INTERVENTIONAL PAIN SPECIALISTS, L.L.C.

A Professional Medical Corporation

1101 South College Rd.
Suite 200
Lafayette, LA 70503
Phone: 337.362.8101
Fax : 337.761.1616

OGHS - South Campus
3983 I-49 S. Service Road
Opelousas, LA 70570
Phone : 337-284-3200
Fax : 800-207-6956

Welcome to Interventional Pain Specialists, L.L.C.

Here at IPS, we know that pain is an experience that is only truly understood by the person experiencing it. Many patients find themselves isolated and depressed because of their pain. We understand that pain can interfere with all aspects of a person's daily life and we want to help you gain control over your life once again. We believe a person's pain is unique and a plan of care must be tailored to that specific individual.

The goal of our clinic here at IPS is to safely help a patient eliminate or reduce their pain while improving both their function and activity levels. We use many different types of therapy to accomplish these goals, including interventional procedures, diagnostic testing, medication, physical medicine, psychological evaluations, etc. Your initial visit is for evaluation purposes only. Our physician will do a thorough exam and review your health information to determine a plan of care specifically tailored to you.

Please read and complete all paperwork included in this packet and bring it with you to your appointment. It is very important that you read and understand all of the information included. Included in this packet are: initial health assessment questionnaire, narcotic contract, billing and financial policy, consent for treatment, demographics sheet (patient information sheet) and authorization for release of medical records. Please complete all of the information included in this packet. If you have any questions regarding these forms, please contact the clinic. Please bring a **CD** with a copy of your most recent MRI or CT scan to your appointment. (This is not necessary if you had the scans done at Opelousas General Hospital or Sunset Imaging Center.)

****If you have been referred for pain management and are accepted into our pain management program, make sure you carefully read the narcotic contract prior to signing it. You will be held accountable for all items included in the contract. Failure to comply will result in you being terminated as a pain management patient.**

We look forward to helping you to regain control of your life by helping you to gain control over your pain.

Sincerely,

Interventional Pain Specialists, L.L.C.

INTERVENTIONAL PAIN SPECIALISTS, LLC

Date: _____
Acct #: _____
Guar Acct #: _____

Attached: ❑ Hospice/HHA/NH/SNF Facility Info Form
❑ Accident/Injury Information Form
❑ ABN Form

PATIENT INFORMATION

Patient: _____ (Last First Middle) Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____

Mailing Address: _____ Zip _____ City _____ State _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____ Other: _____

Email: _____ Date of Birth: _____

Social Security #: _____ Sex: Male or Female (circle one)

Marital Status: Married Single Widowed Divorced (circle one) Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ Caucasian ☐ African American ☐ Other: _____ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Current Employer: _____ Employment Status: Fulltime Self Employed Part Time (circle one) Not Employed Unknown Retired Military Active

Student: Full Time or Part Time (circle one) Prior Name: _____

Emergency Contact (EC) Name: _____ Relationship: _____

Home #: _____ Work #: _____ Cell #: _____

Pharmacy: _____ Address: _____ Phone#: _____

Notification Method: Mail Email Phone (circle one) Patient & Resp Party are the same? Yes or No (circle one)

Blood Type: _____ Referred By: _____

Do you have an advanced directive (living will, durable power of attorney)? Yes or No If 'Yes', provide copy: Rec'd by: _____ Date: _____

Are you or have you been incarcerated within the last year? Yes or No → If 'Yes' please provide Facility Name: _____ Release Date: _____

Is this an Accident or Injury? Yes or No Work Related? Yes or No If 'Yes' to either question, request and complete an Accident/Injury Information Form

Are you currently a Hospice or Home Health Care patient or are you in a Nursing Home or Skilled Nursing Facility? Yes or No
If 'Yes', request a Hospice/HHA/NH/SNF Facility Information Form and ask about an ABN Form.

