MINIMALLY INVASIVE SPINECARE™

# Patient Registration

All shaded areas MUST be completed

*Patient Name* **Last:** _____ **First:** _____ **Middle:** _____ **Maiden:** _____

**Date of Birth:** _____ **Sex:** _____ **Social Security #:** _____ **Marital Status:** _____

**Physical Address:** _____ **City/State/Zip:** _____

**Mailing Address:** _____ **City/State/Zip:** _____

**Phone 1:** _____ Phone 2: _____ Phone 3: _____

Patient's Email: _____ Employer Name: _____

Employer Address: _____ City/State/Zip: _____

**Consents and Contacts:** Please indicate a person(s) with whom we may discuss your health/account. If the patient is a minor, these people will be authorized to bring him/her in for any medical treatment deemed necessary. **NOTE: if the patient is a monor, parent(s) must be listed.**

Name: _____ Relationship to Patient: _____

Phone1: _____ Phone2: _____ Phone3: _____

Name: _____ Relationship to Patient: _____

Phone1: _____ Phone2: _____ Phone3: _____

Name: _____ Relationship to Patient: _____

Phone1: _____ Phone2: _____ Phone3: _____

**If you would like** (Minimally Invasive SpineCare @ SpineCare Institute) **to file with your Insurance these fields MUST be completed.**

**Primary Insurance Company:** _____ **Policy ID #:** _____ **Group #:** _____

Policyholder: **Last:** _____ **First:** _____ **Middle:** _____ **(Policyholder) Relationship to Pt:** _____

**Social Security #:** _____ **Date of Birth:** _____ **Contact Number:** _____

**Address:** _____ **City/State/Zip:** _____

**Secondary Insurance Company:** _____ **Policy ID #:** _____ **Group #:** _____

Policyholder: **Last:** _____ **First:** _____ **Middle:** _____ **(Policyholder) Relationship to Pt:** _____

**Social Security #:** _____ **Date of Birth:** _____ **Contact Number:** _____

**Address:** _____ **City/State/Zip:** _____

Does your insurance require you to obtain referrals for specialist visits: (please circle) Yes or No

Primary Care Provider: _____ Phone Number: _____

Address: _____ City/State/Zip: _____

Preferred Pharmacy Name: _____ Phone Number: _____

Where you referred by a physician? (Please Circle) Yes or No If not, what was your deciding factor on coming here?

Physician's Name: _____ Phone Number: _____

I am aware that for my safety and protection, video and audio surveillance may be used on (Minimally Invasive SpineCare @ SpineCare Institute - MISC@SCI) premises, in public areas only.

I, the undersigned, as patient or on behalf of patient, do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgement of the physician on duty. I understand that no guarantee or assurance has been made as to the results which may be obtained. I understand that I have the right to revoke this consent, in writing, except where MISC@SCI has already made disclosures in reliance on y prior consent. A photocopy of this signature is as valid as the original.

**Patient or Parent/Guardian Signature:** _____

**Date or Signature:** _____

Print Parent/Guardian Name (only needed if patient is under 18): _____

Date of Birth for Parent/Guardian (only needed if patient is under 18): _____

MINIMALLY INVASIVE SPINECARE™

## Patient Waivers, Financial Responsibility Policies and Agreements

Patient Name: A B

In order to reduce confusion and misunderstanding between our patients and practce (Minimally Invasive SpineCare @ SpineCare Institute), we have adopted the following policies. If you have any questions regarding these policies, please feel free to ask the front desk staff to clarify the policies to you. We are dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. This agreement is between Minimally Invasive SpineCare, MISC Surgery Center, MISC Therapy, SCI and Institute for SpineCare, forward in agreement known as (MISC@SCI) and _____ (Patient's Name).

**Please initial beside each policy to signify your understanding.**

_____ **Your Insurance**

We require showing your insurance card at each visit, so we can verify the informaton that is in our system.

In-Network:
We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment and any additional percentage (co-insurance and/or deductibles) due. You could be billed for any remaining amount afer the services are rendered.

