



**AUTHORIZATION TO RELEASE INFORMATION, HEALTH CARE SERVICES LIEN,
ASSIGNMENT OF RIGHTS, AND INSTRUCTIONS FOR DIRECT PAYMENT**

To: _____ Patient's Name: _____
 _____ Address: _____

 Phone: _____ Patient's SSN: _____
 Fax: _____ Patient's DOB: _____

I hereby **authorize** you, as my attorney, and the Las Vegas Pain Relief Centers (LVPRC), as my health care provider, to exchange with each other with all pertinent information including my case history, examination, diagnosis, treatment, and prognosis as to my collision/illness which occurred/ began on _____.

I hereby give a **lien** against any settlement, claim, judgment, or verdict arising from said collision/ illness and/or assign my rights and benefits under any insurance policy covering me in my case to LVPRC as payment for services, devices, and/or products they provide(d) me as related to said collision/illness.

I hereby **authorize** and instruct you as my attorney to pay LVPRC directly from any such settlement, claim, judgment, or verdict arising from said collision/illness to satisfy my account with them. If any policy or procedure prohibits you from paying LVPRC directly, I hereby instruct you to pay me by check and send the check to me in care of the LVPRC at the address above. In the event another attorney is substituted in this matter, the new attorney must honor this lien upon notice, as inherent to the settlement and enforceable upon the case and the recovery.

I understand that I am fully responsible to the LVPRC for all bills submitted by them for my care related to said collision/illness and that this agreement is made solely for their additional protection and in consideration for their awaiting payment I further understand that my responsibility to pay my account is not contingent on any settlement, claim, judgment, or verdict arising from said collision/illness for which I may recover said fee.

A photocopy of this Authorization to Release Information, Health Care Services Lien, Assignment of Rights, and Instructions for Direct Payments shall be considered to be as effective and valid as the original.

Patient Signature _____ Date _____
 (or Parent/Guardian)

Witness _____
 LVPRC has agreed to accept the above patient as of the date on this document.

Doctor Signature _____ LVPRC chooses not to accept Patient on Lien

Acknowledgement of Lien by Attorney

Attorney Signature or Representative _____ Date _____



**AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS,
AND INSTRUCTIONS FOR DIRECT PAYMENT**

To: _____ Patient's Name: _____

Address: _____

Insurance ID# _____ Patient's SSN: _____
Claim/Group# _____ Patient's DOB: _____

I hereby **authorize** you, as my insurance carrier, and the **Las Vegas Pain Relief Centers (LVPRC)**, as my health care provider, to exchange with each other with all pertinent information including my case history, examination, diagnosis, treatment, and prognosis as to my collision/illness which occurred/ began on _____.

I hereby assign my rights and benefits under the coverage of the policy I hold with you to the LVPRC as the payment for the health care (professional services, products, and/or devices) they provide(d) as related to said collision/illness. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.**

I hereby **authorize and instruct** you to pay LVPRC directly for the health care (professional services, products, and/or devices) they provide related to said collision/illness. If my current policy prohibits you from paying them directly, I hereby instruct you to pay me by check and send the check to me in care of LVPRC at the address above.

I understand that I am fully responsible to the LVPRC for all bills submitted by them for my care related to said collision/illness and that this agreement is made solely for their additional protection and in consideration for their awaiting payment I further understand that my responsibility to pay my account is not contingent on any settlement, claim, judgment, or verdict arising from said collision/illness for which I may recover said fee.

A photocopy of this Authorization to Release Information, Assignment of Benefits, and Instructions for Direct Payment shall be considered to be as effective and valid as the original.

Patient Signature _____ Date _____
(or Parent/Guardian)

Printed Name _____

Las Vegas Pain Relief Center
2779 W Horizon Ridge Pkwy #210, Henderson NV 89052
Ph (702) 948 - 2520 Fax (702) 852 - 0642



AUTO COLLISION / PERSONAL INJURY VERIFICATION
MEDICAL PAYMENTS / PIP / NO FAULT

Patient: _____ Insured: _____
Policy #: _____ Claim #: _____
Date of Injury: _____ Adjuster's Name: _____
Relationship to Insured (circle one): SELF FAMILY MEMBER OTHER _____
Has the collision been reported? YES NO Has a medical file been opened? YES NO
Medical Limits _____ Remaining Balance _____
Benefits paid directly to doctor? YES NO If no, payable to patient and mailed to doctor? YES NO

MEDICAL INSURANCE COMPANY ADDRESS/INFORMATION
Name: _____
Address: _____
City, St, Zip: _____
Phone: _____
Payer ID/EDI: _____

ATTORNEY INFORMATION

Attorney Name _____ Attorney Contact Name: _____
Address: _____ Accept and Honor Lien? YES NO
City, St, Zip: _____ Want Bills? YES NO
Phone: _____
Fax: _____

Las Vegas Pain Relief Center
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ABOUT THE INJURY / COLLISION / INCIDENT

Patient/Police Report	Name: _____ Date: _____
	Date of first treatment related to this case: _____
	Date of Collision: _____ Time: _____ AM/PM
	Any passengers? Yes No Names: _____
	Road Conditions at the time of collision Wet Dry Icy Other _____
	Did the police come to the collision scene? Yes No
	Is there a police report? Yes No
Did you request the report? Yes No	

ATTORNEY INFORMATION

Attorney Name: _____ Attorney Contact Name: _____

Address: _____ City, St, Zip: _____

Phone: _____ Fax: _____

Email: _____

YOUR AUTO INSURANCE INFORMATION

Name: _____

Address: _____

City, St, Zip: _____

Phone: _____ Fax: _____

Policy/ID #: _____ Adjuster's Name: _____

AT FAULT AUTO INSURANCE INFORMATION

Name: _____

Address: _____

City, St, Zip: _____

Phone: _____ Fax: _____

Policy/ID #: _____ Adjuster's Name: _____



1. PAIN INFORMATION

Is the patient experiencing pain as a result of the collision/incident? Yes No

What was the cause of the injury (auto vs auto, slip and fall, altercation etc.)? _____

Did you sustain any cuts or scrapes during this collision/incident? _____

What bruises did you sustain during this collision/incident? _____

Where were you seated in the vehicle (driver, passenger, back seat on driver's side, etc.)? _____

Were you aware of the approaching collision prior to impact or did impact catch you by surprise?

Aware Surprised

Were you restrained by a seatbelt? Yes No

If yes, what type? lap only restraint chest and lap restraint

Were you injured by the seatbelt? Yes No

If yes, please describe the injury. _____

Did an airbag deploy? Yes No

Any cuts or abrasions from the airbag? Yes No

Where were you looking at the time of the impact? (straight ahead, turned to the left, turned to the right) _____

Was the trunk of your body pointing forward at impact? Yes No

If no, which direction was your trunk facing? _____

Did you contact the interior of the vehicle? Yes No

What part of the body came in contact? What object in the vehicle did each body part contact? (Ex: Left side of head hit wind shield, Right side of chest hit steering wheel, Right knee hit dash)

Did the patient receive a head injury as a result of this collision/incident? Yes No

Did you experience a flash of light or explosion in your head? Yes No

Describe the discomfort felt at the time of the collision? List each body part injured as a result of the collision? (Ex: Right wrist – sharp, stiff, etc. Low back – dull, achy, pulling, sore, etc.)



Exacerbation of past injury as a result of the collision? (Right wrist – sharp, stiff, pressure etc. Low back – dull, achy, pulling, sore, cramping etc. Neck – popping, loose, etc.)

Are there any activities that have been limited or reproduce pain as a result of the collision/incident/injury?

Activities of Daily Living	Work	School
Home Duties	Child Care	Sports

Are there any movements that reproduce the symptoms that were reported from the collision/incident? Yes No

In which body part? (Ex: Right wrist – bending forward/flexion, bending backward/extension. Low back – bending forward/flexion, twisting right/right rotation, twisting left/left rotation, bending back/extension, bending to the left/left lateral bending.)

2. VEHICLE INFORMATION

List the year, make and model of the vehicle you were in. _____

List the other vehicles year make and model. _____

Was your car stopped at the time of impact? _____

If yes, was the driver’s foot on the brake at the time of impact. Yes No

Where, on the patient vehicle, did impact occur (front, front driver, front passenger, side front driver...)? _____

Which direction was the patient’s vehicle moving (forward, stopped, turning right, backing up)? _____

Was your vehicle slowing down, gaining speed or traveling at a steady rate of speed at the time of impact? _____

List the year, make and model of the other vehicles involved. _____



Was the other vehicle moving at the time of the collision? Yes No
If yes, what was the approximate speed? _____

If the other vehicle was moving at the time of the collision, was it: slowing down, gaining speed, or travelling at a steady speed? _____

What was the estimated speed the patient's vehicle was travelling? _____

What was the estimated amount of damage that the patient's vehicle received (\$100.00, \$1,000...)? _____

Which direction was the other vehicle travelling (forward, turning right, backing up)? _____

What was the estimated speed that the other vehicle was travelling? _____

What was the estimated damage that the other vehicle received as a result of the collision/incident (\$100.00, \$1,000.00)? _____

Was the patient's vehicle towed from the scene of the collision? Yes No

3. HOSPITAL INFORMATION

Was Emergency Medical Services at the scene of the incident? Yes No

Was the patient taken/escorted to the hospital? Yes No
If so what hospital did you go to? _____

What treatments/procedures were done and to what part of the patient's body? (left hip x-ray, head CT, blood work, medication/muscle relaxer, advice). _____

Did you stay in the hospital? Yes No For how long? _____

If the patient did not go to the hospital, where did you go following the collision? _____

How did you get there? _____

What treatments have you received since the collision (ice, heat, x-ray, etc.)? _____

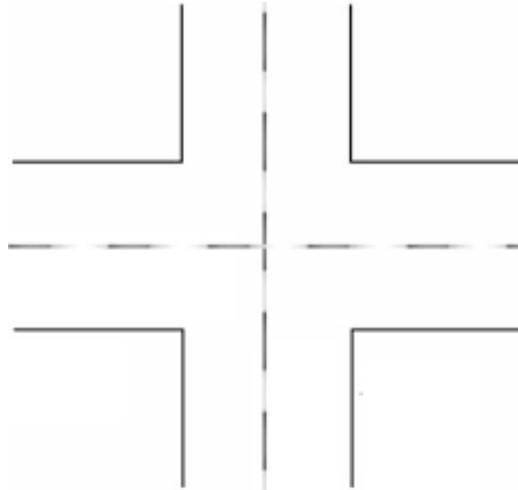
4. ADDITIONAL INFORMATION

Where did the injury occur? (cross streets, city, state) _____

Please describe, to the best of your knowledge, what happened during this collision/incident.

Any pictures of the collision taken? Yes No

DIAGRAM OF THE COLLISION



Where was your headrest positioned? (shoulder level, middle of the head, top of the head) _____

Were both hands on the steering wheel? Yes No

If no, which hand was on the steering wheel? _____

Did anyone witness the collision? Yes No

If yes, who was it? _____

If patient were transported by ambulance, did the ambulance attendants put you in a neck or back brace? Yes No



Do you feel that your conditions is improving, staying the same or worsening?

Improving Staying the same Worsening

What type of work do you do? _____

Please list job requirements?

Can you perform physical work activities? Yes No

Have you had a loss of income due to loss of work? Yes No

How many days of work have you missed as a direct result of this injury and/or collision? _____

Any prior collisions? Yes No If yes, when? _____

Any residual problems? Yes No If yes, please explain

4. PATIENT INFORMATION

Name: _____

Age: _____ Date of Birth: _____

Male Female

If female, could you be/are you pregnant? Yes No

Are you breast feeding? Yes No

Height: _____ Weight: _____

What symptoms are you currently experiencing? _____

What is the intensity of your pain?

Slight	Mild to Moderate	Moderate to Severe
Mild	Moderate	Severe

What is the frequency of your pain?

Occasional (1% - 25%)	Intermittent (25% - 50%)
Frequent (50% - 75%)	Constant (75% - 100%)

How often does your pain occur?

Occasional (1% - 25%)	Intermittent (25% - 50%)
Frequent (50% - 75%)	Constant (75% - 100%)

Which side is the pain located on? Left Right Both



INJURY/COLLISION/INCIDENT QUESTIONNAIRE (page 6)

What aggravates the pain? _____

Is the pain brought on by anything? _____

Does the pain interfere with sleep? Yes No
If yes, please explain how it interferes with sleep _____

Any prior collisions? Yes No
Estimated date of collision? _____

Do you experience any residual symptoms as a result? Yes No
If yes, please explain _____

What new symptoms do you now experience? _____

Please list any past surgeries and the estimated date of each.

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Date: _____ Surgery: _____

Please list all current medications.

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Do you have any drug allergies? Yes No

If yes please list:



INJURY/COLLISION/INCIDENT QUESTIONNAIRE (page 7)

Please list any diagnostic test done since the collision/incident. When was the test done? Where was the test done? (EX: right ankle x-ray on 1/1/201x at American Diagnostic Center)

Any questions or concerns for the doctor?



INJURIES, IMPAIRMENTS & DAMAGES (page 1)

Please mark any of the symptoms you have experienced **SINCE** the accident

- | | | |
|------------------------------|------------------------------|------------------------------------|
| Headaches | Dizziness | Difficulty Concentrating |
| Short Term Memory Loss | Long Term Memory Loss | Forgetting ATM or other numbers |
| Irritability | Change in Personality | Unusual Behavior Since Collision |
| Sleep Disturbances | Intolerance to Heat | Intolerance to Cold |
| Blurred Vision | Vision Changes | Bumping into Objects in View |
| Seizures | Thoughts of death/suicide | Photophobia (sensitivity of light) |
| Loss of Balance | Impaired Comprehension | Attention Impairment |
| Nausea | Vomiting | Fatigue |
| Tinnitus (Ringing of Ears) | Noise Intolerance | Loss of Coordination |
| Hearing Loss | Vertigo (Spinning Sensation) | Anxiety |
| Depression | Missing Periods of time | Panic Attacks |
| Dizziness with Neck Movement | | "Clunk" sound w/Neck Movement |
| Impaired Learning | Writing Problems | Speech Difficulties |
| Menstrual Irregularities | Loss of Libido | Flash back to scene of Collision |
| Reading Problems | Weight Loss/Gain _____ lbs | Loss of Taste/Smell |
| Jaw Pain | Pain with chewing | Clicking in Jaw |

Numbness	Tingling	Weakness in arms?	Yes	No	R	L	Level (1-10) _____
Numbness	Tingling	Weakness in legs?	Yes	No	R	L	Level (1-10) _____



Impaired Activities

Check all activities which have been impaired in any way by the incident in question

Daily Activities

- | | | | |
|-------------|---------------|-----------------|------------------------------|
| sleeping | eating | brushing teeth | bathing/showering |
| lifting | bending | standing | shaving |
| sitting | moving | driving | traveling |
| dining out | shopping | getting dressed | going to the movies |
| reading | watching tv | child care | sexual relations |
| vacationing | church events | social events | religious (bending/kneeling) |

Domestic Activities (Activities within the home)

- | | | | | |
|----------------|-----------|---------|-------------------|------------|
| bending | cooking | ironing | housecleaning | laundry |
| washing dishes | vacuuming | dusting | interior planning | decorating |

Household Activities (Activities outside the home)

- | | | | | |
|-------------------|-------------|---------------|-------------------|-----------------|
| trimming bushes | gardening | tree trimming | mowing lawn | yardwork |
| exterior painting | car washing | landscaping | house maintenance | farm activities |

Work Activities

- | | | | | |
|---------|----------|---------|-----------------|----------------|
| sitting | standing | lifting | using telephone | computer works |
| reading | bending | typing | writing | child care |

Hobby Activities

- | | | | | |
|---------------------|--------------|--------------|--------------|----------------|
| aerobic exercise | archery | backpacking | bowling | badminton |
| baseball | basketball | basketry | bicycling | boxing |
| card playing | camping | dancing | fencing | fishing |
| flying | football | gardening | golf | handball |
| gymnastics | health clubs | hockey | hunting | judo |
| horseback riding | ice skating | karate | painting | yoga |
| jogging/running | photography | racquetball | rafting | sailing |
| mountain climbing | sewing | snow skiing | swimming | walking |
| musical instruments | volleyball | water skiing | water sports | weight lifting |

Activities which you have performed despite pain, due to financial, family or personal needs (Duties under duress):

- | | |
|-----------|--|
| Work | Household (duties outside of the home) |
| Education | Domestic (Activities within the home) |

Past Injuries, Collisions, Workers Compensation Claims or other claims of any sort: _____



INJURIES, IMPAIRMENTS & DAMAGES (page 3)

Describe your headache pain: Sharp Dull Aching Stabbing Cramping
 Your symptoms are: Constant Come and Go
 When did the headache start: Before Incident At the time of Incident After Incident
 How severe are your headaches on a scale of 1 to 10 (10 being worse)? _____
 What makes your headaches worse?
 Washing Dressing Grooming Lifting Sitting Standing

Describe your neck pain: Sharp Dull Aching Stabbing Cramping
 Your symptoms are: Constant Come and Go
 When did the neck pain start: Before Incident At the time of Incident After Incident
 How severe are your neck pain on a scale of 1 to 10 (10 being worse)? _____
 What makes your neck pain worse?
 Washing Dressing Grooming Lifting Sitting Standing
 Do you have any numbness, tingling or weakness in your arms? Yes No

Describe your upper back pain: Sharp Dull Aching Stabbing Cramping
 Your symptoms are: Constant Come and Go
 When did the upper back pain start: Before Incident At the time of Incident After Incident
 How severe are your upper back pain on a scale of 1 to 10 (10 being worse)? _____
 What makes your upper back worse?
 Washing Dressing Grooming Lifting Sitting Standing
 Do you have any numbness, tingling or weakness in your arms? Yes No

Describe your lower back pain: Sharp Dull Aching Stabbing Cramping
 Your symptoms are: Constant Come and Go
 When did the lower back pain start: Before Incident At the time of Incident After Incident
 How severe are your lower back pain on a scale of 1 to 10 (10 being worse)? _____
 What makes your lower back pain worse?
 Washing Dressing Grooming Lifting Sitting Standing
 Do you have any numbness, tingling or weakness in your arms? Yes No

Describe your upper extremity pain: Sharp Dull Aching Stabbing Cramping
 Your symptoms are: Constant Come and Go
 When did the upper extremity pain start: Before Incident At the time of Incident After Incident
 How severe are your upper extremity pain on a scale of 1 to 10 (10 being worse)? _____
 What makes your upper extremity pain worse?
 Washing Dressing Grooming Lifting Sitting Standing
 Do you have any numbness, tingling or weakness in your arms? Yes No

Describe your lower extremity pain: Sharp Dull Aching Stabbing Cramping
 Your symptoms are: Constant Come and Go
 When did the lower extremity pain start: Before Incident At the time of Incident After Incident
 How severe are your lower extremity pain on a scale of 1 to 10 (10 being worse)? _____
 What makes your lower extremity pain worse?
 Washing Dressing Grooming Lifting Sitting Standing
 Do you have any numbness, tingling or weakness in your arms? Yes No

INJURIES, IMPAIRMENTS & DAMAGES (page 4)

MARK THE AREAS ON THE DIAGRAM WHERE YOU FEEL PAIN



*****OFFICE USE ONLY*****

VITALS: TEMP _____ BP _____/_____ P _____

HEIGHT _____ WEIGHT _____



CONSENT FOR TREATMENT

As confirmed by my signature below, the information I have indicated in this Patient’s Case History is complete and accurate as of today.

As the patient or guardian of this patient, I hereby authorize the health care professionals of **LAS VEGAS PAIN RELIEF CENTER (LVPRC)** to administer and/or order: physical examinations, X-ray and/or other radiographic studies, laboratory studies, chiropractic care, soft tissue treatment, physical therapy, massage, and/or any other clinical examinations or treatment the doctor finds necessary for the patient.

If this patient is a minor child, or is otherwise under my guardianship, I understand that I am fully and personally responsible for payment of the patient’s bill to LVPRC and I do hereby guarantee its payment under the terms stated above. A photocopy of this document shall be considered to be as effective and valid.