RESPONSIBLE PARTY INFORMATION

IF OTHER THAN PATIENT, SEND STATEMENT/BILL TO:

Responsible Party: _____ (Employer Info if work related) (Last First Middle) Title: Mr./Mrs./Other: _____ Suffix: Jr./Sr./Other: _____

Mailing Address: _____ Zip _____ City _____ State _____

Home #: _____ Work #: _____ Ext: _____ Cell #: _____ Other: _____

Email: _____ Date of Birth: _____

Social Security #: _____ Sex: Male or Female (circle one) Relationship to Patient: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____ Employment Status: Fulltime Self Employed Part Time (circle one) Not Employed Unknown Retired Military Active

Current Employer: _____

INSURANCE INFORMATION

Scan/Copy Card

PRIMARY:

Relationship to Insured: Self Child Mate Other (circle one)
Insured: Patient Rsp Party Other
Insured Name: _____
Social Security #: _____ DOB: _____
Group #: _____ Policy#: _____
Eff Date: _____ Exp Date: _____
Contact: _____
Phone: _____
PCP (Name/Phone): _____

SECONDARY:

Relationship to Insured: Self Child Mate Other (circle one)
Insured: Patient Rsp Party Other
Insured Name: _____
Social Security #: _____ DOB: _____
Group #: _____ Policy#: _____
Eff Date: _____ Exp Date: _____
Contact: _____
Phone: _____
PCP (Name/Phone): _____

By signing this, I hereby acknowledge Interventional Pain Specialists, LLC (PRACTICE) has the right to use and disclose protected health information (PHI) for treatment, payment and health care operations, and that I have received the *Notice of Privacy Practices for Protected Health Information (NOPP).* I understand I have the right to restrict how protected health information is used or disclosed, and that the PRACTICE is not required to agree to any restriction, but if an agreement is reached, the PRACTICE is bound by the agreement.

_____ Signature
Patient/Responsible Party (circle one)

_____ Date

I hereby authorize Interventional Pain Specialists, LLC to evaluate and recommend any testing and/or additional treatment. _____ Initial _____ Date

I understand I have the right to refuse any such recommendations/treatment. _____ Initial _____ Date

I understand that charges **not covered** by Medicare, Medicaid or Managed Care will be the patient's responsibility. I verify this information is true and accurate as of the below indicated date. I hereby authorize the attached insurance companies to pay directly to Interventional Pain Specialists, LLC benefits due on my behalf, if any, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance.

_____ Signature
Patient/Responsible Party (circle one)

_____ Date

INTERVENTIONAL PAIN SPECIALISTS, L.L.C.
A Professional Medical Corporation

Mailing Address:
P.O. Drawer 69
Opelousas, LA 70571
Phone: 337.362.8101

1101 S. College Rd. Ste 200
Lafayette, LA 70503
Fax: 337.761.1616

CONSENT FOR TREATMENT

1. **GENERAL CONSENT FOR TREATMENT AND TESTS**: I consent to treatment by Dr. Albert Gros and the staff of Interventional Pain Specialists, LLC for my illness and/or health evaluations, including but not limited to x-rays, blood tests, laboratory procedures, medications, and minor procedures. I acknowledge and agree that no guarantees have been made to me as to the results or outcome of my medical care. I also understand that the clinic premises are monitored by Closed Circuit Security Cameras and that these cameras may record images of me which may be classified as Personal Health Information (PHI). I give my consent to the use of the Closed Circuit Security Cameras. These cameras are in place in part to prevent the unauthorized removal of medicine dispensed for the health of our patients and to assist us in preserving the health and safety of all our patients, guests and staff. I also understand that state law requires physicians to report certain communicable diseases to the health department.

2. **RELEASE FROM LIABILITY FOR LEAVING AGAINST MEDICAL ADVICE**: I agree that if I leave a physician's office against the advice of my physicians, the physicians and personnel are released from responsibility or liability for any injuries or damages, which may result from my leaving against medical advice.

3. **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**: I authorize Interventional Pain Specialists, LLC to disclose and release my medical information (which may include alcohol/drug abuse, psychiatric, sickle cell anemia, AIDS and HIV test results) to each other and to any person or organization, which is or may be liable/responsible for payment of my bill, including Medicare intermediaries and fiscal agents.

