CALIFORNIA ADVANCED
PAIN & SPINE SPECIALISTS
ROBERT G. SALAZAR, M.D. ALIREZA ABDOLLAHI-FARD, M.D.

PATIENT INFORMATION

First Name, Middle Initial , Last Name | Date of Birth | Social Security #

Gender Assigned At Birth ☐ Male ☐Female

Gender Identity

Marital Status: ☐ Single ☐Divorced ☐ Separated ☐ Widowed ☐ Married

( ) Cell Phone Number | ( ) Home Phone Number | Email Address

Race: ☐Asian ☐ Black of African American ☐American Indian or Alaska Native ☐White ☐Native Hawaiian or Other Pacific Islander ☐Decline ☐Other

Ethnicity:

Mailing Address

Street

City | State | Zip code

Physical Address

☐Physical address is same as mailing address

Street

City | State | Zip code

PHARMACY INFORMATION

Name of pharmacy | ( ) Phone Number | Address or cross streets

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact | Relationship to patient | ( ) Phone Number

Primary Care Physician | Referring Physician

INSURANCE INFORMATION

Are you being seen today due to a Worker's Compensation Injury? ☐No ☐ Yes (if you marked yes, then do not complete this section)

Are you being seen today on a lien-basis due to personal injury? ☐No ☐ Yes (if you marked yes, then do not complete this section)

Primary Insurance | Employer

Subscriber's information ☐ Self

First Name, Middle Initial , Last Name | Date of Birth | Social Security #

Secondary Insurance | Employer

Subscriber's information ☐ Self

First Name, Middle Initial , Last Name | Date of Birth | Social Security #

We are not contracted with Medi-Cal. If Medi-Cal is your secondary insurance then Medi-Cal eligibility will be verified to determine your financial responsibility for; co-pays, share of cost, deductibles and/or accepting assignment from your primary insurance

ASSIGNMENT OF BENEFITS

The above information is true to the best of my knowledge. I hereby authorize my insurance benefits to be paid directly to Robert G. Salazar, M.D. Inc. for services rendered. I understand that I am financially responsible for all medical services rendered and that your office may bill my insurance plan directly as a convenience to me but that I am personally responsible for such charges until they are paid in full. I also authorize Robert G. Salazar, M.D., Inc. to release any information required to process my claim(s) and / or to provide medical treatment.

Patient/Guardian signature | Date

C A P S S
7152 N. SHARON, STE #102, FRESNO CA 93720
PH (559) 432-6807 FAX (559) 432-6937
www.calpainspine.com

CALIFORNIA ADVANCED
PAIN & SPINE SPECIALISTS

ROBERT G. SALAZAR, M.D. ALIREZA ABDOLLAHI-FARD, M.D.

MEDI-CAL AUTHORIZATION RELEASE

We are not contracted with Medi-Cal. If Medi-Cal is your secondary insurance, Medi-Cal eligibility will be verified to determine your financial responsibility for; co-pays, share of cost, deductibles and/or accepting assignment from your primary insurance.

Do you have Medi-Cal? ☐ **Yes** ☐ **No**

First Name _____ Last Name _____ Date of Birth _____

Effective Date _____ Medi-Cal ID# _____ Social Security # _____

Address

Street _____ County _____ City _____ Zip code _____

The above information is true to the best of my knowledge. I authorize MEDI-CAL to release my eligibility status directly to the office of Robert G. Salazar, M.D. Inc. for verification of eligibility and financial responsibility.

Signature _____ Date _____

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PATIENT FINANCIAL RESPONSIBILITIES

Co-Payment and Deductible

You are responsible for your deductible and co-payment. If your deductible has been satisfied, we will bill your health plan. If your deductible has not been satisfied, payment is required at the time of service. Your co-payment is also due at the time of service.

Assignment

We accept assignment of the approved amount **as full payment** for covered services through insurances we are In-network with. You may be responsible for your deductibles, co-pay and/or co-insurance. Out-of- network insurances reviewed on a case by case basis.

