Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Office uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of 361 Wellness.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website at www.361wellness.com, calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

How Our Office May Use or Disclose Your Health Information

Following are examples of the types of uses and disclosures of your health care information that our Office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment. We may use and disclose your health information to provide you with medical treatment or services or to manage your health care and any related services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance to us with your health care diagnosis or treatment.

For Payment. Our Office may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. This may also include certain activities that your health insurance plan requires to be undertaken before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval

for a hospital stay may require that your relevant health information be disclosed to the health plan to obtain approval for the hospital admission.

For Healthcare Operations. We may use and disclose health information about you in order to support the business activities of our Office. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

evaluate the performance of our staff;
assess the quality of care and outcomes in your case and similar cases;
learn how to improve our facilities and services; and
determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments. Our Office may use your information to provide appointment reminders to you or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In addition, when you arrive at our Office, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician and/or your appointment time. We may also call you by name in the waiting room when your physician is ready to see you.

Required by Law. Our Office may use and disclose information about you as required by law. For example, our Office may disclose information for the following purposes:

for judicial and administrative proceedings pursuant to legal authority;
to report information related to victims of abuse, neglect or domestic violence; and
to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Coroners, Funeral Directors, and Organ Donation. We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Your health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research. Our Office may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. For example, we may disclose your health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.

Inmates. We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Business Associates. We will share your health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Uses and Disclosures That We May Make Unless You Object

Family or Friends involved in Your Healthcare. Unless you object in writing, the health care professionals, using their best judgment, may disclose to a member of your family, a relative, a close friend or any other person you identify, your health information that directly relates to that person's involvement in your health care. If you are unable to object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose your health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Uses. Other uses and disclosures will be made only with your written authorization, unless otherwise permitted or required by law, and you may revoke the authorization except to the extent that our Office has acted in reliance on it.

Required Uses and Disclosures

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

Your Health Information Rights

Although your health record is the physical property of our Office, the information belongs to you. Under the Federal Privacy Rules, 45 CFR Part 164, you have the right to:

request a restriction on certain uses and disclosures of your information as provided by 45 CFR §164.522; however, our Office is not required to agree to your requested restriction.

obtain a paper copy of the notice of our information practices upon request;

inspect and obtain a copy of your health record as provided in 45 CFR §164.524;

request an amendment to your health record as provided in 45 CFR §164.526; however, we are not required to do so.

request confidential communications from us by alternative means or at alternative locations;

revoke your authorization to use or disclose health information except to the extent that action has already been taken; and

receive an accounting of disclosures made of your health information after April 14, 2003, for purposes other than treatment, payment, health care operations as described in this Notice of Privacy Practices and as provided in 45 CFR §164.528, subject to certain exceptions, restrictions and limitations.

Our Responsibilities

We are required by the Federal Privacy Rules to:

maintain the privacy of protected health information;

provide you with this notice of our legal duties and privacy practices with respect to your health information;

abide by the terms of this notice;

notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;

accommodate reasonable requests you may make to communicate health information for reasons other than those listed above and permitted under law.

We reserve the right to change our information practices and to make the new provisions effective for all protected health information it maintains, including health information created or received prior to the effective date of any such revised notice. Should our health information practices change, we will post it in our Office and/or on our website, and/or provide you a copy of the revised notice, upon request.

Effective Date: October 1, 2021

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Health Insurance Portability and Accountability Act

By signing this document, I acknowledge that I have been given the opportunity to read the Notice of Privacy Practices of 361 Wellness.

_____ _____
Print Patient Name Date

_____
Patient Signature

Please fill out and sign the following release form so we can obtain copies of any medical records that may be needed in order to assess your condition more thoroughly.

Date: _____

I, _____ hereby authorize the release of my medical records to:

361 Wellness
6625 Wooldridge Rd Ste 301
Corpus Christi, Tx 78414
361-986-3691

_____
Printed Patient Name

_____ _____
Patient Signature Date

Information Form DATE: _____

Name: _____ Date of Birth: _____ Age: _____

Who referred you to 361 Wellness?_____

What problem are you seeking treatment for (CIRCLE ALL THAT APPLY)

PAIN DEPRESSION PTSD FIBROMYALGIA HEADACHES OTHER_____

When did your symptoms begin? _____

How and when were you treated for this

problem?_____

_____

What other treatments have you received? (i.e., bed rest, physical, therapy, hypnosis, chiropractic manipulation, acupuncture, injections) Please list details:

_____

MEDICATIONS

Please list medications to which you are ALLERGIC, and the type of reaction to each (i.e. rash, upset stomach, etc…..):

