the time.

18. Changes in Appetite

- ☐ 0 I have not experienced any change in my appetite.

- ☐ 1a My appetite is somewhat less than usual.
- ☐ 1b My appetite is somewhat greater than usual.

- ☐ 2a My appetite is much less than before.
- ☐ 2b My appetite is much greater than before.

- ☐ 3a I have no appetite at all.
- ☐ 3b I crave food all the time.

19. Concentration Difficulty

- ☐ 0 I can concentrate as well as ever.
- ☐ 1 I can't concentrate as well as usual.
- ☐ 2 It's hard to keep my mind on anything for very long.
- ☐ 3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

- ☐ 0 I am no more tired or fatigued than usual.
- ☐ 1 I get more tired or fatigued more easily than usual.
- ☐ 2 I am too tired or fatigued to do a lot of the things I used to do.
- ☐ 3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

- ☐ 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 now.
- ☐ 3 I have lost interest in sex completely.

MIND + BODY MEDICINE

Screener and Opioid Assessment for Patients with Pain (SOAPP®)

Name: _____ Date: _____

The following are some questions given to all patients at the Mind + Body Medicine who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment.

Please answer the questions by checking the corresponding boxes below using the following scale:
0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
2. How often do you smoke a cigarette within an hour after you wake up?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
3. How often have you taken medication other than the way that it was prescribed?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
5. How often, in your lifetime, have you had legal problems or been arrested?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

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

MIND + BODY MEDICINE

Patient Comfort Assessment Guide

0	Pain Free
1	Very minor annoyance -occasional minor twinges.
2	Minor annoyance – occasional strong twinges.
3	Annoying enough to be distracting.
4	Can be ignored if you are really involved in your work, but still distracting.
5	Can't be ignored for more than 30 minutes.
6	Can't be ignored for any length of time, but you can still go to work and participate in social activities.
7	Makes it difficult to concentrate, interferes with sleep You can still function with effort.
8	Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain.
9	Unable to speak. Crying out or moaning uncontrollably – near delirium.
10	Unconscious. Pain makes you pass out.

1. **Where is your pain?** _____

2. **Check the boxes that describe your pain:**

☐ aching ☐ throbbing ☐ shooting ☐ stabbing ☐ gnawing ☐ penetrating
☐ nagging ☐ numb ☐ miserable ☐ unbearable ☐ sharp ☐ tender
☐ burning ☐ exhausting ☐ tiring

What time of day is your pain the worst? ☐ occasional ☐ morning ☐ afternoon

Rate your pain at its worst last month:

☐ No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate your pain at its best last month:

☐ No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate your pain on average the last month:

☐ No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Rate your pain now:

☐ No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

What Makes your pain better? _____

What makes your pain worse?_____

MIND + BODY MEDICINE

1. **What treatments or medicines are you receiving for your pain?** Circle the number to describe the amount of relief the treatment or medicine provides.

a) Treatment or Medicine: _____

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

2. **b) Treatment or Medicine:** _____

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

3. **c) Treatment or Medicine:** _____

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

4. **d) Treatment or Medicine:** _____

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

5. **Check boxes that describe side effects are you experiencing:**

☐ Nausea ☐ Vomiting ☐ Constipation ☐ Lack of Appetite ☐ Difficulty Thinking
☐ Nightmares ☐ Sweating ☐ Tired Itching ☐ Insomnia ☐ Withdrawal
☐ Lack of pleasure

6. **Check boxes that describe which pain has caused significant interference in your life:**

☐ General Activity ☐ Mood ☐ Work ☐ Hobbies ☐ Sleep ☐ Enjoyment of Life
☐ Concentration ☐ Intimacy ☐ Relationships

MIND + BODY MEDICINE

Adverse Childhood Experience Questionnaire for Adults

Name: _____ Date: _____

Our relationships and experiences, even those in childhood, can affect our health and well-being. Difficult childhood experiences are very common. Please tell us whether you have had any of the experiences listed below, as they may be affecting your health today or may affect your health in the future. This information will help you and your provider better understand how to work together to support your health and well-being.

Instructions: *Below is a list of 10 categories of Adverse Childhood Experiences (ACES). From the list below, please place a checkmark next to each ACE category that you experienced prior to your 18th birthday. Then, please add up the number of categories of ACEs you experienced and put the total number at the bottom.*

1. Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐
5. Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?	☐
6. Did you live with anyone who went to jail or prison?	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐
Your ACE score is the total number of checked responses	

Do you believe that these experiences have affected your health?

☐ Not Much ☐ Some ☐ A Lot

Experiences in childhood are just one part of a person's life story.

There are many ways to heal throughout one's life.

AFTER YOU COMPLETE ALL FORMS,
PLEASE SAVE YOUR EDITS AND EMAIL THE FORM PACKET TO:

LAmico@stat-management.net