Marla D. Golden, D.O., PA
6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216
(904) 260-1070 Office | (904) 260-1170 Fax

Patient Demographic and Insurance Intake Form

Last Name: ______________________________ First Name: ______________________________ MI: _________

DOB: ________________ SS#: __________________________ Sex: _______ Marital Status: __________________

Address: ____

City: ____ State: _________________ Zip Code: _______________

Home Phone: _____________________ Cell Phone: _____________________ Work Phone: _____________________

E-mail: ___________________________@____________________ Referred by: _______________________________

Primary Care Physician Name and Phone: ____

Pharmacy Name and Phone: ____

Insurance Information

Primary Insurance Co: ___________________________ ID #: ________________________ Grp #: _______________

Secondary Insurance Co: _________________________ ID #: ________________________ Grp #: _______________

Policy Holder name: _____________________________ ID #: ____

Policy Holder DOB: _______________ Policy Holder Address: ____

Policy Holder SS #: ________________________ Policy Holder Sex: __________ Copay Amount: __________________

Patient Authorization

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services rendered.

Patient Signature: ____ Date: _____________________

Parent/Guardian Signature (if minor): ____Date: _____________________

Managed Care / HMO Patients

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or have a referral on file that I may be held financially responsible for services received. I further understand that I am responsible for services that are considered non-covered expenses by my insurer.

Patient Signature: ____ Date: _____________________

Parent/Guardian Signature (if minor): ____Date: _____________________

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Today's Date: _______________

Dear New Patient:

Welcome to the practice! I am looking forward to seeing you and working with you to relieve your pain. We are one of the only practices worldwide targeting the brain as an organ of treatment to combat and relieve pain.

The treatment plan at Marla D. Golden, D.O., PA features the Neuroplastic Transformation program created by me and Dr. Michael Moskowitz. It is based on the core concept of neuroplasticity and the body's ability to change in response to the input it receives. You will be guided through phases of care designed to restore function and allow you to return to a pleasurable life. The emphasis of treatment options will change as you move through the phases.

Please read this letter carefully and be sure you are willing to comply with the following requests:

Please arrive 30 minutes prior to your appointment time and plan to be here an additional 75-90 minutes. Please be considerate of my time and that of other scheduled patients. A 48 to 74 hour notice of cancellation or rescheduling of a new patient appointment is required. A 24 hour notice is required for a follow up visit. A message left on the voicemail the night before does not constitute a 24 hour notice of cancellation.

Please have your medical records sent to us prior to your first visit. Your treating physician can forward your records at your request. These include copies of recent office visit notes of treating physicians, reports of diagnostic studies, x-rays, CT scans, MRI's, ultrasounds and any pertinent lab work prior to your first visit.

You are required to have a primary care physician to manage your basic medical care. I will be providing your pain care. It is my preference to send office visit notes to your primary care physician to keep them informed of your progress. Many patients have additional members of their Pain Care Team. These may include psychiatrists, physical therapists, as well as other types of practitioners in addition to your primary care physician. You have the right to decide who is kept informed; however, a team approach is always beneficial. We can discuss this further at your first visit. Please submit the names and phone numbers of all treating physicians or health care professionals that are part of your pain care team with this paperwork.

Medication regimens will be reviewed at the first visit and throughout treatment. As a general rule, controlled substances are not prescribed at the first visit. We will discuss the role of medications in the different phases of care and use N.O.R.M.A.L., the Neuroplastic Optimization and Reduction of Medications for Adaptive Living.

Urine drug screening may be done at my discretion. The purpose is to monitor medication changes, disconcerting signs or symptoms associated with medications, and to determine how medications are being taken.

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Please bring all of your pain-related medications, and medication list to each appointment. Please bring insurance card(s), a picture ID, and any applicable copayment with you to your initial appointment and to any appointment after a change of information has been made.

If you have any questions or concerns prior to your first appointment, please feel free to call the office. My staff will be happy to answer questions of any kind. If you have any further concerns, I will be happy to discuss them at your initial visit. I am hopeful that we will enjoy an open and honest physician-patient relationship. This is critical to the success of your overall pain care program.

Once again, I am happy to welcome you to the practice and look forward to meeting you.

Sincerely,

Marla D. Golden, D.O. FACEP
Director
Electronically reviewed and signed

Your appointment has been scheduled for ____________________________________ at ______________.

Please be sure to call the office with your insurance information prior to your first appointment.

Thank you!

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Marla D. Golden, D.O., PA Office Policies & Procedures

Please read the following statements, initial by each and sign the sheet after you have gone over each of them.

