JOSEPH J. CIPRIANO, D.C.

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Pain Questionnaire

Patient Name _____ Age _____ Date _____

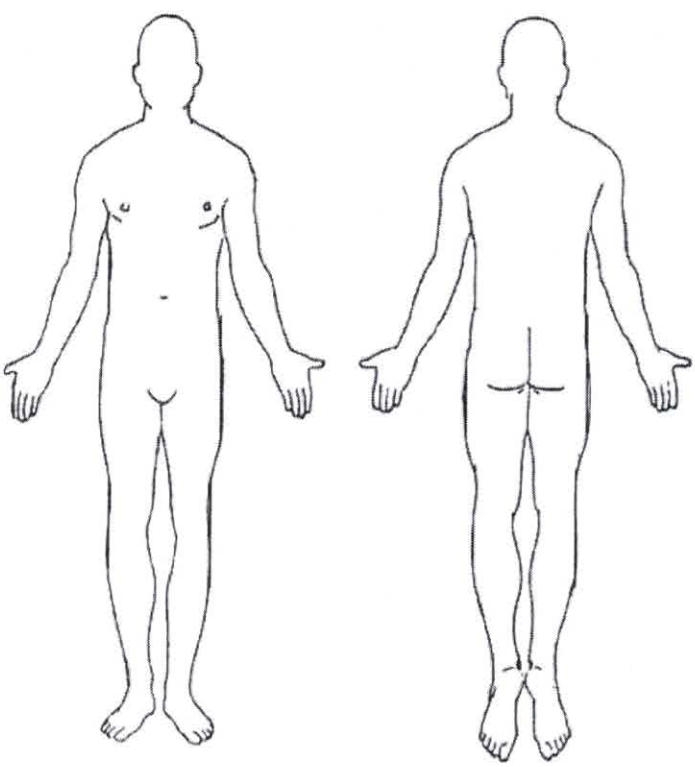
Diagnosis _____

This questionnaire has been designed to tell us more about your pain. This questionnaire will cover four main topics:

1. Where is your pain?
2. What does is it feel like?
3. How does it change with time?
4. How strong is it?

It is important to tell us how your pain feels now using the diagram below. Look next to the diagram to the number chart. Pick the number or numbers that represents the type of pain you are experiencing. Place those numbers on the diagram in the area where you are experiencing that type of pain.

1. Where is your pain?



2. What does your pain feel like?

Place these numbers on the diagram to represent your pain:

1 flickering quivering pulsing	2 jumping flashing shooting	3 pricking boring drilling	4 sharp cutting lacerating
5 pinching pressing gnawing cramping crushing	6 tugging pulling wrenching	7 hot burning scalding searing	8 tingling itchy smarting stinging
9 dull sore hurting aching heavy	10 tender taut rasping splitting	11 tiring exhausting	12 sickening suffocating
13 fearful frightful terrifying	14 punishing grueling cruel vicious killing	15 wretched blinding	16 annoying troublesome miserable intense unbearable
17 spreading radiating penetrating piercing	18 tight numb drawing squeezing tearing	19 cool cold freezing	20 nagging nauseating agonizing dreadful torturing

Please continue and complete the questions on the second page of the questionnaire.

3. How does your pain change with time?

a) Which word or words would you use to describe the pattern of your pain?

1	2	3
continuous	rhythmic	brief
steady	periodic	momentary
constant	intermittent	transient

b) What kinds of things relieve your pain?

_____

_____

_____

c) what kind of things increase your pain?

_____

_____

_____

4. How strong is your pain?

On the line provided, please mark where your "pain status" is today.

0 — 5 — 10

No Pain — Most Severe Pain

On the line provided, please mark where your "pain status" was when it was at its most severe on any occasion.

0 — 5 — 10

No Pain — Most Severe Pain

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Patient Consent for Use and Disclosure of Protected Health Information

This form is necessitated by HIPAA Federal Privacy Regulations. We apologize for the cost, time spent, and inconvenience caused by the administration of HIPAA rules.

I hereby give my consent for Joseph J. Cipriano, D.C. to use and disclose protected health information (P.H.I.) about me to carry out treatment, and obtain payment, and perform healthcare operations (T.P.O.).

Joseph J. Cipriano, D.C. Notice of Privacy Practices provides a more complete description of such uses and disclosures.
I have the right to review the Notice of Privacy Practices prior to signing this consent. Atlanta Orthopedics reserves the right to revise its Notice of Privacy Practices at any time. A revised and current Notice of Privacy Practices may be obtained by forwarding a written request to:

Joseph J. Cipriano, D.C.
3025 Maple Drive Suite 2
Atlanta, GA 30305

With this consent, Joseph J. Cipriano, D.C. may call my home or alternate locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out T.P.O., such as appointment reminders, insurance inquiries, and any call pertaining to my clinical care, including laboratory results among others.

With this consent, Joseph J. Cipriano, D.C. may mail to my home or alternate locations any items that assist the practice in carrying out T.P.O., such as appointment reminders and financial statements.

I have the right to request, in writing, that Joseph J. Cipriano, D.C. restrict how it uses my P.H.I. to carry out T.P.O. However, the practice is not required to agree to my requested restrictions, but if it does agree, it is bound by this agreement.

By signing this agreement, I am consenting to Joseph J. Cipriano, D.C. the use and disclosure of my P.H.I. to carry out T.P.O.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Joseph J. Cipriano, D.C. may decline to provide treatment to me.

THIS FORM MUST BE SIGNED BELOW I have read and agree to the above:

PLEASE PRINT FULL NAME_____

SIGNATURE OF PATIENT (OR GUARDIAN) _____DATE SIGNED _____