Out-of-Network
We do not contract with all insurance companies licensed to do business In Texas. In the event your insurance company is not contraced with us, we will honor you in network out of pocket amounts. It is critical to make sure your insurance has "Out Of Network" benefits.(OON) under your policy. If you do not have OON benefits and you elect to receive care from MISC@SCI, you may not receive ANY insurance reimbursements. If you have OON benefits, your claim will be processed using the prevailing "Usual-Customary and Reasonable (UCR) rates for the servies provided. We will not balance bill you for the remainder.

_____ **Payment & Collection Policies**

It is our office policy to collect the co-payment when you arrive for your appointment. Unless other arrangements have been agreed upon in advance, full payment is due at the time of services provided. This includes co-payments, deductibles, payment plans and any other outstanding balances. We reserve the right to reschedule your appointment until such payments can be made. For your convenience, our office accepts cash and debit/creidt cards.

_____ **Patient's Request for any type of paperwork that is to be completed by physician**

In accordance with Federal Law, our office requires a written request (for available upon request) for the release of any type of forms. In some cases, we will need 15 business days (Monday through Friday) to process your request. According to the HIPAA privacy law, you may need to show identification that you have legal rights to this information. There could be additional fees for these form(s) and you may be required to see a physician.

_____ **Motor Vehicle Accidents and Workers Comp**

You will be responsible for the standard office visit and could be responsible for additional fees. The additional fees could be labs, injections, procedures and any testing that is required by your physician. This cost will also be required at the time of service; however, any extra charges not collected at the time of service may result in a statement. You are agreeing to pay the total amount

MINIMALLY INVASIVE SPINECARE

Patient Name: A B

**_____ Method(s) of Communicating with Patients**

For your convenience, MISC@SCI will call, text or email to remind you about your upcoming appointments. Please give your consent below to allow us to leave you detailed messages.

(Please check all that apply)

MISC@SCI *may leave _____ or may not leave _____ detailed information regarding my appointment(s) on the following phones.*

_____ Home voicemail #_____
_____ Mobile Phone voicemail _____ Mobile text message #_____
_____ Work voicemail #_____ Ext: _____

_____ Email address: (**PLEASE PRINT**) _____

**_____ Mid Level Practitioner and what it means**

When you visit our offices, you will be seen by a Physician, a Nurse Practitioner (NP), a Physician Assistant (PA) or a Registered Nurse (RN).

NPs and PAs are clinical professionals with advanced degrees (Master's Degree) who are licensed to practice medical care and who work in collaboration with physicians. NPs and PAs are collectively referred to as Mid Level Providers or Practitioners. They can diagnose, plan treatment, prescribe medications and therapies (physical therapy and/or occupational therapy). RNs are responsible for caring and educating patients and implementing orders written by physicians, NPs, or PAs. They are not licensed to make official diagnosis or to prescribe medication or therapies.

If you are being seen by a Nurse Practitioner or Physician Assistant, they will evaluate and treat you spinal condition. If a surgical consultation is needed, your NP or PA will eave the room to discuss your concerns and their findings from the physical exam with the attending surgeon. Then both the surgeon and NP/PA will return to your exam room for further assessment and to discuss your treatment plan with you.

**_____ Medical Lifetime Authorization (*MEDICARE PATIENTS ONLY*)**

I authorize any holder of medical or other information about me to release to the Social Security Administration and HealthCare Financial Administration or its intermediaries or carriers that have any information needed for this or any related Medicare claim(s). I permit a cpy of this authorization to be used in lieu of the original and request payment of the medical insurances benefits to the party who accept assignments. Regulations pertaining to Medicare assignment of benefits apply.

**_____ Notice of Privacy Practices**

I have reviewed and understand the Privacy Practices laws. I understand I may request a copy at any time for my own personal

MINIMALLY INVASIVE SPINECARE

Patient Name: A B

**_____ Fascimile or Reproduction Waiver**

I understand that my medical information may be transmitted electronically by MISC@SCI. I authorize MISC@SCI and any of its susidiaries to send and/or receive the confidential electronical health care information as defined by Health Insurance Portability Accountability Act of 1996, 45CFR, Parts 160-164 (HIPAA) with full knowledge that it may be received in error by a third party. I absolve MISC@SCI of any responsibility for issues that might arise from such error. I may revoke this authorization by giving MSIC@SCI 10 days written notice. This revocation will not pertain to information released prior to the date of the receipt of the revocation by MISC@SCI.