_____

Do you: Drink alcoholic beverages? Yes (Amt) _____ No Smoke? Yes (Amt) ____ No
Have you ever been treated for addiction to alcohol or any other substance? Yes No
Do you currently take any illegal drugs or have you taken any narcotics in a non-prescribed manner? Y/N

PERSONAL HEALTH HISTORY (circle all that apply to YOU)

Anxiety	Arthritis	Depression	Diabetes	Hepatitis	Kidney Problems
Asthma	Cancer	Constipation	Genetic Disorder	Headaches	Lung Problems
Genetic Disorder	GI Bleed	Glaucoma	Heart Problems	High Blood Pressure	HIV
Stomach Ulcer	Seizures	Tuberculosis			

*******IF YOU HAVE A HISTORY OF SEIZURES, ARE THEY CURRENTLY UNDER CONTROL? YES / NO**

*******HISTORY OF HYPERTENSION? YES /NO IF YES, IS IT UNDER CONTROL? YES/NO**

FAMILY HISTORY (Circle all that apply TO YOUR BLOOD RELATIVES)

Asthma	Arthritis	Cancer	Diabetes	Genetic Disorders	Headaches
Heart Problems	High Blood Pressure		Lung Problems	Seizures	Tuberculosis

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Please list previous surgeries:

DATE	PROCEDURE	SURGEON	HOSPITAL
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name _____
Last *First* *Middle*

Address _____
Street *City* *State* *ZIP Code*

Home Phone ( )_____ Cell Phone ( )_____

Date of Birth _____ Social Security No. _____

Driver's License No: _____State _____

Email address: _____

Preferred language: ☐ English ☐ Spanish ☐ Other _____

Preferred Reminder Method: ☐ Mail ☐ Home Phone ☐ Cell Phone ☐ Email ☐ Patient Portal*
(*must sign consent form)

Gender: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Race: ☐ Declined ☐ White ☐ Black or African American ☐ Asian ☐ Other _____

Ethnic Group: ☐ Declined ☐ Hispanic ☐ Not Hispanic or Latino ☐ Other _____

Emergency Contact :_____Phone: ( )_____
Last *First* *Middle*

Are you seeking treatment for an injury related to ☐ WORK ☐ MOTOR VEHICLE ACCIDENT ☐ OTHER _____

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KETAMINE EDUCATION

Patient: _____

_____I understand Ketamine is an approved medication by the FDA, but 361 Wellness is using ketamine off label

_____ I acknowledge I have read the consent form, understand the risks of ketamine infusions, have been offered the opportunity to ask any questions concerning ketamine, and agree to proceed with the planned infusion

_____ I understand and accept all risks associated with off label use of ketamine

_____ I understand and acknowledge I am choosing to have the ketamine infusion by my own choice, and at any time I can halt the procedure

_____ I understand and acknowledge I will contact 361 Wellness with any unusual symptoms or concerning signs.

_____ I understand and acknowledge I will call 911 for any life threatening symptoms I may experience after the infusion

_____ I understand and acknowledge ketamine is not guaranteed to provide any benefit, and I may not get any benefit or may have worse symptoms even after repeated infusions.

_____ I understand ketamine is effective in about 70% of patients, and I may get more or less benefit than expected.

_____ I understand and acknowledge potential side effects include dizziness, nausea, vomiting, euphoria, perceptual disturbances, bad dreams, confusion, changes in heart rate, changes in blood pressure, difficulty breathing, anxiety, increased saliva production, musculoskeletal disruptions, increased pressure in lungs, rash, double vision, unusual heart rhythms,

_____ I understand and acknowledge possible complications include seizures, low blood pressure, high blood pressure, bleeding, infections, damage to nerves or surrounding tissues, failure to provide benefit, heart attack, stroke, and death

_____ I understand and acknowledge there are no long term studies involving ketamine infusions and accept all risks associated with long term treatments of ketamine and will notify 361 Wellness as soon as I believe a long term complication is occurring

_____ I understand and acknowledge ketamine infusion is a part of my treatment plan, not a replacement, and will continue to be compliant with my other doctors plans

_____ I understand and acknowledge 361 Wellness has the right to refuse treatment to me at any time without cause

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KETAMINE EDUCATION

Patient: _____

_____I understand and acknowledge 361 Wellness is a cash based business, and I will pay my balance as agreed with 361 Wellness. If I don't maintain my financial responsibility and compliance, 361 Wellness may refuse treatment

_____I understand and acknowledge I will give 361 Wellness 72 hrs notice if I plan to cancel or miss my scheduled treatment; If not, I will be charged $100 for failure to notify 361 Wellness of my cancelation/need to reschedule

_____I understand and acknowledge 361 Wellness will hold my schedule apt for 10 minutes after it is scheduled. If I arrive more than ten minutes after my scheduled appointment, I may not receive my scheduled treatment.

_____I understand and acknowledge symptoms and benefits may fluctuate during and/or between my treatments, and will call 911 or go directly to the nearest ER with any symptoms of wanting to hurt myself or others.

_____I understand and acknowledge 361 Wellness recommends 6 treatments in the first 2-3 weeks to maximize benefit, however , I may choose to alter the recommended treatment guidelines based on my availabilities with the understanding this may decrease my benefit.

_____I understand and acknowledge I have been informed not to drive or operate any heavy machinery on the day of my treatment, consume any alcohol, make any financial, business, or other decisions requiring my signature, or engage in activities requiring motor skills as ketamine may affect my mentation, memory, and motor skills. By doing any of these activities, I am going against medical advice and will be solely responsible for any accidents or problems that may arise by my actions

_____I understand and acknowledge I have provided 361 Wellness with all of mymedical history , medications, and pertinent medical information

_____ _____

361 Wellness Team Member Date

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MEDICATION FORM

Patient Name: _____

Date: _____

Medication Name	Dose	Indication	Total Pills/day	Notes

361 Wellness Member: _____

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months…		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

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POST INFUSION INSTRUCTIONS

Congratulations on resetting your life!!! The benefits of your treatment have already begun even though you may not notice it yet.

You may experience some side effects from your infusion of ketamine even if you are not experiencing any currently. Side effects you may encounter include:

- disorientation or confusion
- heart rate changes or palpitations
- unusual muscle movements
- insomnia
- unusual dreams or nightmares
- redness or swelling at IV site
- nausea
- headaches
- anxiety

If you experience any of these symptoms, please document them: duration, severity, alleviating factors. We will want this information for future analysis and treatment modifications.

More severe possible side effects include:

- seizure like activity
- changes of heart rhythm
- increased or decreased blood pressure
- swelling from allergic reaction
- changes or difficult breathing

IF YOU HAVE ANY SYMPTOMS THAT REQUIRE IMMEDIATE ATTENTION, CALL 911.

If you have any concerns or questions about post treatment expectations, you can call our clinic at 361-986-3691. If you have any concerns or questions after clinic hours, and need evaluation by a physician, please go to nearest Urgent Care Clinic or ER. If you have any questions otherwise after hours, please call back next business day.

Due to possible confusion or memory problems, we do not recommend you engage in any activities that may affect your decision making process, including financial decisions, legal decisions, employment decisions, etc.

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POST INFUSION INSTRUCTIONS

I have read the Post Treatment Instructions and agree to follow them. If I choose to stray from these recommendations, I understand I am going against medical advice and therefore am solely responsible for any consequences caused by my actions:

Patient Name _____ Date _____

361 Wellness Team Member _____ Date _____

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CONSENT FORM

I, _____, have been educated about ketamine infusions. I have been offered to address any of my questions and all questions have been addressed. I understand 361 Wellness suggests to provide an IV infusion of ketamine to me in an attempt to provide benefit for my diagnosis/diagnoses:

- ☐ Depression
- ☐ PTSD
- ☐ Mania
- ☐ Migraine/Headache
- ☐ Post-partum Depression
- ☐ Other
- ☐ Neuropathic Pain
- ☐ Bipolar
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Pelvic Pain

I understand ketamine has been used for decades as a medicine and is FDA approved as an anesthetic agent. However, for the purposes of my infusion, ketamine has not been approved by the FDA. I understand my treatment is not a clinical study, but a procedure performed by 361 Wellness and is not followed by any Institutional Review Board (IRB) or FDA. I also understand 361 Wellness plans to use ketamine as an infusion, or constant drip.

The most common side effects include increased nausea, vomiting, saliva production, vivid or changes in dreams, dizziness, nightmares, increased and /or decreased heart rate, increased and/or decreased blood pressure, unusual movements, altered perceptions during infusion. Less common side effects include rash, eye pressure increases, vision changes, seizure like movements, breathing changes or difficulties, rhythm changes of the heart, allergic reaction requiring other medical interventions, heart attack, stroke, and death. I understand these side effects are much more likely to occur at doses much higher than I will be receiving during my infusion, and these side effects are much more likely to occur with one quick administration of ketamine instead of the slow infusion like I will be receiving over approximately 60-90 minutes.

Patients with a history of drug non-compliance or abuse are at increased risk of developing dependence to ketamine. I understand, there is no guarantee of benefit, I may not obtain any benefit, and my symptoms may get worse. Possible complications of the procedure include but are not limited to bleeding, infection, bruising, damage to nerves or surrounding tissue, failure to provide benefit, requirement of hospitalization, heart attack, stroke, paralysis, and death.