Non-Covered Services

We will verify coverage of services before providing them to you however if your health plan determines not to cover those services once the claim is reviewed you may be responsible for payment in full for those services.

Appointment Cancellation Charge

By way of this notice you are hereby notified you may be charged **$25** for appointments canceled without a **minimum of twenty-four hours'** notification (missed appointment fee). This fee is your responsibility and cannot be billed to your health plan.

If your visit is related to a worker's compensation case, we will notify your workers compensation carrier if your appointment is canceled without a **minimum of twenty-four hours'** notification and/or for no-shows/missed appointment.

Excessive missed appointments may be cause for being discharged from the practice. The purpose of this policy is to have the option to offer the appointment time to another patient.

Payment Arrangements

Payments may be made in by; Visa, MasterCard, Discover Network, JCB International and American Express
Payments by check are payable to: Robert G. Salazar, M.D. Inc and we also accept cash payments.

Collections

If it is necessary to assign your account to a collection agency and/or attorney, you may be responsible for all of our collection agency and attorney fees and costs.

We are happy to discuss with you any questions relating to the information above. We thank you for your consideration of these matters and choosing California Advanced Pain & Spine Specialists for your health care needs.

Print Name	Date of Birth	Signature	Date

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR PROTECTED HEALTH INFORMATION:

Understanding what is in your health record and how your health information is used will help you to ensure its accuracy, allow you to better understand who, what, when, where and why others may access your health information, and assist you in making more informed decisions when authorizing disclosure to others. When you visit us, we keep a record of your symptoms, examinations, test results, diagnoses, treatment plan, and other medical information. We also may obtain health records from other providers. In using and disclosing this protected health information ("PHI"), it is our objective to follow the Privacy Standards of the federal Health Insurance Portability and Accountability Act, 45 CFR Part 464. The law allows us to use and disclose PHI without your specific authorization for treatment, payment, operations and other specific purposes explained on the next page. This includes the sharing of information, when necessary and appropriate, with other physician's, as necessary for your continued care. It also includes contacting you for appointment reminders and follow-up care. All other uses and disclosures require your specific authorization.

YOUR HEALTH INFORMATION RIGHTS ALLOWS YOU TO:

- Request a restriction on the uses and disclosures of PHI as described in this notice, although we are not required to agree to the restriction you request. If you have paid for services out-of-pocket, in full, and request that we not disclose your PHI, related solely to those services, we shall accommodate your request except where the disclosure is required by law. You should address your request in writing to the Privacy Officer. We will notify you within thirty (30) days if we cannot agree to the restriction.
- Obtain a paper copy of this Notice and upon written request, inspect and obtain a copy of your health record for a fee of
- $.25 per page and the actual cost of postage per the U.S. Postal Service, except that you are not entitled to access, or to obtain a copy of, psychotherapy notes and information compiled for legal proceedings. We may deny your request to inspect and/or copy your health record in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
- Amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to the Privacy Officer. We will respond to your request within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) we did not create, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the health information that we keep; (3) you would not be permitted to inspect and copy; or
- (4) is inaccurate and incomplete. Obtain an accounting of disclosures of your health information, except that we are not required to account for disclosures for treatment, payment, operations, or pursuant to authorization, among other exceptions. To obtain this "accounting of disclosures," you must submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date on which the accounting is requested. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting in any twelve (12) month period is free of charge. Additional requests for accounting of disclosures may result in charges to you for the costs of

providing such accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. We will respond to your request for an accounting of disclosures within sixty (60) days of receipt of your written request, unless additional time is needed to respond, at which time we may extend our response deadline for up to an additional thirty (30) days and provide you with an explanation as to the reason for the delay.
Request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.
Revoke an authorization to use or disclose PHI at any time except where action has already been taken.

OUR RESPONSIBILITIES AS REQUIRED BY LAW:

- Maintain the privacy of PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by terms of the notice currently in effect. We have the right to change our notice of privacy practices and we will apply the change to your entire PHI, including information obtained prior to the change.
- Post notice of any changes to our Privacy Policy in the lobby, or on our practice website (if any), and make a copy available to you upon request.
- Notify affected individuals following a breach of unsecured PHI.
- Use or disclose your PHI only with your authorization except as described in this notice.
- Follow the more stringent law in any circumstance where other state or federal law may further restrict the disclosure of your PHI.

FOR MORE INFORMATION OR TO REPORT A PROBLEM, CONTACT THE PRIVACY OFFICER AT:

California Advanced Pain & Spine Specialists
7152 North Sharon, Suite 102
Fresno, California 93720
Telephone: 559.432.6807

If you feel your rights have been violated, you may file a complaint in writing with the Privacy Officer. If you are not satisfied with the resolution of the complaint, you may also file a complaint with the Office of Civil Rights either writing to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ Filing a complaint will not result in retaliation.

We may use or disclose your PHI for treatment, payment and operations, and for purposes described below:

TREATMENT

We will use and exchange information obtained by a physician, nurse practitioner, nurse or other medical professionals, staff, trainees and volunteers in our office to determine your best course of treatment. The information obtained from you or from other providers will become part of your medical records. We may also disclose your PHI to other outside treating medical professionals and staff as deemed necessary for your care. For example, we may disclose your PHI to an outside physician for referral. We will also provide your health care providers with copies of various reports to assist them in your treatment. If you are an athlete, and wish to have your trainer or coach notified, we may disclose PHI to athletic trainers and coaches pertaining to medical conditions that may restrict your ability to compete.

PAYMENT

We may use and disclose protected health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as that portion of your PHI necessary to obtain payment

HEALTH CARE OPERATIONS

Members of the medical staff, trainees, medical students, a Risk or Quality Improvement team, or similar personnel may use your information to assess the care and outcomes of your care in an effort to improve the quality of the healthcare and service we provide or for educational purposes. For example, an internal review team may review your medical records to determine the appropriateness of care. There may also be times in which our accountants, auditors, health information specialists or attorneys may review your PHI to meet their responsibilities.

OTHER USES AND DISCLOSURES NOT REQUIRING AUTHORIZATION

- Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.
- Notification: We may disclose limited health information to friends or family members identified by you as being involved in your care or assisting you in payment. We may also notify a family member, or another person responsible for your care, about your location and general condition.
- Legally Required Disclosures & Public Health: We may disclose PHI as required by law, or in a variety of circumstances authorized by federal or state law. For example, we may disclose PHI to government officials to avert a serious threat to health or safety or for public health purposes, such as to prevent or control communicable disease (which may include notifying individuals that may have been exposed to the disease, although in such circumstances you will not be personally identified), federal or state health oversight agencies, child abuse or neglect, domestic violence, to an employer to evaluate work related injuries, and to public officials to report births and deaths.
- Law Enforcement & Subpoenas: We may disclose PHI to law enforcement such as limited information for identification and locations purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.
- Information Regarding Decendents: We may disclose health information regarding a deceased person to: 1) coroners and medical examiners to identify cause of death or other duties 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donation.
- Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
- Marketing & Funding Raising: We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort, unless you instruct us not to.
- Directory Information: We may disclose limited information regarding your name and location for directory purposes to those persons who ask for you by name or to members of the clergy. You may request that we not include your name in the directory.

DISCLOSURES REQUIRING AUTHORIZATION

The release of health information, other than those identified above, will be made with written authorization from the patient, which you have the right to revoke at any time, except to the extent we have already relied upon the authorization or in the event of an emergency.

CALIFORNIA ADVANCED
PAIN & SPINE SPECIALISTS
ROBERT G. SALAZAR, M.D. ALIREZA ABDOLLAHI-FARD, M.D.

ACKNOWLEDGMENT OF RECEIPT

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below.

I acknowledge that I have received and/or been offered this **Notice of Privacy Practices** with an effective date of _____ , and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Print Name	Date of Birth	Signature	Date

Please indicate how you prefer to be contacted by providing one of the following
☐By phone (_____)_____ ☐By mail (Mail to mailing address provided on Demographic form)

For Office Use Only

Signed Acknowledgment of Receipt received on: _____

Notice of Privacy Practices sent/delivered on: _____

Patient Refused or Failed to Acknowledge Receipt on: _____

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AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____ Date of birth: ____/____/____

USE AND DISCLOSURE OF HEALTH INFORMATION

I, _____ hereby authorize **Surescripts** to release the following information:
(Name of patient)

Current medication history, including both my prior medication history, discontinued medications and my future medication which may be prescribed until this consent is revoked. In order to verify current medications and drug interactions without limitations
To: **California Advanced Pain & Spine Specialists at 7152 N. Sharon Avenue, Suite 102, Fresno, California 93720.**

Furthermore, I hereby authorize **California Advanced Pain & Spine Specialists** to release the following health information:

a. ☐ Financial and billing information.
b. ☐ Verbal communication regarding appointment times.
c. ☐ Prescription refill requests, including picking up prescriptions.
d. ☐ All of the above

TO: ☐ Caregiver ☐ Spouse ☐ Other, Relationship: _____ Name: _____

Purpose of requested use or disclosure regarding (a) (b) (c) or (d): ☐Patient request

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EXPIRATION: three years after the date of the signature.

MY RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to the following address: *7152 N. Sharon Avenue, Suite 102, Fresno, California 93720.*

My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

- I have a right to receive a copy of this authorization.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

SIGNATURE

Signature:_____ Date: _____Time: _____am/pm

Signed by: ☐ patient ☐ legal representative

If signed by someone other than the patient, state your legal relationship to the patient and provide the appropriate documentation.

Print name: _____ Relationship: _____

Staff's Initials: _____

Beck's Anxiety Inventory

INSTRUCTIONS: Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by checking the box in the corresponding space in the column next to each symptom.

	Not at All	Mildly but it didn't bother me much.	Moderately It wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	☐ 0	☐ 1	☐ 2	☐ 3
Feeling hot	☐ 0	☐ 1	☐ 2	☐ 3
Wobbliness in legs	☐ 0	☐ 1	☐ 2	☐ 3
Unable to relax	☐ 0	☐ 1	☐ 2	☐ 3
Fear of worst happening	☐ 0	☐ 1	☐ 2	☐ 3
Dizzy or lightheaded	☐ 0	☐ 1	☐ 2	☐ 3
Heart pounding/racing	☐ 0	☐ 1	☐ 2	☐ 3
Unsteady	☐ 0	☐ 1	☐ 2	☐ 3
Terrified or afraid	☐ 0	☐ 1	☐ 2	☐ 3
Nervous	☐ 0	☐ 1	☐ 2	☐ 3
Feeling of choking	☐ 0	☐ 1	☐ 2	☐ 3
Hands trembling	☐ 0	☐ 1	☐ 2	☐ 3
Shaky / unsteady	☐ 0	☐ 1	☐ 2	☐ 3
Fear of losing control	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty in breathing	☐ 0	☐ 1	☐ 2	☐ 3
Fear of dying	☐ 0	☐ 1	☐ 2	☐ 3
Scared	☐ 0	☐ 1	☐ 2	☐ 3
Indigestion	☐ 0	☐ 1	☐ 2	☐ 3
Faint / lightheaded	☐ 0	☐ 1	☐ 2	☐ 3
Face flushed	☐ 0	☐ 1	☐ 2	☐ 3
Hot/cold sweats	☐ 0	☐ 1	☐ 2	☐ 3
Column Sum				

Beck's Depression Inventory

Please check one box for each question listed below

1
- 0 ☐I do not feel sad.
- 1 ☐I feel sad.
- 2 ☐I am sad all the time and I can't snap out of it.
- 3 ☐I am so sad and unhappy that I can't stand it.

2
- 0 ☐I am not particularly discouraged about the future.
- 1 ☐I feel discouraged about the future.
- 2 ☐I feel I have nothing to look forward to.
- 3 ☐I feel the future is hopeless and that things cannot improve.

3
- 0 ☐ I do not feel like a failure.
- 1 ☐I feel I have failed more than the average person.
- 2 ☐As I look back on my life, all I can see is a lot of failures.
- 3 ☐I feel I am a complete failure as a person.

4
- 0 ☐I get as much satisfaction out of things as I used to.
- 1 ☐I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 ☐I am dissatisfied or bored with everything.

Print Name:

Today's Date:

5	0	☐I don't feel particularly guilty
	1	☐I feel guilty a good part of the time.
	2	☐I feel quite guilty most of the time.
	3	☐I feel guilty all of the time.
6	0	☐I don't feel I am being punished.
	1	☐I feel I may be punished.
	2	☐I expect to be punished.
	3	☐I feel I am being punished.
7	0	☐I don't feel disappointed in myself.
	1	☐I am disappointed in myself.
	2	☐I am disgusted with myself.
	3	☐I hate myself.
8	0	☐I don't feel I am any worse than anybody else.
	1	☐I am critical of myself for my weaknesses or mistakes.
	2	☐I blame myself all the time for my faults.
	3	☐I blame myself for everything bad that happens.
9	0	☐I don't have any thoughts of killing myself.
	1	☐I have thoughts of killing myself, but I would not carry them out.
	2	☐I would like to kill myself.
	3	☐I would kill myself if I had the chance.
10	0	☐I don't cry any more than usual.
	1	☐I cry more now than I used to.
	2	☐I cry all the time now.
	3	☐I used to be able to cry, but now I can't cry even though I want to.
11	0	☐I am no more irritated by things than I ever was.
	1	☐I am slightly more irritated now than usual.
	2	☐I am quite annoyed or irritated a good deal of the time.
	3	☐I feel irritated all the time.
12	0	☐I have not lost interest in other people.
	1	☐I am less interested in other people than I used to be.
	2	☐I have lost most of my interest in other people.
	3	☐I have lost all of my interest in other people.
13	0	☐I make decisions about as well as I ever could.
	1	☐I put off making decisions more than I used to.
	2	☐I have greater difficulty in making decisions more than I used to.
	3	☐I can't make decisions at all anymore.
14	0	☐I don't feel that I look any worse than I used to.
	1	☐I am worried that I am looking old or unattractive.
	2	☐I feel there are permanent changes in my appearance that make me look unattractive
	3	☐I believe that I look ugly.
15	0	☐I can work about as well as before.
	1	☐It takes an extra effort to get started at doing something.
	2	☐I have to push myself very hard to do anything.
	3	☐I can't do any work at all.
16	0	☐I can sleep as well as usual.
	1	☐I don't sleep as well as I used to.
	2	☐I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
	3	☐I wake up several hours earlier than I used to and cannot get back to sleep.
17	0	☐I don't get more tired than usual.
	1	☐I get tired more easily than I used to.
	2	☐I get tired from doing almost anything.
	3	☐I am too tired to do anything.
18	0	☐My appetite is no worse than usual.
	1	☐My appetite is not as good as it used to be.
	2	☐My appetite is much worse now.
	3	☐I have no appetite at all anymore.
19	0	☐I haven't lost much weight, if any, lately.
	1	☐I have lost more than five pounds.
	2	☐I have lost more than ten pounds.
	3	☐I have lost more than fifteen pounds.
20	0	☐I am no more worried about my health than usual.
	1	☐ I am worried about physical problems like aches, pains, upset stomach, or constipation.
	2	☐ I am very worried about physical problems and it's hard to think of much else.
	3	☐ I am so worried about my physical problems that I cannot think of anything else
21	0	☐I have not noticed any recent change in my interest in sex.
	1	☐ I am less interested in sex than I used to be.
	2	☐ I have almost no interest in sex.
	3	☐ I have lost interest in sex completely.

OSWESTRY DISABILITY QUESTIONNAIRE

Instructions: this questionnaire has been designed to give us information as to how your pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE box which applies to you at this time. Only mark the one box which most closely describes your current condition.

1. On average, what is your pain level from zero to ten?

□1 □2 □3 □4 □5 □6 □7 □8 □9 □10

2. PAIN INTENSITY

0 ☐ I can tolerate the pain I have without having to use pain killers
1 ☐ The pain is bad but I manage without taking pain killers
2 ☐ Pain killers give complete relief from pain
3 ☐ Pain killers give moderate relief from pain
4 ☐ Pain killers give very little relief from pain
5 ☐ Pain killers have no effect on the pain and I do not use them

3. PERSONAL CARE (e.g. Washing, Dressing)

0 ☐ I can look after myself normally without causing extra pain
1 ☐ I can look after myself normally, but it causes extra pain
2 ☐ It is painful to look after myself and I am slow and careful
3 ☐ I need some help but manage most of my personal care
4 ☐ I need help every day in most aspects of self-care
5 ☐ I stay in bed all day

4. LIFTING

0 ☐ I can lift heavy weights without extra pain
1 ☐ I can lift heavy weights, but it gives extra pain
2 ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table
3 ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
4 ☐ I can lift very light weights
5 ☐I cannot lift or carry anything at all

5. WALKING

0 ☐ Pain does not prevent me walking any distance
1 ☐ Pain prevents me walking more than one mile
2 ☐ Pain prevents me walking more than ½ mile
3 ☐ Pain prevents me walking more than ¼ mile
4 ☐ I can only walk using a stick or crutches
5 ☐ I am in bed most of the time and have to crawl to the toilet

6. SITTING

0 ☐ I can sit in any chair as long as I like
1 ☐ I can only sit in my favorite chair as long as I like
2 ☐ Pain prevents me from sitting more than one hour
3 ☐ Pain prevents me from sitting more than ½ hour
4 ☐ Pain prevents me from sitting more than 10 minutes
5 ☐ Pain prevents me from sitting at all

7. STANDING

0 ☐ I can stand as long as I want without extra pain
1 ☐ I can stand as long as I want but it gives me extra pain
2 ☐ Pain prevents me from standing for more than one hour
3 ☐ Pain prevents me from standing for more than 30 minutes
4 ☐ Pain prevents me from standing for more than 10 minutes
5 ☐ Pain prevents me from standing at all

8. SLEEPING

0 ☐ Pain does not prevent me from sleeping well
1 ☐ I can sleep well only by using medication
2 ☐ Even when I take medication, I have less than 6 hrs sleep
3 ☐ Even when I take medication, I have less than 4 hrs sleep
4 ☐ Even when I take medication, I have less than 2 hrs sleep
5 ☐ Pain prevents me from sleeping at all

9. SOCIAL LIFE

0 ☐ My social life is normal and gives me no extra pain
1 ☐ My social life is normal but increases the degree of pain
2 ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. dancing, etc.
3 ☐ Pain has restricted my social life and I do not go out as often
4 ☐ Pain has restricted my social life to my home
5 ☐ I have no social life because of pain

10. TRAVELLING

0 ☐ I can travel anywhere without extra pain
1 ☐ I can travel anywhere but it gives me extra pain
2 ☐ Pain is bad, but I manage journeys over 2 hours
3 ☐ Pain restricts me to journeys of less than 1 hour
4 ☐ Pain restricts me to short necessary journeys under 30 minutes
5 ☐ Pain prevents me from traveling except to the doctor or hospital

11. EMPLOYMENT/ HOMEMAKING

0 ☐ My normal homemaking/ job activities do not cause pain.
1 ☐ My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
2 ☐ I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting, vacuuming)
3 ☐ Pain prevents me from doing anything but light duties.
4 ☐ Pain prevents me from doing even light duties.
5 ☐ Pain prevents me from performing any job or homemaking chores.