HIPAA: The patient understands and agrees to allow LVPRC, Inc. to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information in going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent. If there is anyone you do not want to receive your medical records, please inform our office.

 (Initial Here, stating you have read above statement.)

RELEASE OF HEALTH CARE RECORDS

I authorize you to release all patient records and any other information related to my examination, laboratory tests and results, diagnosis, treatment and results to the LAS VEGAS PAIN RELIEF CENTER.

A photocopy of this authorization to Release of Health Care Records shall be considered to be as effective and valid as the original.

Patient (or Parent/Guardian) Signature _____

Printed Name _____

Date _____

Affiliated Business Disclosure Statement

This is to give you notice that the Dr. Jon Petrick D.C, Dr. Lee Moorer have a percentage ownership interest and/or financial relationship with the following legal and business entities:

The Las Vegas Pain Relief Center, Integrated Pain Relief Center, Rapid Recovery Care Centers Because of this relationship, the referring parties listed above may have financial or other benefits.

The Patients Choice Act of 2009, does NOT require to use any one the of provider(s) that we recommend as a condition for treatment or care.

THERE ARE OTHER LOCAL MEDICAL AND PHYSICAL MEDICINE PROVIDERS WITH SIMILAR BUT NOT EXACT SERVICES AVAILABLE. YOU ARE FREE TO SHOP AROUND AND CHOOSE THE RIGHT TREATMENT CENTER FOR YOUR PERSONAL NEEDS, TO ENSURE THAT YOU ARE RECEIVING THE HIGHEST LEVEL OF CARE.

Patient Acknowledgement,

I have read this disclosure form and I understand that I am being referred to the above-prescribed medical and chiropractic center. Furthermore; I am accepting this referral knowing, having been clearly disclosed to me, that the above parties may receive a financial or other benefit as the result of this referral and I am choosing to follow the advice and suggestion of my treating doctor(s).

Patient (or Parent/Guardian) Signature _____

Printed Name _____

Date _____

Table 8.12 is from Croft Whiplash Guidelines and the Grade I-V classification system

Table 8.12	
Classification of Cervical Acceleration/Deceleration Injuries from Motor Vehicle Accidents SRISD = Spine Research Institute of San Diego. These criteria do not consider loss of consciousness, the use of seatbelts/shoulder harnesses, or other factors that will be accounted for in a forthcoming revised prognostic index.	
A. Types of Collisions	
Type I	Primary rear impact (struck car moving or stationary)
Type II	Primary side impact
Type III	Primary frontal impact
B. Grades of Severity of Injury	
Grade I	Minimal; No limitation of motion; No ligamentous injury; No neurological findings
Grade II	Slight; Limitation of motion; No ligamentous injury; No neurological findings
Grade III	Moderate; Limitation of motion; Some ligamentous injury; Neurological findings may be present
Grade IV	Moderate to Severe; Limitation of motion; Ligamentous instability; Neurological findings present; Fracture or disc derangement
Grade V	Severe; Requires surgical management/stabilization
C. Stages of Injury	
Stage I	Acute; Inflammatory phase; Up to 72 hours
Stage II	Subacute; Repair phase; 72 hours to 14 weeks
Stage III	Remodeling phase; 14 weeks to 12 months or more
Stage IV	Chronic; Permanent



CONCUSSION DAILY SYMPTOMS CHECKLIST

Patient Name: _____

Date: _____

Symptoms Checklist

- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Headache
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Pressure in head
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Neck Pain
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Nausea / Vomiting
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Dizziness
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Vision Problems / Blurred Vision
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Balance Problems
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Sensitivity to Light
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Sensitivity to Noise
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Feeling Slowed Down
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Feeling Mentally Foggy
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – “Not Feeling Right”
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Difficulty Concentrating
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Difficulty Remembering
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Fatigue / Decreased Energy
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Confusion
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Drowsiness
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Trouble Falling Asleep
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – More Emotional than Usual
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Irritability
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Sadness
- 0 – 1 – 2 – 3 – 4 – 5 – 6 – Nervousness / Anxiousness

Total Symptoms: _____ / 22

Symptom Score: _____ / 132

Clinician Signature: _____

Date: _____

Supervising Signature: _____

Date: _____