

AUSTIN ALLEN GENTRY, D.C., P.T.  
899 N. Wilmot Road, Suite A-3  
Tucson, AZ 85711

CONFIDENTIAL PATIENT CASE HISTORY

Name \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ APT# \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Marital Status: M S W D

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

In case of emergency notify \_\_\_\_\_ Phone \_\_\_\_\_

What is your MAJOR complaint? \_\_\_\_\_

When did pain initially start? \_\_\_\_\_

Most recent occurrence? \_\_\_\_\_ Is it constant? \_\_\_\_\_

If pain travels, where? \_\_\_\_\_

What time of day is it worse? \_\_\_\_\_

What makes the pain better? \_\_\_\_\_ What makes it worse? \_\_\_\_\_

Describe the kind of pain (e.g. sharp dull) \_\_\_\_\_

What caused the pain to begin? \_\_\_\_\_ Getting worse? \_\_\_\_\_

Have you been treated for this type of pain before? \_\_\_\_\_

If yes, what facility? \_\_\_\_\_

Name of Family Physician \_\_\_\_\_

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance and payment by the insurance company will be credited to my account on receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care at this office, any outstanding charges for professional services rendered me will be immediately due and payable.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ Date \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SEX \_\_\_\_\_ Case No. \_\_\_\_\_

CHILDREN (list ages & sex) \_\_\_\_\_

Describe major complaints & symptoms (indicate areas of pain on reverse side of this form) .

Date you first noticed symptoms \_\_\_\_\_

Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.

OCCASIONAL  
FREQUENT

- GENERAL**
- Allergy (list below)\*
  - Convulsions
  - Dizziness or Fainting
  - Headache
  - Neuralgia
  - Numbness
- MUSCLE & JOINT**
- Arthritis
  - Bursitis
  - Foot trouble
  - Low back pain
  - Neck pain or stiffness
  - Pain between shoulders
  - Sciatica
  - Swollen joints
  - Pain, numbness or Cramps
  - Shoulders
  - Arms
  - Elbows
  - Hands
  - Hips
  - Legs
  - Knees
  - Feet

- GASTRO-INTESTINAL**
- Colon trouble
  - Constipation
  - Diarrhea
  - Difficult digestion
  - Distension of abdomen
  - Gall bladder trouble
  - Hemorrhoids
  - Liver trouble
  - Pain over stomach

- EYES, EARS, NOSE & THROAT**
- Asthma
  - Colds
  - Deafness
  - Earache
  - Ear discharge
  - Ear noises
  - Eye pain
  - Nasal obstruction
  - Nosebleeds
  - Sinus infection

- CARDIO-VASCULAR**
- Hardening of arteries
  - High blood pressure
  - Low blood pressure
  - Pain over heart
  - Poor circulation
  - Rapid heart beat
  - Slow heart beat
  - Swelling of ankles

- RESPIRATORY**
- Chest pain
  - Chronic cough
  - Difficult breathing
  - Spitting up blood
  - Spitting up phlegm
  - Wheezing

- SKIN**
- Bruise easily
  - Dryness
  - Skin eruptions (rash)
  - Varicose veins

- GENITO-URINARY**
- Bed-wetting
  - Blood in urine
  - Frequent urination
  - Inability to control kidneys
  - Kidney infection or stones
  - Painful urination
  - Prostate trouble
  - Pus in urine

- FOR WOMEN ONLY**
- Congested breasts
  - Cramps or backache
  - Excessive menstrual flow
  - Hot flashes
  - Irregular cycle
  - Lumps in breast
  - Menopausal symptoms
  - Painful menstruation
  - Vaginal discharge

Pregnant  Yes  No  
Date of last period \_\_\_\_\_  
Previous miscarriages  Yes  No

- DATE OF LAST: (Approx.)**
- \_\_\_\_\_ Physical examination
  - \_\_\_\_\_ Blood test
  - \_\_\_\_\_ Chest x-ray
  - \_\_\_\_\_ Spinal x-ray
  - \_\_\_\_\_ Dental x-ray
  - \_\_\_\_\_ Urine test

- HABITS:**
- Alcohol
  - Coffee
  - Tobacco
  - Drugs
  - \_\_\_\_\_

- HAVE YOU EVER:**
- Been knocked unconscious?
  - Used a crutch, or other support?
  - Been treated for a spine or nerve disorder?
  - Had a fractured bone?
  - Been hospitalized for other than surgery?
  - Ever had surgery? (list below)

\*Please list any drugs now taken, allergies and past surgeries — \_\_\_\_\_

HAVE  
HAD

**CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAD:  
CIRCLE ITEMS THAT ARE COMMON TO OTHER FAMILY MEMBERS**

- |                                       |                                    |  |   |                                       |
|---------------------------------------|------------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Gout          | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Eczema    | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio              | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Miscarriage   | <input type="checkbox"/> Rheumatic fever    | <input type="checkbox"/> Ulcers       |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Goiter    |  |   | <input type="checkbox"/> Foot Problem |

After reading and filling out the case history, your signature will verify that all the information you have given us is accurate and that you have read the case history questions entirely.

Sign Your Name \_\_\_\_\_ Date \_\_\_\_\_

**FEES PAYABLE WHEN SERVICE RECEIVED UNLESS SPECIAL ARRANGEMENTS ARE MADE**

**CASE HISTORY**

Name \_\_\_\_\_ Date \_\_\_\_\_

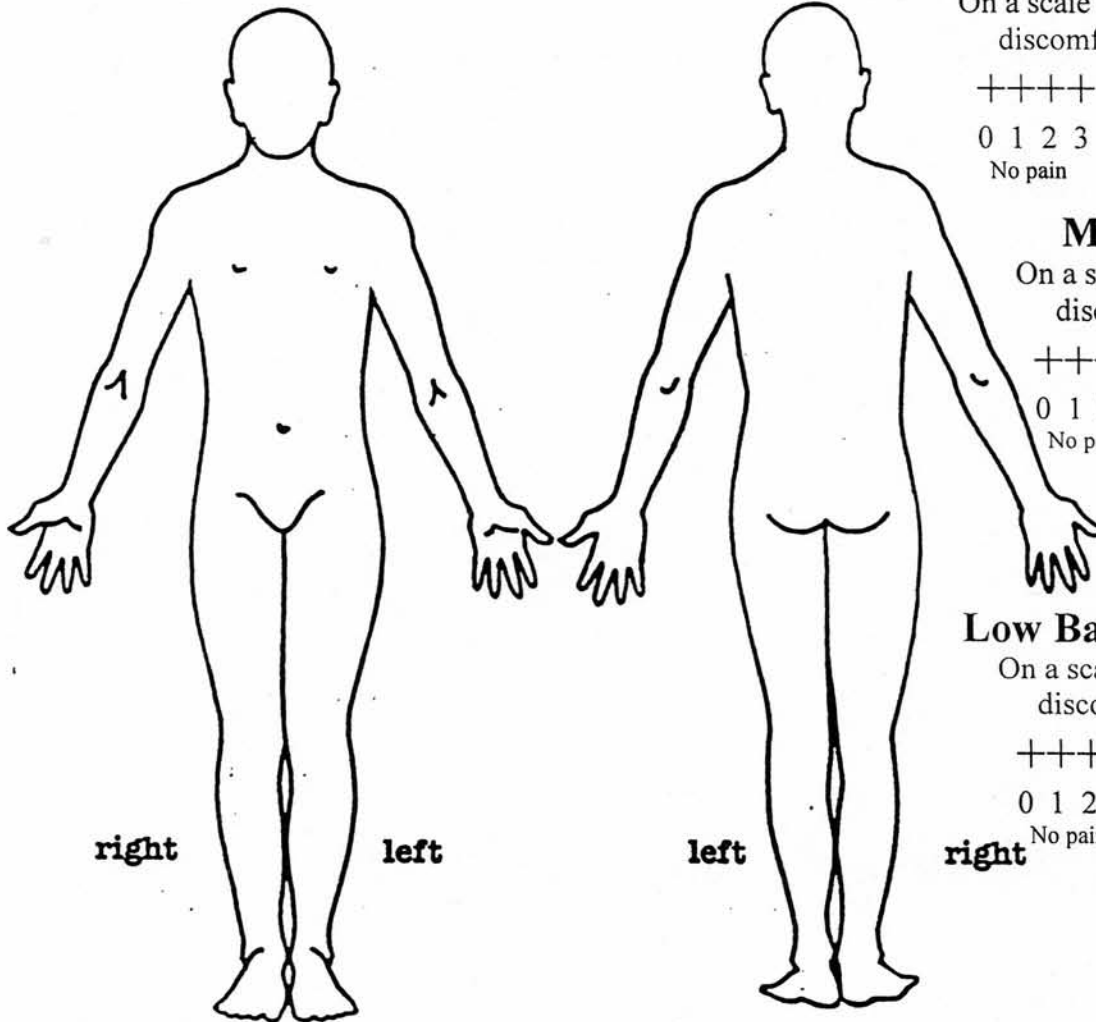
**SHOW AREA(S) OF PAIN OR UNUSUAL FEELING**

Mark the areas on this body where you feel the described sensations.  
 Use the appropriate symbols.  
 Mark areas of radiation.  
 Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////
-----	00000	XXXXXX	*****	/////

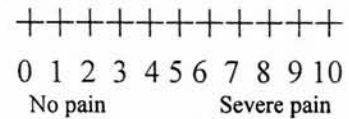
Please mark on the pain scale from zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition.

**Pain Chart**



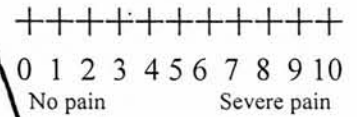
**Neck-Shoulder-Arm Pain**

On a scale of 0-10, I rate my discomfort as follows:



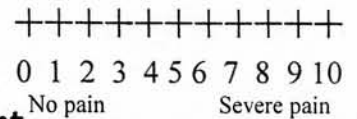
**Mid Back Pain**

On a scale of 0-10, I rate my discomfort as follows:



**Low Back and Leg Pain**

On a scale of 0-10, I rate my discomfort as follows:



Date: \_\_\_\_\_

Signature \_\_\_\_\_

## Protocol for Preservation of Patient Records

Pursuant to ARS 32-3210 and the requirements of the State of Arizona for the preservation of patient records, this documents is intended to inform all patients of Dr. Gentry of their rights and obligations.

Patients or their representatives may request copies of their records, in writing. Dr. Gentry agrees to comply with Arizona law for the production of these records and will timely respond to any reasonable requests.

Dr. Gentry will maintain your records for a periods of seven (7) years following your last date of service. After 7 years from the last date of service, Dr. Gentry reserves the right to destroy your records. Should Dr. Gentry exercise that right, Dr. Gentry will first attempt to contact you and inform you of your right to obtain a copy of these records. Dr. Gentry will attempt to contact you by regular mail, at your last known address, and will give you thirty (30) business days to request that your records not be destroyed. If you do not respond to this notice, you will be waiving your rights to have your records preserved.

Should Dr. Gentry retire, cease to practice, or sell his practice to another health care professional, Dr. Gentry will notify all eligible patients, by regular mail, concerning the location of their records and how they may request copies of those records. The required notice will be sent to each eligible patient's last known address.

\_\_\_\_\_  
Patient's Signature

I acknowledge receipt of this document

### Acknowledgement and Agreement: Patient's Protocol for Records Preservation

I, \_\_\_\_\_, patient of Dr. Gentry, do hereby acknowledge I have read and understand the doctor's protocol for the preservation of patient records. I agree to inform Dr. Gentry's office of any address changes and acknowledge that all requests for records, either by me or by my representatives, must be in writing. I agree that the doctor's office may comply with all statutory notification requirements to me by regular mail to my indicated address.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Address

## AUSTIN ALLEN GENTRY, D.C., P.T.

### Notices of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **PLEASE READ IT CAREFULLY.**

We provide this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As our patient, we create paper and electronic medical records about your health, our care for you, and the services and/or items we provide to you.

#### **We Protect Your Information.**

We maintain protocols to ensure the security and confidentiality of your personal information. We have passwords to protect databases and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

#### **How We May Use and Disclose Medical Information About You**

Medical Treatment. We may disclose medical information about you to individuals and businesses outside our practice that may be involved in your medical care. Our Business associates must promise that they will respect the confidentiality of your health information.

Communication with Family. We may disclose to a family member or close personal friend (or any other person you identify) health information relevant to that person's involvement in your care or payment related to your care.

Payment. We may use and disclose medical information about you to bill for our services and to collect payment

from you or your insurance company. We may also inform your payer of treatment you are going to receive in order to obtain prior approval or to determine whether the service is covered.

Health Care Operations. We may use and disclose information about you for the general operation of business. For example, we may use and disclose information about you for internal or external utilization review and/or quality assurance, for purposes of helping us to comply with our legal requirements, or to auditors or billing companies to aid us in this process.

Appointment and Patient Recall Reminders. We may ask that you sign a "Sign In" log on the day of your appointment. We may use and disclose medical information to contact you as a reminder that you have an appointment or that you are due to receive periodic care from the Practice.

Emergency Situations. We may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that you family can be notified about your condition, status and location.

Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

Worker's Compensation. We may disclose health information to the extent authorized by law to workers' compensation programs for work-related injuries or illness.

Investigation and Government Activities. We may disclose medical information about you to a local, state or federal agency for activities authorized by law.

Lawsuits and Disputes. We may disclose medical information about you in response to a subpoena, or a court or administrative order. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information if you so desire. We may use such information to defend ourselves or any member of our Practice in any legal or threatened action.

Law Enforcement. We may release information if asked to do so by a law enforcement official.

*We are required to obtain written authorization from you for any other uses and disclosures of medical information other than those described above. If you provide such permission, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose personal information about you for the reasons covered by our written authorization, except to the extent we have already relied on your original permission.*

#### **Changes To This Notice**

We reserve the right to make changes to this notice at any time.

#### **For More Information or to Report a Problem**

If you have questions or complaints concerning our Privacy Practice, you may contact:

A. Allen Gentry, D.C., P.T.  
Privacy Officer  
899 N. Wilmot, Suite A-3  
Tucson, AZ 85711

If you believe your privacy rights have been violated, you can either file a complaint with Retina Associates Privacy Officer or with the Office for Civil Rights, U.S. Dept of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The addresses for the OCR is as follows:

Office for Civil Rights  
U.S. Dept of Health & Human Services  
200 Independence Ave., S.W.  
Room 509F, HHH Bldg.  
Washington, DC 20201

#### **PATIENT RIGHTS**

Right to Inspect and Copy. You have the right to inspect and copy medical, billing, and other records used to make decisions about your care. Upon proof of an appropriate legal relationship, records of others related to you or under your care may also be disclosed.

You must submit your request in writing to our Privacy Officer. We may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Amend. If you feel that the medical information we have in your record is incorrect or incomplete you have the right to request an amendment.

You must make your request in writing, along with your intended amendment and a reason that supports your request. The amendment must be dated and signed by you and notarized.

Right to an Accounting of Disclosures. You have the right to request a list of the disclosures we made of medical information about you to others.

Submit your request in writing. Your request may not include dates before April 14, 2003 (or the actual implementation date of HIPAA Regulations). We will notify you of the cost and you may choose to withdraw before any costs are incurred.

Right to Request Restrictions. You have the right to request that we limit disclosure about your care to someone who is involved in your care or the payment for your care. For example, you may ask that we not use or disclose information about a particular treatment you received.

You must make your request in writing. *We are not required to agree to your request.*

Right to Request Confidential Communications. You have the right to request that we communicate with you in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail, that we not leave voice mail or e-mail.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time.

**A. Allen Gentry, D.C., P.T.**  
899 N. Wilmot Rd.  
Suite A-3  
Tucson, AZ 85711  
(520) 745-0545

# Austin Allen Gentry, DC, PT

The doctors' choice for effective pain relief

A. Allen Gentry,  
DC, PT

*Over 28 years of experience*

DC: Los Angeles College of  
Chiropractic *magna cum laude*,  
Los Angeles, CA

BS: Physical Therapy,  
University of Oklahoma,  
Norman, OK

Member: American Physical  
Therapy Association, Arizona  
Physical Therapy Association,  
American Chiropractic  
Association, Arizona

Association of Chiropractic  
(Board of Delegates Member),  
CareAdvantage (Board  
Member)

#### ***Comprehensive care for:***

- Acute or chronic back pain
- Acute or chronic neck pain
- Work injuries
- Headaches
- Arthritis
- Leg & arm pain
- Postsurgical rehabilitation
- Auto injuries
- Sports injuries

#### ***Conveniences that matter:***

- Modern facility
- Advanced technology
- Convenient location
- Walk-ins & same-day  
emergencies welcome
- Affordable rates
- Insurance accepted & filed
- Detailed & timely paperwork  
for PCPs
- Open five days a week

## **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

\_\_\_\_\_  
Patient Name (Print)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Authorized Representative (if applicable)

\_\_\_\_\_  
Signature

# Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

## Pain Intensity

- Ⓐ I have no pain at the moment.
- Ⓛ The pain is very mild at the moment.
- Ⓜ The pain comes and goes and is moderate.
- Ⓨ The pain is fairly severe at the moment.
- Ⓩ The pain is very severe at the moment.
- Ⓟ The pain is the worst imaginable at the moment.

## Personal Care

- Ⓐ I can look after myself normally without causing extra pain.
- Ⓛ I can look after myself normally but it causes extra pain.
- Ⓜ It is painful to look after myself and I am slow and careful.
- Ⓨ I need some help but I manage most of my personal care.
- Ⓩ I need help every day in most aspects of self care.
- Ⓟ I do not get dressed, I wash with difficulty and stay in bed.

## Sleeping

- Ⓐ I have no trouble sleeping.
- Ⓛ My sleep is slightly disturbed (less than 1 hour sleepless).
- Ⓜ My sleep is mildly disturbed (1-2 hours sleepless).
- Ⓨ My sleep is moderately disturbed (2-3 hours sleepless).
- Ⓩ My sleep is greatly disturbed (3-5 hours sleepless).
- Ⓟ My sleep is completely disturbed (5-7 hours sleepless).

## Lifting

- Ⓐ I can lift heavy weights without extra pain.
- Ⓛ I can lift heavy weights but it causes extra pain.
- Ⓜ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- Ⓨ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- Ⓩ I can only lift very light weights.
- Ⓟ I cannot lift or carry anything at all.

## Reading

- Ⓐ I can read as much as I want with no neck pain.
- Ⓛ I can read as much as I want with slight neck pain.
- Ⓜ I can read as much as I want with moderate neck pain.
- Ⓨ I cannot read as much as I want because of moderate neck pain.
- Ⓩ I can hardly read at all because of severe neck pain.
- Ⓟ I cannot read at all because of neck pain.

## Driving

- Ⓐ I can drive my car without any neck pain.
- Ⓛ I can drive my car as long as I want with slight neck pain.
- Ⓜ I can drive my car as long as I want with moderate neck pain.
- Ⓨ I cannot drive my car as long as I want because of moderate neck pain.
- Ⓩ I can hardly drive at all because of severe neck pain.
- Ⓟ I cannot drive my car at all because of neck pain.

## Concentration

- Ⓐ I can concentrate fully when I want with no difficulty.
- Ⓛ I can concentrate fully when I want with slight difficulty.
- Ⓜ I have a fair degree of difficulty concentrating when I want.
- Ⓨ I have a lot of difficulty concentrating when I want.
- Ⓩ I have a great deal of difficulty concentrating when I want.
- Ⓟ I cannot concentrate at all.

## Recreation

- Ⓐ I am able to engage in all my recreation activities without neck pain.
- Ⓛ I am able to engage in all my usual recreation activities with some neck pain.
- Ⓜ I am able to engage in most but not all my usual recreation activities because of neck pain.
- Ⓨ I am only able to engage in a few of my usual recreation activities because of neck pain.
- Ⓩ I can hardly do any recreation activities because of neck pain.
- Ⓟ I cannot do any recreation activities at all.

## Work

- Ⓐ I can do as much work as I want.
- Ⓛ I can only do my usual work but no more.
- Ⓜ I can only do most of my usual work but no more.
- Ⓨ I cannot do my usual work.
- Ⓩ I can hardly do any work at all.
- Ⓟ I cannot do any work at all.

## Headaches

- Ⓐ I have no headaches at all.
- Ⓛ I have slight headaches which come infrequently.
- Ⓜ I have moderate headaches which come infrequently.
- Ⓨ I have moderate headaches which come frequently.
- Ⓩ I have severe headaches which come frequently.
- Ⓟ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck  
Index  
Score

# Patient Summary Form

PSF-750 (Rev.2/18/2009)

### Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

\*Fax number may vary by plan.

### Patient Information

Patient name Last First MI			<input type="radio"/> Female	Patient date of birth		
Patient address			City	State	Zip code	
Patient insurance ID#	Health plan	Group number				
Referring physician (if applicable)	Date referral issued (if applicable)	Referral number (if applicable)				

### Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) AUSTIN ALLEN GENTRY, DC, PT					2. Federal tax ID(TIN) of entity in box #1 80-0582770								
3. Name and credentials of the individual performing the service(s) AUSTIN ALLEN GENTRY					<input type="checkbox"/> 1 MD/DO	<input type="checkbox"/> 2 DC	<input type="checkbox"/> 3 PT	<input type="checkbox"/> 4 OT	<input type="checkbox"/> 5 Both PT and OT	<input type="checkbox"/> 6 Home Care	<input type="checkbox"/> 7 ATC	<input type="checkbox"/> 8 MT	<input type="checkbox"/> 9 Other
4. Alternate name (if any) of entity in box #1					5. NPI of entity in box #1 1568429413					6. Phone number (520) 745-0545			
7. Address of the billing provider or facility indicated in box #1 899 N. WILMOT RD., STE. A-3					8. City TUCSON					9. State AZ	10. Zip code 85711		

### Provider Completes This Section:

<b>Date you want THIS submission to begin:</b> [ ][ ][ ]	<b>Cause of Current Episode</b> <input type="radio"/> 1 Traumatic <input type="radio"/> 4 Post-surgical <input type="radio"/> 2 Unspecified <input type="radio"/> 5 Work related <input type="radio"/> 3 Repetitive <input type="radio"/> 6 Motor vehicle	<b>Date of Surgery</b> [ ][ ][ ]	<b>Diagnosis (ICD code)</b> Please ensure all digits are entered accurately 1° [ ][ ][ ] [ ][ ][ ] 2° [ ][ ][ ] [ ][ ][ ] 3° [ ][ ][ ] [ ][ ][ ] 4° [ ][ ][ ] [ ][ ][ ]
<b>Patient Type</b> <input type="radio"/> 1 New to your office <input type="radio"/> 2 Est'd, new injury <input type="radio"/> 3 Est'd, new episode <input type="radio"/> 4 Est'd, continuing care	<b>Type of Surgery</b> <input type="radio"/> 1 ACL Reconstruction <input type="radio"/> 2 Rotator Cuff/Labral Repair <input type="radio"/> 3 Tendon Repair <input type="radio"/> 4 Spinal Fusion <input type="radio"/> 5 Joint Replacement <input type="radio"/> 6 Other	<b>DC ONLY</b> <b>Anticipated CMT Level</b> <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943	
<b>Nature of Condition</b> <input type="radio"/> 1 Initial onset (within last 3 months) <input type="radio"/> 2 Recurrent (multiple episodes of < 3 months) <input type="radio"/> 3 Chronic (continuous duration > 3 months)	<b>Current Functional Measure Score</b> Neck Index [ ][ ] DASH [ ][ ][ ][ ] Back Index [ ][ ] LEFS [ ][ ] (other) [ ][ ][ ]		

### Patient Completes This Section:

Symptoms began on: [ ][ ][ ]

(Please fill in selections completely)

1. Briefly describe your symptoms: \_\_\_\_\_

2. How did your symptoms start? \_\_\_\_\_

3. Average pain intensity:  
Last 24 hours: no pain  0  1  2  3  4  5  6  7  8  9  10 worst pain  
Past week: no pain  0  1  2  3  4  5  6  7  8  9  10 worst pain

4. How often do you experience your symptoms?  
 1 Constantly (76%-100% of the time)  2 Frequently (51%-75% of the time)  3 Occasionally (26% - 50% of the time)  4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)  
 1 Not at all  2 A little bit  3 Moderately  4 Quite a bit  5 Extremely

6. How is your condition changing, since care began at this facility?  
 0 N/A — This is the initial visit  1 Much worse  2 Worse  3 A little worse  4 No change  5 A little better  6 Better  7 Much better

7. In general, would you say your overall health right now is...  
 1 Excellent  2 Very good  3 Good  4 Fair  5 Poor

Patient Signature: X \_\_\_\_\_ Date: \_\_\_\_\_

Indicate where you have pain or other symptoms:

