PAIN ASSESSMENT QUESTIONNAIRE

Please take a few minutes to fill out this medical intake to facilitate your appointment today.

Reason for your visit today: ____________________________________________________________

Please use the diagram below to describe the location of your pain.

Please check all that apply to describe your pain

- Aching  ○ Constant  ○ Numbing  ○ Burning  ○ Sharp  ○ Stinging  ○ Stabbing  ○ Tingling
- Dull  ○ Cramping  ○ Radiating  ○ Hot to Touch  ○ Other: ________________________________
When did you first have this pain?

Is the pain constant?  YES  NO  How long does the pain last? ________________________________

Please select the appropriate choice to describe the amount of your daily average pain on a scale of 0-10.

<table>
<thead>
<tr>
<th></th>
<th>0 (no pain)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 (worst pain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please rate your pain without pain medication on a scale from 0 to 10

<table>
<thead>
<tr>
<th></th>
<th>0 (no pain)</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10 (worst pain)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is your pain the result of an accident  illness  unsure  N/A

If yes, please describe: ____________________________________________

If accident, is there litigation involved?  YES  NO  If yes, please provide your case worker and contact information:

Contact number: __________________________

Have your tried Physical Therapy?  YES  NO  When? ______________  For how long? ______________

Did this help?  YES  NO

Have you been treated by a Pain Specialist in the past?  YES  NO

When? ________________________ By who? ________________________

Previous Treatments

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Area of body</th>
<th>Date</th>
<th>Relief?</th>
<th>If yes, how much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidural Injections</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Joint Injections</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Muscle Injections</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nerve Blocks</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Radiofrequency Ablations</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stimulator Trial</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Stimulator Implant</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Botox</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
**MEDICAL HISTORY QUESTIONNAIRE**

Dear New Pain Management Patient,

Welcome to INTEGRATED PAIN ASSOCIATES. Please take a few moments to carefully and completely fill out the following questions regarding your pain history and medical history. Accurate completion of this form is important, so please ask the receptionist or the nurse if you have any questions. When choices are given, mark the answer that is most correct. At INTEGRATED PAIN ASSOCIATES, your time is important to us. We greatly appreciate your arriving on time and will always do our best to stay on schedule. Occasionally, we do get behind schedule because of emergencies or because prior patients have required more time for their appointment than we had anticipated. In the event that this happens, please be assured that you will be seen as soon as possible and always in the order which you were scheduled.

**Your Medical History**

Are you currently experiencing any of the following issues below?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Issue</th>
<th>Yes</th>
<th>No</th>
<th>Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Chills</td>
<td>Yes</td>
<td>No</td>
<td>Hallucinations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Night sweats</td>
<td>Yes</td>
<td>No</td>
<td>Pain with urination</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fever</td>
<td>Yes</td>
<td>No</td>
<td>Difficulty controlling urine</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visual changes</td>
<td>Yes</td>
<td>No</td>
<td>Erectile dysfunction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Constipation</td>
<td>Yes</td>
<td>No</td>
<td>Swelling</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nausea</td>
<td>Yes</td>
<td>No</td>
<td>Stiffness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Vomiting</td>
<td>Yes</td>
<td>No</td>
<td>Joint pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decrease in sex drive</td>
<td>Yes</td>
<td>No</td>
<td>Loss of body hair</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest pains</td>
<td>Yes</td>
<td>No</td>
<td>Memory loss</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Headaches</td>
<td>Yes</td>
<td>No</td>
<td>Numbness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shortness of breath</td>
<td>Yes</td>
<td>No</td>
<td>Bleeding disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sores</td>
<td>Yes</td>
<td>No</td>
<td>Rash</td>
</tr>
</tbody>
</table>

Have you ever been diagnosed with the following condition?

- AIDS
- Asthma
- Cancer
- Diabetes
- Emphysema
- Epilepsy
- Fibromyalgia
- Stroke
- HIV Positive
- Heart Disease
- Hepatitis (A, B, C, D)
- High Blood Pressure
- Kidney Disease
- Lupus
- Migraines
- Osteoarthritis
- Peripheral Vascular Disease
- Shingles
- Arthritis

Are you currently pregnant?  ○ YES  ○ NO  If yes, how far along? _________________________

**Sleep Behavior**

Have you ever been evaluated for sleep apnea with a sleep study?  ○ YES  ○ NO

Were you diagnosed with sleep apnea?  ○ YES  ○ NO

If yes, are you currently using a CPAP machine or BiPAP machine?  ○ YES  ○ NO
Surgical History

Do you currently have an implanted ICD, Pacemaker, defibrillator or any surgical steel?  ○ YES  ○ NO

If yes, please provide a copy for our staff to update your medical record.

Please list prior surgeries or procedures you have completed in the past 5 years.

<table>
<thead>
<tr>
<th>Date</th>
<th>Surgery/procedure</th>
<th>Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list the diagnostic tests you have received. Please include the approximate date and location in which the testing was performed in the past 5 years.