**_____ Assignment of Benefits (required for filing insurance claims)**

I hereby assign my interest and title to all medical benefits to which I am entitled to MISC@SCI and any of its subsidiaries. I hereby authorize my insurance carrier to issue payments directly to MISC@SCI for medical services rendered to myself regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

**_____ Authorization of Release of Information (required for filing insurance claims)**

I hereby authorize MISC@SCI and any of its subsidiaries to:

1) Release any information necessary to insurance carriers regarding my illness and treatments to facilitate payments.
2) Process insurance claims generated in the course of examinations and treatments.
3) Allow a photocopy of my signature to be used to process insurance claims for the period of a lifetime.

This order will remain in effect until revoked by me in writing.

I have requested medical services from MISC@SCI and any of its subsidiaries on my behalf and understand that by making this request, I become fully responsible for any and all charges incurred in te course of treatment authorized.

X_____
Patient's (Printed) Name

X_____
Date of Birth

X_____
Patient's (Signed) Name

X_____
Date of Signature

X_____

X_____

MINIMALLY INVASIVE SPINECARE

Patient Name: A B
DOB:

**Patient Health History Form**

Please list any medication(s) you are currently taking: _____ _____

_____ _____

Drug Allergies: _____

I have: [ ] Not missed any work because of this problem [ ] How much work have you missed: _____

Please check if you have or have been known to have any of the following:

[ ] Hypertension (high blood pressure) [ ] Cardiovascular disorder(s) [ ] Stroke

[ ] Discomfort, pressure or tightness in check [ ] High Cholesterol [ ] Hernia

[ ] Irregular heart rhythm or palpitation [ ] Low blood sugar [ ] Diabetes

[ ] Repeated shortness of breath or difficulty breathing [ ] Are you currently pregnant?

[ ] Respiratory Disorder (asthma, chronic bronchitis, emphysema, etc.) [ ] Do you currently smoke?

Please list any medical complications not mentioned above:

_____

_____

Have you ever had an injury, surgery, arthritis, bursitis, tendinitis, or other joint disorders?

_____

_____

What diagnostic test have you had for your current injury? Test Date: _____

[ ] X-Ray [ ] MRI Scan [ ] EMG [ ] CT Scan [ ] ESIs [ ] Myelogram

Other: _____

Family history: Have any of your blood relatives suffered from the following medical problems?

[ ] Heart Attack [ ] Stroke [ ] Heart Surgery

[ ] Diabetes [ ] High Blood Pressure [ ] High Cholesterol

I hereby certify that the answers in this questionnaire are tru and correct.

Patient Signature: _____ Date: _____

I have reviewed this and incorporated the information in the patients plan of care.

MINIMALLY INVASIVE SPINECARE

Patient Name: A B
DOB:

## PAIN CHART

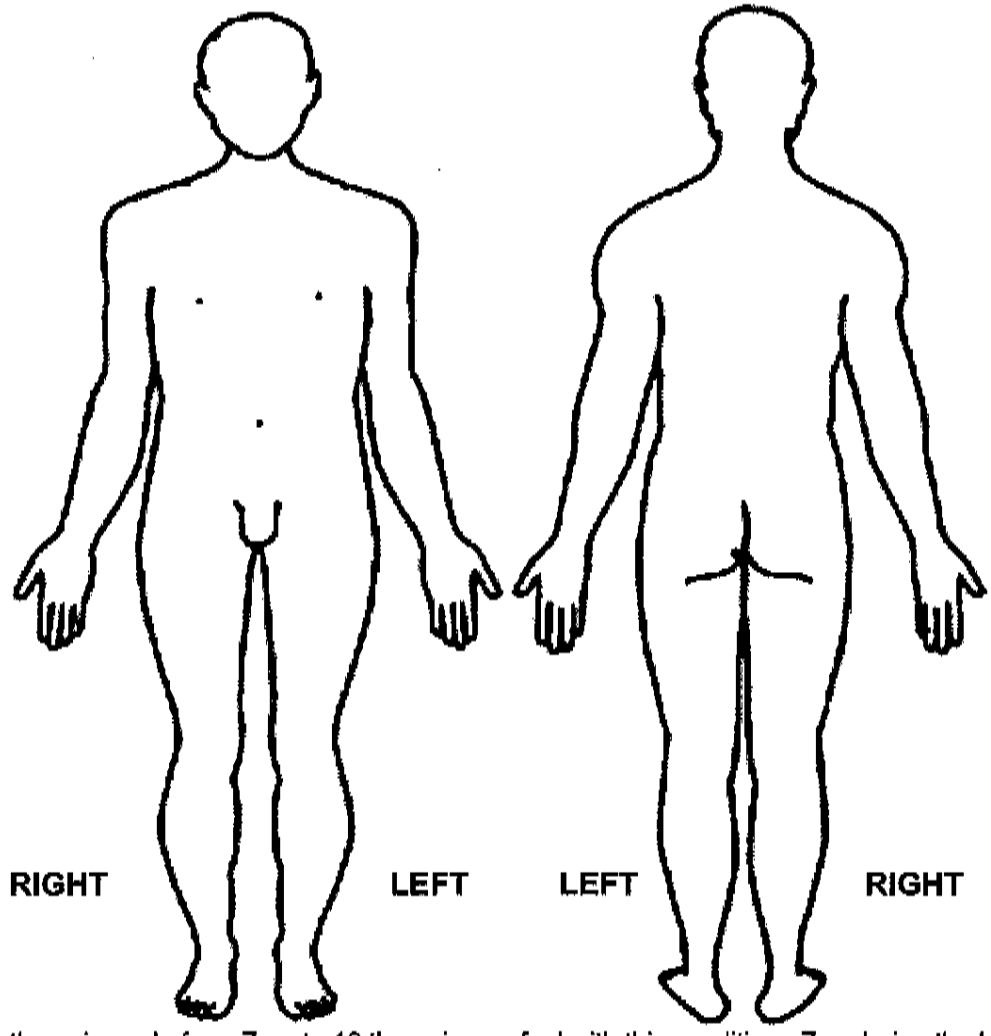
Please use this chart to describe how you feel TODAY

Mark the appropriate areas on the diagram below where you feel the described sensations:

Use the appropriate symbols; Mark areas of radiation; Include all affected areas.

| Numbness | Pins & Needles | Burning | Aching | Stabbing |
|---|---|---|---|---|
| ---------- | oooooooooo | xxxxxxxxxx | ********** | ////////// |
| ---------- | oooooooooo | xxxxxxxxxx | ********** | ////////// |
| ---------- | oooooooooo | xxxxxxxxxx | ********** | ////////// |
| ---------- | oooooooooo | xxxxxxxxxx | ********** | ////////// |

Show Area(s) of Pain or Unusual Feeling




Please mark on the pain scale from Zero to 10 the pain you feel with this condition. Zero being the least amount and 10 being the worst pain you have felt with this condition.

Neck/Shoulder/Arm Pain or Discomfort: (None) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Severe)
Mid Back Pain or Discomfort: (None) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Severe)
Lower Back and Leg: (None) 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 (Severe)

Signature: _____ Date: _____

MINIMALLY INVASIVE SPINECARE

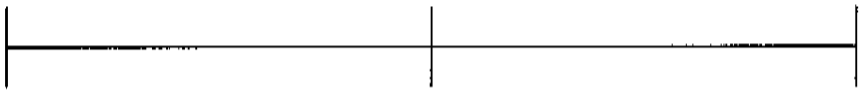
Patient Name: A B
DOB:

**OPTIMAL INSTRUMENT**

Difficulty - Baseline

| Instructions: Please circle the level of difficulty you have for each activity today. | No Difficulty | | Little Difficulty | | Moderate Difficulty | | Much Difficulty | | Not Able to Do | Not Applicable |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 Lying Flat | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 2 Rolling over | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 3 Moving - lying to sitting | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 4 Sitting | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 5 Squatting | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 6 Bending / stooping | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 7 Balancing | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 8 Kneeling | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 9 Walking - Short Distance | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 10 Walking - Long Distance | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 11 Walking - Outdoors | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 12 Climbing Stairs | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 13 Hopping | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 14 Jumping | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 15 Running | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 16 Pushing | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 17 Pulling | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 18 Reaching | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 19 Grasping | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 20 Lifting | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |
| 21 Carrying | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 0 |

22. Thinking about all of the activities you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with these activities today.



