AASEM/ DTSC Study
Physician / Technician Extended Evaluation Patient Questionnaire
CPT Code 99214

Date of consented entity _____ Sex: M ◯ F ◯

First Name _____ Middle Initial _____ Last Name _____ DOB _____

The following questions are generic in form. Please be specific as to your disorder, when possible.

1 Please describe in your own words, the reason why you desire entry into the AASEM/ DTSC study:

_____

_____

2 What are the issues or the disorder you are seeking a management solution for:

_____

_____

3 Approximately how long have you suffered from this disorder? Years _____ Months _____

4 Has your disorder been defined by another physician or physicians, if so, by whom and when?

	Physician's Name:	Date of Diagnosis:
1		
2		
3		

Are you experiencing pain, if so, where and how much?

	Areas:	Rating (none) 1-10 (Unbearable)
1		
2		
3		

		Yes	No
6	Does your disorder affect your balance or stability?	◯	◯
7	Do you suffer from any other sensory issues, if so, which? Sight ◯ Smell ◯ Hearing ◯ Taste ◯ Touch ◯	◯	◯
8	Is there a family history of your disorder, if so, who? Mother ◯ Father ◯ Brother ◯ Sister ◯ Grandparent ◯ Other relative ◯	◯	◯
9	Have others ever told you that you need hearing aids?	◯	◯
10	Do you ever experience dizziness or a light headed feeling?	◯	◯
11	Do you wear Eyeglasses ◯ Hearing Aids ◯		
12	Have you ever been diagnosed with:		
	1 Macular Degeneration	◯	◯
	2 Cataracts	◯	◯
	3 Hearing Loss	◯	◯
	4 Balance Disorder		
	A Dizziness	◯	◯
	B Stability	◯	

Physician / Technician Extended Evaluation Patient Questionnaire

Continued

13 Other injuries / Trauma:

Head ◯ Neck ◯ Back ◯ Arm ◯ Hand ◯ Leg ◯ Foot ◯

14 Please list other medical history – Past and Present:

_____

_____

15 Please list all surgeries with approximate dates:

	Description:		Date:
1	_____	4	_____
2	_____	5	_____
3	_____	6	_____

16 Please list all current medications:

1	_____	5	_____
2	_____	6	_____
3	_____	7	_____
4	_____	8	_____

17 Please list all allergies, including medication and reactions experiences, if any.

_____

_____

_____

18 Please list your history of diagnostic tests, with approximate dates:

	Description:	Date:
1	_____	_____
2	_____	_____
3	_____	_____
4	_____	_____

		Amount	Yes	No
19 Do you drink?	1 Coffee	_____	◯	◯
	2 Tea	_____	◯	◯
	3 Soft Drinks	_____	◯	◯
	4 Alcohol	_____	◯	◯

		Amount	Yes	No
20 Do you smoke?	1 Cigarettes	_____	◯	◯
	2 Cigars	_____	◯	◯
	3 Pipe	_____	◯	◯
	4 Other	_____	◯	◯

		Yes	No
21 Family History	1 High Blood Pressure	◯	◯
	2 Low Blood Pressure	◯	◯
	3 High Blood Sugar (Diabetes)	◯	◯
	4 Low Blood Sugar	◯	◯
	5 Thyroid Disease	◯	◯
	6 Asthma	◯	◯

Please list any other diseases that run in your immediate family:

22 Symptom Review / Check all applicable symptoms:

Constitutional

◯ Recent Weight Change	◯ Fever	◯ Fatigue	◯ N/A

Eyes:

◯ Loss of Vision ◯ Left ◯ Right ◯ Both	◯ Pain ◯ Left ◯ Right ◯ Both	◯ Discharge/Tearing ◯ Left ◯ Right ◯ Both	◯ N/A

Ears, Nose, Mouth, Throat:

◯ Itchy Ears	◯ Facial Weakness	◯ Nasal Obstruction	◯ Snoring
◯ Nosebleed	◯ Sneezing	◯ Stuffy Nose	◯ Drooling
◯ Loss of sense of smell	◯ Growth in nose	◯ Nasal Bleeding	◯ Dental Problems / Poorly fitting dentures
◯ Mouth growth/Ulcer	◯ Chewing Difficulty	◯ Lump in neck	
◯ Pain when swallowing	◯ Heartburn	◯ Sore Throat	◯ Bleeding from throat
◯ Voice Changes	◯ Breathing Difficulty	◯ Nasal Discharge	

Cardiovascular

◯ Chest Pain	◯ Irregular Heartbeat	◯ Swelling of legs	◯ Leg pain while walking
◯ Leg pain with rest	◯ N/A		

Respiratory

◯ Wheezing	◯ Cough	◯ Shortness of breath	◯ Mucus
◯ Coughing up blood	◯ N/A		

Gastrointestinal

◯ Decrease in Appetite	◯ Nausea/Vomiting	◯ Blood in stool	◯ Difficulty Swallowing
◯ Diarrhea/Constipation	◯ Indigestion	◯ Food intolerance	◯ N/A