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CONSENT FORM

I understand 361 Wellness is recommending to follow published literature of 6 treatments over 2-3 weeks to maximize benefit, but I may choose to alter my treatment schedule at any time with the understanding this may decrease my benefit. I also understand my ketamine infusion treatment is a cash option only, and there will be no refunds for any failure of treatments. If I choose to give a testimonial about my treatment, 361 Wellness has the right to share the testimonial on the company social media or website.

_____ _____

Patient Name Date

_____ _____

Name of Driver Date

_____ _____

361 Wellness Team Member Date

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
3. Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
4. Feeling tired or having little energy	**0**	**1**	**2**	**3**
5. Poor appetite or overeating	**0**	**1**	**2**	**3**
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9. Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

FOR OFFICE CODING *0* + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

BDI-II

Date:

Name: _____ Marital Status: _____ Age: _____ Sex: _____

Occupation: _____ Education: _____

Instructions: This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today.** Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

1. Sadness

0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism

0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3. Past Failure

0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure

0 I get as much pleasure as I ever did from the things I enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5. Guilty Feelings

0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. Punishment Feelings

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. Self-Dislike

0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticalness

0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes

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. Crying

0 I don't cry anymore than I used to.
1 I cry more than I used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

_____ Subtotal Page 1

Continued on Back

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11. Agitation

0 I am no more restless or wound up than usual.

1 I feel more restless or wound up than usual.

2 I am so restless or agitated that it's hard to stay still.

3 I am so restless or agitated that I have to keep moving or doing something.

12. Loss of Interest

0 I have not lost interest in other people or activities.

1 I am less interested in other people or things than before.

2 I have lost most of my interest in other people or things.

3 It's hard to get interested in anything.

13. Indecisiveness

0 I make decisions about as well as ever.

1 I find it more difficult to make decisions than usual.

2 I have much greater difficulty in making decisions than I used to.

3 I have trouble making any decisions.

14. Worthlessness

0 I do not feel I am worthless.

1 I don't consider myself as worthwhile and useful as I used to.

2 I feel more worthless as compared to other people.

3 I feel utterly worthless.

15. Loss of Energy

0 I have as much energy as ever.

1 I have less energy than I used to have.

2 I don't have enough energy to do very much.

3 I don't have enough energy to do anything.

16. Changes in Sleeping Pattern

0 I have not experienced any change in my sleeping pattern.

1a I sleep somewhat more than usual.
1b I sleep somewhat less than usual.

2a I sleep a lot more than usual.
2b I sleep a lot less than usual.

3a I sleep most of the day.
3b I wake up 1-2 hours early and can't get back to sleep.

17. Irritability

0 I am no more irritable than usual.

1 I am more irritable than usual.

2 I am much more irritable than usual.

3 I am irritable all the time.

18. Changes in Appetite

0 I have not experienced any change in my appetite.

1a My appetite is somewhat less than usual.
1b My appetite is somewhat greater than usual.

2a My appetite is much less than before.
2b My appetite is much greater than usual.

3a I have no appetite at all.
3b I crave food all the time.

19. Concentration Difficulty

0 I can concentrate as well as ever.

1 I can't concentrate as well as usual.

2 It's hard to keep my mind on anything for very long.

3 I find I can't concentrate on anything.

20. Tiredness or Fatigue

0 I am no more tired or fatigued than usual.

1 I get more tired or fatigued more easily than usual.

2 I am too tired or fatigued to do a lot of the things I used to do.

3 I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex

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 am much less interested in sex now.

3 I have lost interest in sex completely.

_____ Subtotal Page 2

_____ Subtotal Page 1

_____ Total Score

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DN4 – QUESTIONNAIRE

To estimate the probability of neuropathic pain, please answer yes or no for each item of the following four questions.

INTERVIEW OF THE PATIENT

QUESTION 1: Does the pain have one or more of the following characteristics?	**YES**	**NO**
Burning	☐	☐
Painful cold	☐	☐
Electric shocks	☐	☐

QUESTION 2: Is the pain associated with one or more of the following symptoms in the same area?	**YES**	**NO**
Tingling	☐	☐
Pins and needles	☐	☐
Numbness	☐	☐
Itching	☐	☐

EXAMINATION OF THE PATIENT

QUESTION 3: Is the pain located in an area where the physical examination may reveal one or more of the following characteristics?	**YES**	**NO**
Hypoesthesia to touch	☐	☐
Hypoesthesia to pinprick	☐	☐

QUESTION 4: In the painful area, can the pain be caused or increased by:	**YES**	**NO**
Brushing?	☐	☐

YES = 1 point
NO = 0 points

Patient's Score: /10