I have extreme difficulty doing any of the activities that I would like to do.

I have no difficulty doing any of the activities that I would like to do.

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. *12* 2. *8* 3. *13* )

1. _____ 2. _____ 3. _____

MINIMALLY INVASIVE SPINECARE

Patient Name: A B
DOB:
Today's Date:_____

PLEASE READ CAREFULLY:

Instructions: Please circle the number that best describes your symptoms.

Note: If you have more than one complaint location, please answer each question for each individual issue and indicate the level for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example

| No Pain | | | | | Moderate | | | | | Worst Possible Pain |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | (2) Arm | 3 | 4 | (5) Headache | 6 | 7 | (8) Lower Back | 9 | 10 |

1. What is your current pain?

| No Pain | | | | | Moderate | | | | | Worst Possible Pain |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

2. What is your usual daily pain?

| No Pain | | | | | Moderate | | | | | Worst Possible Pain |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

3. What is your pain level AT ITS BEST?

| No Pain | | | | | Moderate | | | | | Worst Possible Pain |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

4. What is your pain level AT ITS WORST?

| No Pain | | | | | Moderate | | | | | Worst Possible Pain |
|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

5. Is your pain more severe at any particular time of day? [ ] N [ ] Y Explain:_____

Additional Information or Comments:

Patient's Signature: _____

MINIMALLY INVASIVE SPINECARE

Patient Name: A B
DOB:

**Please Read:** This questionnaire is designed to enable us to understand how much NECK PAIN has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which closely describes your problem right now.

**1 - Pain Level**
- A. I have no pain at the moment.
- B. The pain is mild at the moment.
- C. The pain is inconsistant and is moderate.
- D. The pain is moderate and does not change much.
- E. The pain is severe but it comes and goes.
- F. The pain is severe and is consistant.

**2 - Personal Care**
- A. I can wash and dress myself without extra pain.
- B. I can wash and dress myself normally, but it causes extra pain.
- C. It is painful to wash and dress myself and I am slow and careful.
- D. I need some help, but manage most of the time.
- E. I need help every day with washing and dressing.
- F. I can not wash and dress myself.

**3 - Lifting**
- A. I can lift any weight without extra pain.
- B. I can lift heavy weight, but with extra pain.
- C. Pain prevents me from lifting heavy weight off the floor, but I can if they are positioned properly.
- D. Pain prevents me from lifting any heavy weight, but I can manage light to medium weight, if they are positioned properly.
- E. I can lift very light weight.
- F. I cannot lift or carry anything at all, due to pain.

**4 - Reading**
- A. I can read as much as I like with no neck pain.
- B. I can read as much as I like with slight neck pain.
- C. I can read as much as I like with moderate neck pain.
- D. I cannot read as much as I would like because of moderate neck pain.
- E. I cannot read as much as I would like because of severe neck pain.
- F. I cannot read at all due to neck pain.

**5 - Headache**
- A. No headaches at all.
- B. Only slight headaches which are infrequent
- C. Moderate headaches which are infrequent.
- D. Moderate headaches which are frequent.
- E. Severe headaches which are frequent.
- F. Headaches almost daily.

**6 - Concentration**
- A. I can concentrate fully with no difficulty.
- B. I can concentrate fully with slight difficulty.
- C. I have some degree of difficulty in concentrating.
- D. I have great difficulty in concentrating.
- E I cannot concentrate at all.

**7 - Work**
- A. I can work as I want to.
- B. I can only do some work but no more.
- C. I can do most of the work, but no more.
- D. I cannot do my daily work.
- E. I can hardly do any work at all.
- F. I cannot do any work at all.

**8 - Driving**
- A. I can drive my car without any neck pain.
- B. I can drive my car as I want, with slight neck pain.
- C. I can drive my car as I want, with only moderate neck pain.
- D. I cannot drive my car as I want, because of moderate neck pain.
- E. I can hardly drive my car at all because of the severe neck pain.
- F. I cannot drive at all.

**9 - Sleeping**
- A. I have no trouble sleeping at night.
- B. Sleep is somewhat disturbed 1-4 hrs.
- C. Sleep is mildly disturbed 1-4 hrs.
- D. Sleep is moderately disturbed 1-4 hrs.
- E. Sleep is very disturbed 1-6 hrs.
- F. Sleep is completely disturbed 6-7 hrs.