4. **SERVICES AND TREATMENT POLICY**: We are pleased that your physician has requested a consultation/referral for you at Interventional Pain Specialists, LLC. Our goal is to provide you with a proper diagnosis and plan for the most effective treatment of your pain. We expect that you may have had previous attempts to treat your pain prior to your consultation with us. In many instances, the use of pain medication on a long term basis is appropriate. However, Interventional Pain Specialists, LLC is not obligated to prescribe narcotic drugs or provide any treatment procedures during your first consultation/visit with us. We firmly believe it is in your best interest to have a complete evaluation in order to determine the most effective method to reduce pain and restore function. Continuing a therapy that does not achieve these goals would defeat the purpose of a new evaluation. **Additionally, please do not terminate care with another physician because you have an appointment with Interventional Pain Specialists, LLC.** Based on the outcome of your evaluation, we may make recommendations to your current physician without arranging further follow up with Interventional Pain Specialists, LLC.

I HAVE READ AND UNDERSTOOD THIS ENTIRE DOCUMENT AND I AGREE TO ITS TERMS.

Patient name (printed)	Patient signature	Date

Witness

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Billing Statement and Financial Policy

Medical Services provided by Interventional Pain Specialists, LLC and the payment for those services are transactions between you and the clinic staff. Like any other business activity you are responsible for payment of services on the day those services are given. The cost of medical care is determined by the nature and complexity of the illness. There is no "flat rate" for examinations and treatment.

Insurance is a contract between you and your insurance company. As a service to you, the clinic makes every reasonable effort to obtain payment according to your coverage. Regardless of the type of insurance coverage you have, **you** are ultimately responsible for paying your medical bills. If your insurance company rejects the claim or delays payment, Interventional Pain Specialists, LLC will bill you after 30 days for those charges. That bill is due. Finance charges are applied to the account after 30 days for all accounts not paid in full. The finance charge by the Interventional Pain Specialists, LLC is 18% per year or 1.5% per month.

- **All co-pay's, deductibles and non-covered charges are due at the time of service. They will be collected prior to your being placed in an exam or procedure room. <u>You</u> are responsible for paying your portion of your bill on the day of service. For example, you may owe 20% or greater of your bill depending on your insurance policy.**

- **Payment in full for outstanding balances is required prior to the day of new services.**

<u>ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY</u>: In consideration of services rendered and to be rendered by Interventional Pain Specialists, LLC, I hereby guarantee payment for all charges incurred for the account of the patient below. I understand and agree that payment for such services shall be due at the time of service. I authorize and direct any person, firm, or corporation, including but not limited to insurance companies or attorneys representing the patient or any other party for such services, to assign proceeds of any payment for services rendered to said patient directly to Interventional Pain Specialists, LLC. Accepting assignment of said benefits, the provider does not relinquish the right to collect any balance not paid by any third party. I further agree that if such indebtedness is placed in the hands of a collector or attorney for collection, I will pay reasonable collection fees and attorney fees, interest, court costs and other collection expenses.

For your convenience, Interventional Pain Specialists, LLC offers you several payment options including cash, personal check, and/or credit cards including Visa, MasterCard, American Express and Discover. There is a 3% surcharge for all credit card payments.

****Missed appointments: Please note that if you are unable to make your schedule appointment, you must cancel at least 24 hours prior to the scheduled appointment time. If you fail to cancel your appointment within the 24 hour period, you will be charged a "no show" fee. Repeated "no show" and cancellations of your appointment may result in your being discharged from the care of** Interventional Pain Specialists, LLC.

<u>I HAVE READ AND UNDERSTOOD THIS ENTIRE DOCUMENT AND I AGREE TO ITS TERMS.</u>

Patient name (printed)	Patient signature	Date

Witness

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)		Date of Birth
ADDRESS	SSN	
CITY	STATE	ZIP

PERSONS TO RELEASE PHI INFORMATION TO:

INTERVENTIONAL PAIN SPECIALISTS, LLC **1101 S. College Road Ste 200** **Lafayette, LA 70503** **337-362-8101** **337-761-1616(FAX)**	PHYSICIANS ***Dr. Albert Gros, Jr.*** ATTENTION: ***Patient Care Coordinator***

This authorization will expire on the following date or event:
Date: **Event:**

Purpose of this Disclosure:

PHI AND DATES OF PHI AUTHORIZED FOR USE OF DISCLOSURE

Description	Start date	End Date
□ All PHI in the record		
□ Progress Notes		
□ Laboratory Tests		
□ X-ray Tests / Reports		
□ History and Physical Examination		
□ Discharge Summary		
□ Consultation Reports		
□ Itemized Billing Statement		
□ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

□ AIDS or HIV test results
□ Alcohol, drug or substance abuse treatment
□ Psychiatric or mental care / treatment
□ Other (specify):

I understand that:

1. I may refuse to sign this authorization and it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing to the provider authorized to release the protected health information, but if I do, it will not have any affect on any actions taken prior to receiving revocation.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
5. I have the right to receive a copy of this form after I sign it.