Print Name:

Today's Date:

CALIFORNIA ADVANCED
PAIN & SPINE SPECIALISTS
ROBERT G. SALAZAR, M.D. ALIREZA ABDOLLAHI-FARD, M.D.

Opioid Risk Tool (ORT)

Patient Form

Name:_____ Date of Birth:_____ Date:_____

Please answer the questions below using the following scale:

0= Never 1= Seldom 2= Sometimes 3= Often 4= Very Often

1. How often do you have mood swings?	☐0	☐1	☐2	☐3	☐4
2. How often do you smoke a cigarette within an hour after you wake up?	☐0	☐1	☐2	☐3	☐4
3. How often have you taken medication other than the way that is was prescribed?	☐0	☐1	☐2	☐3	☐4
4. How often have you used illegal drugs (for example marijuana, cocaine, etc.) in the past five years?	☐0	☐1	☐2	☐3	☐4
5. How often, in your lifetime, have you had legal problems or been arrested?	☐0	☐1	☐2	☐3	☐4

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How do you describe your pain? Please check the following:

☐Throbbing ☐Shooting ☐Sharp ☐Cramping ☐Gnawing Burning

☐Punishing- Cruel ☐ Aching ☐Heavy ☐Tender ☐Splitting

☐Tiring ☐Sickening

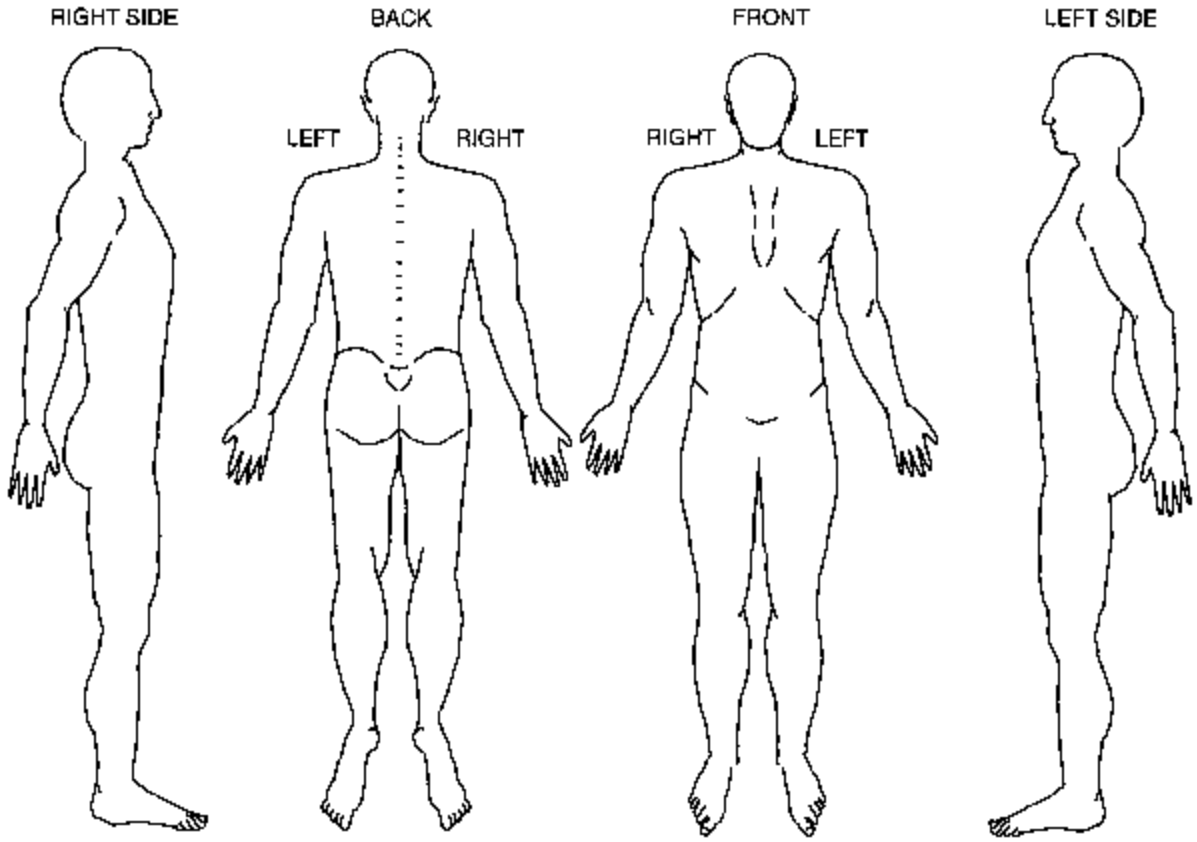
Intensity of Pain

☐ Mild ☐ Moderate ☐ Severe

Frequency of Pain:

☐Occasional 25 % ☐Intermittent 50 % ☐Frequently 75 % ☐Constant 100 %

Please circle the areas that you experience pain



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PAIN & SPINE SPECIALISTS
ROBERT G. SALAZAR, M.D. ALIREZA ABDOLLAHI-FARD, M.D.

Review of Medical History

Name: _____ Date of Birth: _____ Date: _____

Please check all that apply

RESPIRATORY

☐ ASTHMA ☐ PNEUMONIA ☐ CHRONIC COUGH ☐ SMOKER
☐ EMPHYSEMA ☐ WHEEZING ☐ VALLEY FEVER ☐ COPD

CARDIOVASCULAR

☐ HIGH BLOOD PRESSURE ☐ IRREGULAR HEARTBEAT ☐ HEART ATTACK ☐ CHEST PAIN
☐ ANGINA ☐ BLOOD CLOTS ☐ CHF ☐ HEART MURMUR
☐ RHEUMATIC FEVER ☐ STENTS

METABOLIC/ENDOCRINE

☐ DIABETES ☐ THYROID DISORDER ☐ KIDNEY PROBLEMS

IMMUNE SYSTEM

☐ RECENT STEROIDS ☐ CANCER ☐LEUKEMIA ☐ CHEMOTHERAPY
☐ RADIATION THERAPY ☐ UNEXPLAINED WEIGHT LOSS ☐ NIGHT SWEATS ☐ LYMPHOMA

HEMA/HEPTIC/GI

☐ FREQUENT HEART BURN ☐ BLEEDING DISORDER ☐ HEPATITIS/JAUNDICE
☐ DIFFICULTY SWALLOWING ☐ COLON PROBLEM ☐ HIATAL HERNIA
☐ STOMACH PROBLEMS ☐ ANEMIA

MUSCULOSKELETAL/NEURO

☐ HEADACHE/MIGRAINE ☐ BLACKOUTS/FAINTING ☐ LIMITED JOINT MOVEMENT
☐ NERVE/MUSCLE PROBLEMS ☐ BACK INJURY PAIN ☐ SEIZURE
☐ MENTAL HEALTH ☐ NUMBNESS ☐ STROKE

Is your pain a result of an injury? ☐No ☐Yes If yes, enter DATE OF INJURY _____

ANESTHESIA/SURGERY HISTORY

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Our Address:
CALIFORNIA ADVANCED PAIN & SPINE SPECIALISTS
7152 N. Sharon, Suite 102
Fresno, California 93720

CALIFORNIA ADVANCED
PAIN & SPINE SPECIALISTS
ROBERT G. SALAZAR, M.D. ALIREZA ABDOLLAHI-FARD, M.D.

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Printed Name	Date
Signature of Parent/Guardian	Date

Please print your email address:

☐@gmail.com ☐@outlook.com ☐@yahoo.com ☐@aol.com ☐@comcast.net ☐@att.net

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Signature	Date
Printed Name	Date
Signature of Parent/Guardian	Date

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