<table>
<thead>
<tr>
<th>Diagnostic test</th>
<th>Area of body</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-RAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-RAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-RAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI SCAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI SCAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI SCAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT SCAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT SCAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT SCAN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMG</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Psychological History

Have you ever been diagnosed with or received treatment/evaluation for any of the following diagnosis/problems?

- Alzheimer’s
- Anxiety
- Bipolar Disease
- Dementia
- Depression
- Multiple Personality Disorder
- Schizophrenia
- Other: _______________
Social History
Do you have a history of Drug use, addiction or abuse? □ YES □ NO
If yes, explain______________________________________________________________

Have you ever used any drugs that are illegal in Texas? (Cocaine, marijuana, ect)?
□ YES, in the past □ NO, never □ In the past, when? ____________________________

Have you ever been treated for addiction or alcoholism?
□ YES, in the past □ NO, never □ In the past, when? ____________________________

Do you have a history of alcohol abuse or addiction? □ YES □ NO

Do you currently drink alcohol? □ YES □ NO
If yes what kind, how much and how often?

Do you use tobacco? □ YES □ NO □ Smokeless □ tobacco □ Cigar □ Cigarettes □ Dip

If you smoke cigarettes, how many packs per day?
□ Less than □ 1 □ 1 □ 2 □ 3 □ More than 3 packs

Have you ever had an issue with prescription medications (misuse, abuse, addiction, ect)?
□ YES, in the past □ NO, never □ In the past, when? ____________________________

Lifestyle
Marital Status
□ Single □ Married □ Divorced □ Widowed Separated

Current living situation
□ Alone □ Spouse □ With Family □ Friend □ Long Term/ Assisted Living Facility

Employment Status
□ Currently Employed □ Retired □ Disabled □ Unemployed
If currently working what type of work: _________________________________________
□ Full time □ Part time

Weight Questionnaire
Have you had a recent weight □ loss □ Gain? □ No □ Yes
If yes, how much? ____________ Time frame? _______________________________
Current Medications
Please list ALL pain related medications that you are currently taking or provide our office with a current list.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Strength</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Integrated Pain Associates would like to access your pharmacy records and drug formulary information through a third party database. This service provides IPA with accurate information from other prescribing physicians and will allow our system to check which medications are on your drug formulary.

I authorize Integrated Pain Associates access to my prescription history through my pharmacy or access through certain third party databases.

Patient Signature: ______________________________________  Date: ____________________

Medication Allergies and Side Effects
Please list ALL medication allergies or side effects that you have experienced.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Reaction /Side Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you allergic to Latex?  YES  NO
Are you allergic to Iodine?  YES  NO
Pain Medication History
Please mark all medications that you have tried in the past.

<table>
<thead>
<tr>
<th>Opioid Medications</th>
<th>Duration of Use</th>
<th>Relief?</th>
<th>If no, please explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baclofen</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Buspar</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Butrans Patch</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Celebrex</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Codeine</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cymbalta</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diclofenac</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dilaudid</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Embeda</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Fentanyl Patches</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Flector Patch</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Flexeril</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Gabapentin</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Imitrex</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Keppra</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Lyrica</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Maxalt</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Methadone</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mobic</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Morphine</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Motrin</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Naproxen</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nucynta</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Opana</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Oxycontin</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Oxycodeine</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Robaxin</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Soma</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tramadol</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tylenol</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zanaflex</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Zohydro</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Family History
Do any of your family members have a history of or are currently suffering from any of the following medical conditions.

<table>
<thead>
<tr>
<th>Medical Condition</th>
<th>Suffering?</th>
<th>Who?</th>
<th>Side of the family?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addiction/substance abuse</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Cancer</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Chronic Pain</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Depression</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Stroke</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
<tr>
<td>Other:</td>
<td>Yes</td>
<td>No</td>
<td>Paternal</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Maternal</td>
</tr>
</tbody>
</table>

Treatment Goals
We are dedicated to helping you improve your quality of life. Please list your personal pain goals that you would like to achieve.

Examples: Biking, Dancing, Hiking, ect
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
PAIN MANAGEMENT SPECIALISTS
Opioid Risk Tool (ORT)

<table>
<thead>
<tr>
<th>MARK EACH BOX THAT APPLIES</th>
<th>FEMALE</th>
<th>MALE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FAMILY HISTORY OF SUBSTANCE ABUSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALCOHOL</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>ILLEGAL DRUGS</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>PRESCRIPTIONS DRUGS</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>PERSONAL HISTORY OF SUBSTANCE ABUSE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALCOHOL</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>ILLEGAL DRUGS</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>PRESCRIPTIONS DRUGS</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td><strong>AGE BETWEEN 16 AND 45 YEARS</strong></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>HISTORY OF PREADOLESCENT SEXUAL ABUSE</strong></td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td><strong>PSYCHOLOGICAL DISEASE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADD, OCD, BIPOLAR, SCHIZOPHRENIA</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>DEPRESSION</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

**SCORING TOTALS**

**SCORING (RISK)**

0-3 = LOW  4-7 = MODERATE  >8 = HIGH