Musculoskeletal

◯ Neck Pain	◯ Arthritis	Name Joints	
◯ Joint Pain/Stiffness	◯ N/A		

Skin

◯ Rash	◯ Jaundice	◯ Recent Baldness	◯ N/A

Neurologist

◯ Headache	◯ Blackout	◯ Seizures	◯ Paralysis
◯ Tremor	◯ N/A		

Psychiatric

◯ Insomnia	◯ Depression		
On Medication?	◯ Yes	◯ No	◯ N/A

Endocrine

◯ Thyroid Trouble	◯ Heat or Cold intolerance	◯ Excessive Sweating	◯ Excessive thirst, hunger, urination
◯ N/A			

Genitourinary

◯ Painful Urination	◯ Venereal Disease	◯ Blood in urine	◯ Frequent urination at night
◯ Difficulty passing urine	◯ Incontinence	◯ N/A	

Hematologic / Lymphatic

◯ Anemia	◯ Bleeding Problem	◯ Easy Bruising	◯ Blood disorder, e.g. Sickle Cell
◯ N/A			

23 Have you ever been diagnosed with limes disease, if so, when and by whom? ◯ Yes ◯ No

24 Do you have anything else to tell us about your particular problems, which we have not Asked in this questionnaire?

25 Physician / Technician review with patient

Physician / Technician Signature

Date

Patient's (Last, First, MI)

PATIENT PROFILE FORM - PRINT ALL INFORMATION CLEARLY

Date: _____

I. PATIENT INFORMATION

SSN# _____

Insured's Last Name _____ First Name: _____ DOB: _____

Patient's Last Name: _____ First Name: _____ DOB: _____

Street Address _____ Phone # _____

City: _____ State: _____ Zip Code: _____

Sex of Patient M ___ F ___ Sex of Insured M ___ F ___ Patient Marital Status Single ___ Married ___

II. INSURANCE INFORMATION

IF YOU ARE A MEDICARE PATIENT, PLEASE SUPPLY ID# Medicare ID # _____

Phone # : _____

Address: _____

City: _____ State: _____ Zip Code: _____

Name of **Primary** Insurance Company: _____ Phone # : _____

Street Address: _____

City: _____ State: _____ Zip Code _____

Group Plan _____ ID #: _____

Patients Relationship to Insured Spouse ___ Child ___ Other ___ Self ___

Name of **Secondary** Insurance Company: _____ Phone # : _____

Street Address: _____

City: _____ State: _____ Zip Code _____

Group Plan _____ ID #: _____

Patients Relationship to Insured Spouse ___ Child ___ Other ___ Self ___

III. EMPLOYER INFORMATION

Employer Name of the Insured: _____ Phone # : _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

IV. PHYSICIAN INFORMATION

Primary Physician: _____ Physician phone #: _____

Physician's address: _____

Physician city _____ State: _____ Zip Code: _____

V. REFERRING PROVIDER INFORMATION

Referring Doctor (if any): _____ UPIN # : _____

Address of Referring Doctor: _____

City: _____ State: _____ Zip Code: _____

AASEM/ DTSC GLOBAL SUBJECTIVE PAIN SCALE

Patient Name _____

Patient ID# _____

Instructions: For each question, please indicate your level of pain by circling a number from 0 to 10.

YOUR PAIN:

My **current** pain is	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**: Extreme pain**
During the *past week*, the **best** my pain has been is	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**: Extreme pain**
During the *past week*, the **worst** my pain has been is	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**: Extreme pain**
During the *past week*, my **average** pain has been	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**: Extreme pain**
During the *past 3 months*, my **average** pain has been	**No pain:**	0	1	2	3	4	5	6	7	8	9	10	**: Extreme pain**

YOUR FEELINGS: During the past week I have felt:

Afraid	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Depressed	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Tired	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Anxious	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Stressed	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**

YOUR CLINICAL OUTCOMES During the past week:

I had trouble sleeping	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
I had trouble feeling comfortable	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
I was less independent	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
I was unable to work (or perform normal tasks)	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
I needed to take more medication	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**

YOUR ACTIVITIES: During the past week I was **NOT** able to:

Go to the store	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Do chores in my home	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Enjoy my friends and family	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Exercise (including walking)	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**
Participate in my favorite hobbies	**Strongly Disagree:**	0	1	2	3	4	5	6	7	8	9	10	**: Strongly Agree**

Add up total score and divide by 2. Each subset is worth 50 points. The maximum score is 200

TOTAL _____

_____ Physician/Tech Name

_____ NPI#

_____ Date

_____ %

_____ Previous Date

_____ Previous Total

_____ New Total

Pain Improvement +/- _____ %

Total Improvement +/- _____ %