BILLING AND INSURANCE

If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize; however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

Most insurance companies consider our fees usual, customary, and reasonable. If your insurance company does not cover the whole fee, the balance becomes your responsibility.

_____ Payment for office services is due at the time services are rendered unless we participate with your insurance plan or payment arrangements have been approved in advance by our staff. We accept cash, checks, Visa and Master Card. If we participate with your insurance carrier, we expect applicable co-payment and deductibles at the time of service.

_____ A $30.00 fee will be charged for returned checks. Repayment of original fee plus returned check fee is due prior to the next office visit by cash, credit card, money order or cashier’s check.

_____ I understand all services are not covered by all contracts and I am responsible for uncovered services.

_____ If you have health insurance that has a timely filing limit and you do not provide this information prior to that deadline, the responsibility for the medical debt is yours, regardless of what your insurance tells you.

_____ **I understand it is my responsibility to provide the correct insurance information, whether it be a change in insurance carrier or policy, *prior to my next scheduled appointment*. Failure to inform the office of any changes can result in denial of payment by my insurance company and any charges will be my responsibility.**

_____ If your health insurance sends you their payment, you are required to remit the payment to Dr. Golden immediately.

_____ If you are being seen for a work related injury, we must have the date of injury, W/C carrier name and address, the claim number assigned to your case and the adjusters name and phone number. The office will verify this information with the carrier. If the carrier says your employer did not report your injury, you will not be seen by Dr. Golden under workers compensation insurance.

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BILLING AND INSURANCE (CONTINUED)

______ If you are being seen for injuries related to an auto accident, we will need the date of the accident, the claim number assigned by your auto insurance company, the adjusters name and phone number assigned to your claim and the address where claims should be mailed. If you are unable to furnish this information, you may reschedule your appointment or pay for the charges at the time of service. It is the responsibility of the patient to provide all insurance information. The office will verify the information given. If you have a high deductible and it has not been met, you will be required to pay that amount prior to being seen. Dr. Golden DOES NOT accept Letters of Protection.

______ If you are being seen for an injury that is a result of a fall or injury that is a liability case, you must inform us prior to being seen and you must pay the medical debt in full. Dr. Golden does not file liability claims. You can take the receipt for the medical treatment and give that receipt to the person handling your liability case and they will reimburse you.

______ If you do not have health insurance, payment is due in full at the time of service.

______ Patients will not be able to carry a balance on their account over 30 days. Once your insurance carrier has processed the claim, and determined that the patient has a financial responsibility, you will receive a statement from our office. Statements are mailed once a month and payment is due upon receipt or by your next office visit, whichever comes first. Delinquent accounts over 90 days and 3 statements with failed attempts to collect unpaid balances will be turned over to a collection agency. You will be responsible for any administrative/collection fees and legal costs that are incurred.

APPOINTMENTS

______ You are expected to arrive for your appointment on time. It is even advisable to be a few minutes early to update any necessary information and address any payment issues prior to being seen.

______ Monday appointments must be cancelled by 2 PM on Friday **PRIOR** to the weekend or a $50.00 late cancellation fee will be charged.

______ Tuesday through Friday appointments require a 24-hour notice of **CANCELLATION** to avoid a $35.00 late cancellation fee.

______ Stand-alone NMT appointment cancellations or no shows will be charged in the same fashion as the above.

______ Cancellations sent via text message, or email will not be accepted and will be considered a No-Show, and a No Show fee will be charged.

______ New patient’s that do not show for scheduled appointments will be rescheduled once.

______ More than 2 late cancellations or no shows may result in discharge from the practice.

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MESSAGES/EMERGENCIES/AFTER HOURS CALLS

_____ If you have concerns after hours, call the office, you will be able to leave a message that will be checked the next business day. If there is an emergency, call 911. My cell phone is available for **URGENT** telephone communication **AFTER HOURS**. It should not be used for non-urgent matters. It should not be used during normal business hours. Scheduling and rescheduling requests or clinical communication is done by phone conversation via office phone during normal business hours. **DO NOT** text or e-mail me clinical questions or information or scheduling requests.

_____ I am available by cell phone if you are being treated in the emergency department or are hospitalized. Please feel free to give my number to treating physicians should they need to coordinate care.

_____ **DO NOT** e-mail or fax the office about clinical concerns, appointments or medications. Email is not protected for privacy. Fax communications can be unreliable. They may not get through or may be delayed on either end. *(All such e-mails or faxes that were previously acknowledged will be no longer).*

_____ Voicemail is checked hourly on workdays, when the office is open. You will have **PLENTY of** advance notice of any office closures. All calls are returned to patients in order of clinical acuity. When you leave a message, please specify whether or not you require a return phone call. Expect telephone conversations to be brief and to the point.

_____ You will be charged a $50.00 fee per 15 minutes for non-urgent phone conversations with Dr. Golden.

_____ Urgent matters should be able to be resolved in 15 minutes. Extended conversations will be charged $50.00 per 15 minutes after the 1st 15 minutes.

_____ Dr. Golden does not answer the office phone. Please direct all questions and concerns to the office personnel, they will communicate with me and get back to you. If necessary, Dr. Golden will call you directly.

PRESCRIPTIONS AND MEDICATIONS

_____ State law requires patients on controlled substances to be seen every 3 months. **NO** medications will be prescribed if you have not been seen in SIX months. Your chart will be closed and in order to reopen it you will need to schedule an extended time visit and interim medical records will be required.

_____ Medications are prescribed and refilled at office visits. Please know what is needed when you come in for your appointment.

_____ If you send someone else to pick up your prescription, this person must be listed on the Release of Information form you signed. This person also must show valid proof of identification in order to pick up your prescription.

PRESCRIPTIONS AND MEDICATIONS (CONTINUED)

_____ If refills are necessary at times other than office visits, please allow **THREE** business days for refills to be processed. Remember, we try to avoid this as much as possible and refill medications at office visits.

_____ There is **NO** guarantee urgent demands for refills that are made inside this three-day window will be met.

_____ **ALL** fees must be paid, or payment plans must have been set up through our office prior to any prescription(s) being called in, refilled or provided.

_____ Patients who misuse or overuse medications will be referred to the appropriate practitioner or law enforcement agency at Dr. Golden's discretion and per controlled substance agreement.

MISCELLANEOUS

_____ Please make sure your contact information is current and correct. It is your responsibility to notify us of any changes.

_____ If someone calls our office to inquire about you and this person is not listed on your Release of Information form, **NO** information will be released regardless of your relationship to this person. We will neither confirm nor deny that you are a patient in this practice.

_____ Office staff must be treated with courtesy and respect. Failure to do so will most likely result in discharge from the practice.

If you have a complaint about our office, please provide me/us with specific date, time, employee or service in question. I cannot operate on generalities.

I hereby attest that I have read and understand the information provided to me regarding the Policies and Procedures of Marla D. Golden, D.O., PA and agree to abide by these terms and conditions.

Signature: ____ Date: _________________________

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Controlled Substance Policy Information Consent

As part of your treatment with Dr. Golden, you may need a prescription to control your pain. These medications can include narcotics (painkillers) and sedative/hypnotic (anti-anxiety/sleeping pills). These medications are called controlled substances. They are monitored closely by the Drug Enforcement Agency in Washington, D.C.

Therefore, we have a strict set of rules you must follow while under our care using these medications.

Please read the following statements, initial by each and sign the sheet after you have gone over each of them.

_____ I agree to bring in all of my medications to every visit. This includes all pill bottles, pills, daily dose packs, and pill containers of any kind. This policy is to ensure your safety when prescribing medications.

_____ I agree to never share or sell any of my medications.

_____ I understand and agree that I am fully responsible for all my medications.

_____ I agree never to obtain additional pain medications from any other Healthcare Provider including my Primary Care Provider unless I get approval from Dr. Golden.

_____ I agree to fill my prescriptions with only one pharmacy, if possible. I will make Dr. Golden or Marla D. Golden, DO staff aware of pharmacy issues.

_____ I agree never to increase my dose prior to discussing this with Dr. Golden. I understand no early refills will be provided if I escalate my medication use without prior approval.

_____ I understand that there exists a risk of developing an addictive behavior with many of these drugs, although this behavior is a rare occurrence, it still can happen. I agree to discuss any craving or compulsive use of medications with Dr. Golden as soon as it occurs.

_____ I understand that if my medications are stolen, I will report to my local police department within 24 hours and prior to Dr. Golden prescribing another refill. I agree to obtain a stolen/missing item report from the police. More than one lost or stolen medication occurrence is considered irresponsible behavior and will result in discharge from our practice.

_____ I understand that Marla D. Golden, D.O., PA may conduct random quarterly drug screens on all patients. Drug screens may also be conducted with medication changes, disconcerting signs or symptoms associated with medications, or at Dr. Golden's discretion.

_____ I understand and agree that due to the seriousness of these medications, Dr. Golden will **NEVER** be able to phone in any refills. All prescriptions will be given out at office visits only. **NO EXCEPTIONS**.

_____ I understand that I waive all rights to HIPAA regulations if found in violation of any controlled substance act with respect to illicit or prescription drug use, abuse or diversion.

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Controlled Substance Policy Information Consent

_____ I understand that any and all violations of the controlled substance acts with respect to illicit or prescription drug use, abuse or diversion will be handed over to law enforcement to take the necessary and proper steps to investigate.

_____ I have read and understand the above policy and by signing this form, I agree to follow these rules.

_____ I understand that any breech in any rule are grounds to be discharged from the practice formally by a written letter; as well as, personally contacting your primary care physician or referring physician.

Patient Signature: ____ Date: _________________________

Patient Printed Name: ____

Pharmacy: ____ Phone: ________________________

Name: ____ Date: _________________________

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Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to the use or disclosure of my protected health information by Marla D. Golden, D.O., PA, for purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Marla D. Golden, D.O., PA.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. However, if Marla D. Golden, D.O., PA agrees to the restrictions that I request, the restriction is binding on Marla D. Golden, D.O., PA. I have the right to revoke this consent, in writing, at any time, except to the extent that Marla D. Golden, D.O., PA have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider or hospital (including all departments of such), a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have reviewed Marla D. Golden, D.O., PA Notice of Privacy Practices prior to signing this document. The Marla D. Golden, D.O., PA Notice of Privacy Practices was provided to me. It is also posted in the waiting room for my information. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Marla D. Golden, D.O., PA. The Notice of Privacy Practices also describes my and Marla D. Golden, D.O., PA duties with respect to my protected health information. Marla D. Golden, D.O., PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy.

____ ________________________
Signature of Patient or Personal Representative Date

____ ________________________
Name of Patient or Personal Representative Description of Personal Rep. Auth.

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ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT

Necessary forms will be completed to help expedite insurance reimbursement. However, unless we participate with your insurance company, the patient is responsible for all fees regardless of insurance coverage. Patients with insurance with which we participate are responsible for all co-insurance, co-pays, deductibles and non-covered services. Co-pays are due at the time of service, unless other arrangements have been made in advance with our office.

Medical Information Release Form (HIPAA Release Form)

Name: ____ Date of Birth: _____/_____/_______

RELEASE OF INFORMATION

☐ I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

- ☐ Spouse: ____
- ☐ Child(ren): ____
- ☐ Other: ____

☐ Information is **<u>not</u>** to be released to anyone other than the patient.

This ***Release of Information*** will remain in effect until terminated by me in writing.

MESSAGES

Please call ☐ my home ☐ my work ☐ my cell Telephone Number: ________________________

If unable to reach me:

☐ You may leave a detailed message

☐ Please leave a message asking me to return your call

☐ ____

The best time to reach me is (day) ________________________ between (time) ___________________.

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Insurance Authorization and Assignment of Benefits

I request that payment or authorized Medicare/Other insurance company benefits be made on my behalf to Marla D. Golden, D.O. for any services furnished to me by Marla D. Golden, D.O. I authorize any holder of medical information about me to release to the Centers of Medicare & Medicaid services (CMS) and its agents/Other insurance companies any information needed to determine the benefits payable to related services.

I understand my signature requests that payments be made and authorize release of medical information necessary to pay any claims.

Signature: ____ Date: ___________________

Witness: ____ Date: ___________________

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Patient History

PATIENT NAME: ___________________________________ DATE: _____________________

PLEASE CHECK ALL THAT APPLY

____ Stroke
____ Hypertension
____ Arrhythmia
____ Heart Attack/MI

____ Mitral Valve Prolapse
____ Pacemaker
____ Emphysema/COPD
____ Pneumonia
____ Seizures
____ Depression
____ Meningitis/Encephalitis
____ Bipolar Disorder
____ Hepatitis Type: _____
____ Cirrhosis
____ Cancer: ____________
____ Ulcer Disease
____ GERD (acid reflux/heartburn)

____ Hiatal Hernia
____ Inflammatory Bowel Disorder
____ Crohn's Disease
____ Osteoarthritis
____ Rheumatoid Arthritis
____ Diabetes
____ Lupus/Scleroderma
____ Hypothyroid/Graves
____ Crohn's Disease

PREVIOUS PAIN MANAGEMENT
____ Massage
____ Biofeedback
____ Injections
____ Physical Therapy
____ Chiropractor
____ Acupuncture

Prostate Problems ____
Interstitial Cystitis ____
Endometriosis ____
Peripheral Vascular Disease ____
Blood Clots/Location: _________ ____
Fibromyalgia ____
Kidney Disease ____
Neuropathy ____
CRPS/(RSD) ____
Other: _____________________ ____

SOCIAL HISTORY
Tobacco ____PPD ____Years ____
Alcohol ___Type _____Amt____Yrs___
Recreational Drugs ____Type___Yrs__

Current Occupation _________________
Partially Disabled_____%_____
Totally Disabled_____
Pre-Disability Occupation_____________
Living Situation______________________

FAMILY HISTORY
____
____
____
____

PERTINENT SURGICAL HISTORY
____
____
____
____

ALLERGIES: _______________________
____

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Review of Systems

PATIENT NAME: ______________________________ DATE: ____________________

Please circle what applies:

Constitutional
No constitutional symptoms Fever night sweats weight loss fatigue poor appetite

Respiratory
No respiratory symptoms Shortness of breath cough wheezing bloody sputum

Female Reproductive
No female reproductive symptoms abnormal periods vaginal bleeding vaginal discharge pain with intercourse decreased libido

Psychiatric
No psychiatric symptoms depression anxiety nervousness agitation

Eyes
No eye symptoms blurry vision eye pain itchy eyes redness

Allergy
No allergy symptoms excessive sneezing frequent infections frequent colds

Constitutional
No constitutional symptoms Fever night sweats weight loss fatigue poor appetite

Male Reproductive
No male reproductive symptoms penile discharge testicular pain or mass erectile dysfunction decreased libido

Endocrine
No endocrine symptoms excessive urination excessive thirst cold intolerance heat intolerance

Cardiovascular
No cardiovascular symptoms chest pain “smothering” at night irregular heartbeat racing heart exercise intolerance

Urinary
No urinary symptoms frequent urination difficulty initiating dribbling reduction in flow pain with urination

Musculoskeletal
No musculoskeletal symptoms muscle pain joint pain joint swelling joint deformity

Blood
No blood symptoms enlarged lymph nodes easy bruising prolonged bleeding

ENT
No ENT symptoms hearing loss ear pain ringing nosebleeds runny nose facial pain sore throat hoarseness difficulty speaking

Neurologic
No neurologic symptoms weakness numbness frequent headache confusion fainting spells seizures tremor

Gastrointestinal
No GI symptoms indigestion bloating abdominal pain difficulty swallowing nausea or vomiting vomiting blood
constipation diarrhea rectal bleeding dark, tar-like stool light, clay-like stool

Skin
No skin symptoms rash fingernail changes toenail changes itching abnormal pigment edema (fluid)

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Patient Comfort Assessment Guide

PATIENT NAME: ___________________________________ DATE: _____________________

1. **Where is your pain?** ____
2. **Circle the words that describe your pain.**

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

Circle one. Occasional Continuous

What time of day is your pain the worst? Circle one.

morning afternoon evening nighttime

3. **Rate your pain by circling the number that best describes your pain at its worst in the last month.**

   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

4. **Rate your pain by circling the number that best describes your pain at its least in the last month.**

   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

5. **Rate your pain by circling the number that best describes your pain at its average in the last month.**

   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

6. **Rate your pain by circling the number that best describes your pain right now.**

   No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as you can imagine

7. **What makes your pain better?** ____
8. **What makes your pain worse?** ____
9. **What treatments or medicines are you receiving for your pain? Circle the number to describe the amount of relief the treatment or medicine provide(s) you.**

   a) ______________________________ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
   Treatment or Medicine (include dose)

   b) ______________________________ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
   Treatment or Medicine (include dose)

   c) ______________________________ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
   Treatment or Medicine (include dose)

   d) ______________________________ No Relief 0 1 2 3 4 5 6 7 8 9 10 Complete Relief
   Treatment or Medicine (include dose)

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PATIENT NAME: ________________________________ DATE: ____________________

10. **What side effects or symptoms are you having? Circle the number that best describes your experience during the past week.**

	Symptom													
a)	Nausea	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
b)	Vomiting	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
c)	Constipation	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
d)	Lack of Appetite	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
e)	Tired	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
f)	Itching	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
g)	Nightmares	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
h)	Sweating	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
i)	Difficulty Thinking	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine
j)	Insomnia	Barely Noticeable	0	1	2	3	4	5	6	7	8	9	10	Severe Enough to Stop Medicine

11. **Circle the one number that describes how during the past week pain has interfered with your:**

	Activity													
a)	General Activity	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
b)	Mood	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
c)	Normal Work	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
d)	Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
e)	Enjoyment of Life	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
f)	Ability to Concentrate	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
g)	Relations with Other People	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

Where is the location of the pain?

____

____

Does the pain radiate or move to other areas? If so, where?

____

____

How long have you had this problem?

____

____

Do you experience emotional distress when you **think** about the pain?

____

____

Marla D. Golden, D.O., PA
6817 Southpoint Parkway, Suite 1404
Jacksonville, FL 32216
(904) 260-1070 Office | (904) 260-1170 Fax

PATIENT NAME: ___________________________________ DATE: _____________________

Do you experience emotional distress when you **talk** about the pain?

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On a scale of 0-10 with 10 being the worst, what is your pain level at its **best**?

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How would you describe the pain? (sharp, dull, aching, stabbing, burning, etc.)

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If you imagined your pain to be a person, what type of person would it be?

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Besides the pain, what is the #1 stressor in your life right now?

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Is there anything in your life that you would consider painful to think about or talk about?

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Place a check mark by **any** feelings listed below that you are currently experiencing in your life. Circle the **one** that is the strongest.

Anxiety_____	Fear_____	Rage_____	Anger_____	Loss/Grief_____	Sadness_____
Doom_____	Despair_____	Nervous_____	Restless_____	Guilt_____	Cravings_____
Panic_____	Rejected_____	Shame_____	Frustration_____	Jealous_____	Confused_____

What do you do to relieve stress in your life?

____

____

Have you ever learned or practiced any type of relaxation technique? What type?

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____

List any other health problems or illness that you are currently experiencing.

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Do you smoke? _______________________________ How long? ____

Are you currently seeing a mental health counselor, psychologist or psychiatrist? ________________________________

Signature: ____ Date: ______________________

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PATIENT NAME: ___________________________________ DATE: _____________________

During the past six months, how often have you used each of the following methods to reduce your physical and emotional tension?

N – Never R – Rarely S – Sometimes O – Often

_____ 1. Drink alcoholic beverage

_____ 2. Smoke

_____ 3. Take a prescription medication

_____ 4. Blame someone

_____ 5. Take an over-the-counter relaxant

_____ 6. Drink coffee, cola, or tea

_____ 7. Eat

_____ 8. Yell, hurt or otherwise take it out on someone else

_____ 9. Forget about it and keep going

_____ 10. Used TV, books, or movies to “escape”

_____ 11. Grin and bear it

_____ 12. Redefine the situation more positively in your mind

_____ 13. Take a leisurely walk

_____ 14. Change your approach to the person or stress

_____ 15. Exercise or stretch

_____ 16. Practiced deep relaxation with meditation or visualization

_____ 17. Practiced deep breathing or other relaxation technique

_____ 18. Listened to soothing music

_____ 19. Talked it over with someone

_____ 20. Pray

_____ 21. Use humor

_____ 22. Practiced a hobby

_____ 23. Took a hot bath

_____ 24. Had a massage

_____ 25. Other____

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PATIENT NAME: ________________________________ DATE: ____________________

Circle any of the statements below that you believe are true for you.

1. I don't believe I can ever be pain free…
2. I'm destined to always be in pain…
3. The health care system has let me down…
4. I don't trust any doctors/surgeons…
5. I'm convinced the pain will always be there…
6. I don't believe there's anything that can help me get rid of the pain…
7. I'm in pain because of the injury/accident…
8. I'm in pain because of the surgery…
9. I believe I'll have to be on pain medicine the rest of my life…
10. I'm afraid of the pain…
11. I feel like no one understands the pain…
12. I feel like no one is listening to me…
13. I don't deserve to be pain free…
14. Even if the pain is gone I think I'll still feel overwhelmed and unhappy…
15. My body is too damaged to ever be pain free…
16. It's not safe for me to be pain free…
17. I've had this pain for so long it must be permanent…
18. I would have to change too much in my life if I were pain free…
19. The doctors told me I would always have pain…
20. The doctors told me there was nothing more that could be done…
21. I believe this pain is a punishment…
22. I think I inherited this pain problem…
23. I believe no one will find the answer to this pain…
24. I know I'll have to take pain medicine forever…
25. The only treatment option that exists for me is medication…
26. I feel like no one understands me…

Add anything else that may come to your mind to describe how you feel.

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Draw or color area of pain or discomfort.