**10 - Recreational Activity**
- A. I am able to engage in all recreational activities with no neck pain.
- B. I am able to engage in all recreational activities with only some neck pain.
- C. I am able to engage in most, but not all recreational activities because of neck pain.
- D. I am able to participate in a few recreational activities because of neck pain.
- E. It is difficult to do any recreational activities because of neck pain.
- F. I cannot participate in recreational activities at all.

**Patient Signature:** _____ **Date:** _____

MINIMALLY INVASIVE SPINECARE

Patient Name: A B
DOB:

**Please Read:** This questionnaire is designed to enable us to understand how much LOWER BACK PAIN has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but please just circle the one choice which closely describes your problem right now.

**1 - Pain Level**
- A. I have no pain at the moment.
- B. The pain is mild at the moment.
- C. The pain is inconsistant and is moderate.
- D. The pain is moderate and does not change much.
- E. The pain is severe but it comes and goes.
- F. The pain is severe and is consistant.

**2 - Personal Care**
- A. I can wash and dress myself without extra pain.
- B. I can wash and dress myself normally, but it causes extra pain.
- C. It is painful to wash and dress myself and I am slow and careful.
- D. I need some help, but manage most of the time.
- E. I need help every day with washing and dressing.
- F. I can not wash and dress myself.

**3 - Lifting**
- A. I can lift any weight without extra pain.
- B. I can lift heavy weight, but with extra pain.
- C. Pain prevents me from lifting heavy weight off the floor, but I can if they are positioned properly.
- D. Pain prevents me from lifting any heavy weight, but I can manage light to medium weight, if they are positioned properly.
- E. I can lift very light weight.
- F. I cannot lift or carry anything at all, due to pain.

**4 - Walking**
- A. Pain does not prevent me from walking any distance.
- B. Pain prevents me from walking more that one mile.
- C. Pain prevents me from walking a mile.
- D. Pain prevents me from walking more that 1/2 mile.
- E. I can only walk while using a cane, crutches, or assistance.
- F. I am in bed most of the time and have to crawl to the toilet.

**5 - Sitting**
- A. I can sit in any chair for any length of time.
- B. I can sit in a comfortable chair for as long as I like.
- C. Pain prevents me from sitting more than one hour.
- D. Pain prevents me from sitting more than 1/2 hour.
- E. Pain prevents me from sitting more that 10-15 minutes.
- F. Pain prevents me from sitting at all.

**6 - Standing**
- A. I can stand as long as I need to without pain.
- B. I have some pain while standing, but it does not increase with time.
- C. I cannot stand for longer than one hour without increasing pain.
- D. I cannot stand for more than 1/2 our without increasing pain.
- E. I cannot stand for more than 10 minutes without increased pain.
- F. I cannot stand because it increases pain.

**7 - Sleeping**
- A. I have no pain in bed.
- B. I have some pain but it does not prevent me from sleeping.
- C. Due to pain, my normal night's sleep is reduced slightly.
- D. Pain reduces my sleep by half.
- E. Due to pain, my usual night's sleep is reduced 2-4 hrs.
- F. Pain prevents me from sleepin at all during the night.

**8 - Social Life**
- A. My social life is normal and gives me no pain.
- B. My social life is normal, but increases my pain.
- C. Pain has no significant effect on my social life apart from limiting my activity.
- D. Pain has restriced my social life and I do not go out very often.
- E. Pain has restriced my social life to my home.
- F. Pain prevents me from all social activity.

**9 - Traveling**
- A. I get no pain while traveling
- B. I get some pain while traveling
- C. I have pain while traveling, but it does not stop me.
- D. I have pain while traveling which alters my forms of travel.
- F. Pain restricts all forms of travel.

**10 - Increasing or Decreasing Degree of Pain**
- A. My pain is steadily getting better.
- B. My pain fluctuates, but overall is getting better.
- C. My pain seems to be getting better, but improvement is slow.
- D. My pain is neither getting better or worse.
- E. My pain is gradually worsening.
- F. My pain is worsening rapidly.

**Patient Signature:** _____ **Date:** _____