Signature of Patient:	**Date:**
Signature of Patient's Representative (if necessary)	**Date:**

Personal Representative's Relationship to Patient:

INTERVENTIONAL PAIN SPECIALISTS INITIAL HEALTH HISTORY

PLEASE FILL OUT ALL OF THE BELOW INFORMATION AS DETAILED AND AS ACCURATE AS POSSIBLE.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Drug Allergies: ☐None ☐Allergies: _____

_____

What is the name of the physician who sent you here? _____

Why did he/she send you here? _____

Chief Complaint: ☐PAIN ☐NUMBNESS ☐WEAKNESS

Location of pain:

Head – ☐R ☐L	Neck – ☐R ☐L	Shoulder – ☐R ☐L	Arm – ☐R ☐L
Hand – ☐R ☐L	Upper back – ☐R ☐L	Mid back – ☐R ☐L	Lower back – ☐R ☐L
Groin – ☐R ☐L	Hip – ☐R ☐L	Leg – ☐R ☐L	Foot – ☐R ☐L

Other: _____

Location of numbness:

Head – ☐R ☐L	Neck – ☐R ☐L	Shoulder – ☐R ☐L	Arm – ☐R ☐L
Hand – ☐R ☐L	Upper back – ☐R ☐L	Mid back – ☐R ☐L	Lower back – ☐R ☐L
Groin – ☐R ☐L	Hip – ☐R ☐L	Leg – ☐R ☐L	Foot – ☐R ☐L

Other: _____

Is this the result of some type of work or motor vehicle accident? ☐**YES** ☐ **NO**

If yes, what was the date of the injury? _____

Description of the accident/injury: _____

_____

_____

Is Worker's Compensation or an attorney involved in this case? YES NO

If yes, what is their name and contact information? _____

_____

Description of pain: ☐Aching ☐Sharp ☐Stabbing ☐Shocking ☐Squeezing
☐Tingling ☐Prickling ☐Numb ☐Burning ☐Other- _____

Severity of Pain (VAS): *(Please circle appropriate number)*

0 1 2 3 4 5 6 7 8 9 10
(None) (Moderate) (Severe)

How long have you been having this pain?

☐*0-3 months* ☐*3-6 months* ☐*6-12 months* ☐*1-2 years* ☐*Longer than 2 years*

Timing of Pain:

☐*Pain is constant* ☐*Pain comes and goes* ☐*Pain is worse in the morning*

☐*Pain is worse in the evening* ☐*Other:* _____

Pain is worsened by:

☐Lying ☐Sitting ☐Standing ☐Walking ☐Stairs ☐Changes in position

☐Bending ☐Other: _____

Pain is better with:

☐Rest ☐Lying ☐Standing ☐Bending forward ☐Changes in position

☐Pain medication ☐Other: _____

Related problems:

☐None ☐ Bowels ☐ Urinating ☐ Describe: _____

Previous treatment:

☐Physical therapy ☐Massage therapy ☐Chiropractic therapy ☐Traction therapy

☐Back brace ☐Muscle stimulator ☐Spinal cord stimulator ☐Medication

☐Epidural injections ☐Spine surgery Other: _____

Previous Spine surgery: ☐ Yes ☐ No

If yes to above, please list dates of spine surgery, type of surgery and surgeon: _____

_____

_____

Recent symptoms/problems:

☐Recent weight change: _____ ☐Fatigue ☐Weakness ☐Dizziness

☐Recent falling ☐Blurry vision ☐Fainting ☐Fever ☐Headaches

☐Hearing loss ☐Shortness of breath ☐Chest pain ☐Difficulty swallowing

☐Irregular heart rate ☐Constipation ☐Diarrhea ☐Frequent urination

☐Abdominal pain ☐Swelling ☐Skin rash ☐Cough

☐Other: _____

Sleep problems:

☐No problem with sleep ☐Difficulty falling asleep ☐Difficulty staying asleep

☐Restless sleep ☐Sleep Apnea ☐Sleep Medication helps

****Are you currently taking any blood thinners? ☐Yes ☐No**

If yes to above, name of blood thinner and doctor giving it: _____

Past Medical history: (Check all that apply)

☐Obesity ☐Sleep Apnea ☐Diabetes ☐High Blood Pressure

☐Heart Attack ☐Heart Disease ☐Vascular Disease ☐Arthritis

☐Fibromyalgia ☐Lupus ☐Hypothyroidism ☐Hyperthyroid

☐Cancer ☐Asthma ☐Seizures ☐Blood clots

☐Glaucoma ☐Reflux (GERD) ☐Hepatitis ☐Depression

☐Anxiety ☐COPD ☐Migraines ☐Stroke

Other: _____

Have you ever had any trouble with sedation or anesthesia? ☐ Yes ☐ No

If yes, please explain: _____

Family History: ☐Unremarkable ☐Depression ☐Anxiety ☐Addiction ☐Arthritis

Social History:

Do you smoke? ☐Yes ☐No
If yes to above – How much do you smoke a day? _____ For how many years? _____

Do you drink alcohol? ☐Yes ☐ No
If yes to above – How much do you drink?_____ For how many years? _____

Do you use recreational drugs? Yes No
If yes, please list: _____

Do you have a history of addiction? Yes No
Do you have a history of drug or alcohol abuse? Yes No
Does any member of your family have a problem with addiction or drug/alcohol abuse? Yes No
If you circled yes for any of the above, please explain: _____

_____

****Please list <u>all</u> medication you are currently taking (including all pain medication, regular medication, herbs, and over-the-counter medications:**

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all previous surgeries: _____

_____

_____

_____

*If you are a female, is there any chance you may be pregnant? ☐Yes ☐No ☐N/A
(Please note that x-ray equipment is in use during injections and procedures in the clinic.)

Height: ____feet____inches Weight: _____lbs

_____ _____
PATIENT SIGNATURE DATE

Medication Log

Please complete this list if you are on any medication. It is a very important part of your care. You will not be seen if this list is left blank. Thank you!

Name: ______________________________ Date: ______________

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Prescribed by:	Time: am/pm

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. We realize you may consider 2 of the statements in any section may relate to you, but please mark the box which most closely describes your current condition.

1 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

2 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 don't get dressed, I was with difficulty and stay in bed

3 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

4 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 1/2 mile
3 ☐ Pain prevents me walking more than 1/4 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

5 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 1/2 hour
4 ☐ Pain prevents me from sitting more than 10 minutes
5 ☐ Pain prevents me from sitting at all

6 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

7 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 hours sleep
3 ☐ Even when I take medication , I have less than 4 hours sleep
4 ☐ Even when I take medication, I have less than 2 hours sleep
5 ☐ Pain prevents me from sleeping at all

8 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

9 TRAVELING

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

10 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 stressfull 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

Patient Name:_____ Date of Visit:_____

PLEASE PRINT

Appendix

WellRx Questionnaire

DOB_____ Male___ Female ____

WellRx Questions

1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food?	
____ Yes	____ No
2. Are you homeless or worried that you might be in the future?	
____ Yes	____ No
3. Do you have trouble paying for your utilities (gas, electricity, phone)?	
____ Yes	____ No
4. Do you have trouble finding or paying for a ride?	
____ Yes	____ No
5. Do you need daycare, or better daycare, for your kids?	
____ Yes	____ No
6. Are you unemployed or without regular income?	
____ Yes	____ No
7. Do you need help finding a better job?	
____ Yes	____ No
8. Do you need help getting more education?	
____ Yes	____ No
9. Are you concerned about someone in your home using drugs or alcohol?	
____ Yes	____ No
10. Do you feel unsafe in your daily life?	
____ Yes	____ No
11. Is anyone in your home threatening or abusing you?	
____ Yes	____ No

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily