

*****IMPORTANT*****

Notice of Medical Visit

St Charles Spine Institute
Jason Hartman, DO
558 St. Charles Drive, Suite #200
Thousand Oaks, CA 91360
Telephone No: (805) 379-2322 Fax No: (805) 379-2373
www.stcharlesspine.com

Please do not miss this medical examination. This appointment is to evaluate your medical condition.

Please bring the following:

- Picture ID such as Driver's License
- X-Rays, MRI Films, CT Scans and reports (within 2 years)
- Past EMG and Op. Reports, Medication List

All attached forms need to be completed by your appointment date.

****You will be rescheduled if forms are not completed.****

Should you need to cancel this appointment for any reason, please call our office at 805-379-2322 at least 48 hours in advance.

Thank you for your cooperation in this matter.



Patient Information

Title: Mr. Mrs. Miss Dr.	Email:	
Name:	Birthday:	Gender: M / F
Street Address:	Suite/Apt #:	
City:	State:	Zip Code:
Home Phone:	Mobile:	Work:
Driver's License #:	State Issued:	SS Number:

Parent/Spouse/Guardian Details

Name:	Date of Birth:	Relation:
Address:		
Phone:	SS Number:	

Primary insurance info:

Secondary insurance info:

Insurance Co:	Insurance Co:
Member ID:	Member ID:

Employer Details

Employer Name:	Occupation:	Employment Status:
Address:	Phone:	

Background information:

Marital Status:	Married	Single	Divorced	Widowed	Separated	Live-in
Preferred language:						

Physician and Referral Details

Primary Physician:	Phone:
Referring Physician/Source:	



NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1998 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relation: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

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Pain Management Treatment Agreement

This document is an agreement between _____, the patient, and Dr. Jason Hartman. Patient agrees to the policies as listed below to manage chronic pain. Patient acknowledges the fact of habituation on the opioid medication as a direct consequence of its use. Because of the controlled nature of these medications, strict accountability is required. The following policies are necessary for continued treatment:

- **Regularly monthly visits for patient with schedule II medication must be made to assess response and observe complications**
- **ALL pain medications will be prescribed by ONE physician, Dr. Jason Hartman.**
- **ALL pain medications prescriptions will be filled at one pharmacy, patient chooses:**

Pharmacy Name: _____

Address: _____

Phone: _____

- Physician has complete liberty to discuss treatment details with the pharmacist at the dispensing pharmacy, and may ask the pharmacy for information about other medications, which have been prescribed for the patient.
- Random urine drug screens will be requested at any time. Urine must be given before given medication prescription
- Prescribed medication will be closely guarded. Please note these medications could be hazardous or lethal to another person, who is not tolerant to their effect. Patient will take as much care with medications, and written prescription, as they would their driver license or credit cards.
- Medications WILL NOT be replaced (if they are lost, fall in the toilet, eaten by pets, etc.) If your medications are lost or stolen an INCIDENT REPORT must be filed at the local police station or by a police officer. Once a hard copy of the police report is obtained, ONE exception may be made. Be sure to ask officer for turnaround time.
- Early refills will not be given. If a patient uses a month supply of medications within three weeks, the last week will be without medications.

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- All confidentiality of prescription and medication records is waived if there is any request from legal authorities for the information concerning inappropriate or unlawful use of controlled substances. Failure to adhere to these policies will result in permanent cessation of pain medication prescribed by Dr. Jason Hartman. Patient understands that he/she will not take medications or substances (prescription or recreational), which have been disclosed to the physician.
- Pursuant to Health and Safety Code section 11165.4(a), the mandatory consultation requirement requires health care practitioners to consult the CURES database to review a patient's controlled substance history under both of the following circumstances:
 1. Before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time*; and
 2. At least once every four month thereafter if the substance remains part of the treatment of the patient.

*"First time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

Signature:	Date:
Print Name:	Witness:
Physician:	Date:



OFFICE POLICY & INFORMATION

Financial Policies

Insurance coverage is an arrangement between the insurance carrier and the patient. As a courtesy to you, we may obtain eligibility and/or benefit information from your insurance company and communicate this to you as well as file a claim for any services rendered. Ultimately, you and only you are responsible for understanding the specifics of your insurance plan. You bear full financial responsibility for the services rendered and products provided by Jason Hartman, DO and agree to pay in FULL at TIME OF SERVICE. Additionally, you authorize and request that insurance payments be made directly to ST. CHARLES SPINE INSTITUTE should we elect to receive such payments.

Payments that you are responsible for include, but are not limited to, any and all copayments, coinsurance, and deductibles. You have agreed with your insurance company to pay these at each doctor’s office visit. Please note that copayments for office visits are usually higher for specialists (like orthopaedists) versus primary-care physicians. So check with your insurance carrier to determine if you have a higher copayment for specialists. Additional diagnostic and therapeutic procedures may be subject to separate copayments, coinsurances, and deductibles than your office visit. Again, check with your insurance carrier to determine how your benefits apply.

Though St. Charles Spine Institute will attempt to determine and collect your payment responsibility at the time of service, you understand that you are responsible for any additional payment responsibilities determined after any claims are processed by your insurance company within 30 days of being notified by either your insurance company or St. Charles Spine Institute. Our charges may be estimated based on each insurance company’s fee schedule. After your insurance processes the claim and if a balance is due, you will receive a statement. If a refund is due, we will be happy to mail it to you.

Returned Checks

There will be a \$25.00 charge for all returned or cancelled checks

Keeping Your Account Up-To-Date

It is your responsibility to inform us of any changes in your insurance, telephone numbers, and address. Please have your insurance card available at all office visits. Insurance companies give us 90 days to file a claim. Therefore, if we bill the wrong insurance carrier because you failed to provide the correct information, the visit will be your responsibility.

Delinquent Accounts

Accounts turned over to a collection agency will be assessed a \$25.00 fee. You may also be given notice legally dismissing you from our practice and be asked to find another physician. You agree to pay all reasonable attorney fees and collection costs in the event of default of payment. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that your account can be properly managed.

Lab/Diagnostic Testing Results

It is the patient’s responsibility to contact this office for the results of any lab work or diagnostic testing.

Release of Medical Records

There will be a \$15 clerical fees, plus up to \$.25 cents per page for medical records. If you need any insurance forms completed by our office, there will be a \$20.00 charge on each form. You authorize us to release all medical records to the referring and family physicians and to your insurance company, if applicable. You allow fax transmittal, telephone and by mail of your medical records, if necessary.

Please note:

The surgeons at St. Charles Spine Institute may hold the patents or have worked on the development of some implants purposed for your spinal surgery. They do NOT receive any financial compensation for implanting these devices. If you have questions, please discuss this with your Surgeon during your appointment.

All copayments, coinsurances, deductible fees, and outstanding balances must be settled before seeing the physician. We reserve the right to immediately cancel your care for conduct, non-cooperation, or non-payment.

You will be responsible for your Medicare Co-insurance if you don’t have secondary insurance.

I have read all policies in its entirety. I understand and accept all policies detailed above.

Patient Signature:	Date:
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Advanced Directive Status

Jason Hartman, DO
St. Charles Spine Institute

I have been informed of my right to formulate an Advanced Directive, and I have been provided with information regarding the execution of an Advanced Directive.

Please Select One:

- I have previously completed an Advanced Directive and have provided a copy of inclusion in my medical record
- I will provide a copy of my previously executed Advanced Directive to St. Charles Spine Institute for Inclusion in my medical record
- A copy of my Advanced Directive is on file with: _____
Name of Provider or Health Care Facility
- I have not executed an Advanced Directive and I am not interested in any further information
- I am interested in formulating an Advanced Directive and will discuss my options with my primary care physician

Patient Signature: _____ **Date:** _____

Patient Name (Print): _____

Comments: Include steps taken to obtain a copy of Advanced Directive

- A copy of the Advanced Directive has been requested

Signature of Group Representative: _____ Date: _____

Jason Hartman, DO

Please fill out this form in its entirety and fill in the bubbles completely.

PATIENT INFORMATION

Patient Name:		Date:
Date of Birth:	Height:	Weight
Referring Physician:		Primary Care Physician:

I. What are you being seen for today? Neck Back Other _____

II. Which side is affected? Right Left Bilateral
Are you? Left handed Right handed

III. Date of Injury or start of pain: _____
How did the pain occur? Injury Chronic Spontaneous
Is this work related? Yes No
Is this the result of a motor vehicle accident? Yes No

IV. Pain Description
Quality of your pain? Mild Moderate Severe
Type of pain? Sharp Dull Other: _____

V. Pain Calculation: Questions A and B should total 100%
A. What percentage of your problem is due to back/neck pain?
 0% 25% 50% 75% 100%
B. What percentage of your problem is due to leg/arm pain?
 0% 25% 50% 75% 100%

VI. General Questions
How would you rate your pain? Place a vertical mark on the line below:
No pain 0 | 1 2 3 4 5 6 7 8 9 |10 very severe pain

Have you had any change in bowel or bladder function? Yes No

Does your pain disrupt your sleep? Yes No

Does pain or weakness keep you from doing your regular activities? Yes No

Have you had physical therapy? Yes No

Does your pain radiate? Yes No If so, where _____

VII. Pain medications?
Anti-inflammatory agent Yes No Drug Name: _____
Pain Medication Yes No Drug Name: _____
Tylenol Yes No
Have you had any injections/epidurals? Yes No
How many in the last 12 months? _____ Date of most recent injection: _____
Did you get any relief? Yes No
If yes, for how long? _____

VIII. Have you had any testing? MRI EMG/NCS X-ray CT Scan

Medical History

Do you have or have you had:	Yes	No		Yes	No
Asthma/COPD	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	High Blood Pressure	<input type="radio"/>	<input type="radio"/>
Acid Reflux Disease	<input type="radio"/>	<input type="radio"/>	Heart Attack	<input type="radio"/>	<input type="radio"/>
Osteoporosis	<input type="radio"/>	<input type="radio"/>	Hypertension	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>	<input type="radio"/>
Stroke	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>	<input type="radio"/>
Gout	<input type="radio"/>	<input type="radio"/>	Thyroid Disease	<input type="radio"/>	<input type="radio"/>
Kidney Problems	<input type="radio"/>	<input type="radio"/>	Blood Clots	<input type="radio"/>	<input type="radio"/>

Social History

Marital status:	<input type="radio"/> Single	<input type="radio"/> Married	<input type="radio"/> Widowed	<input type="radio"/> Divorced
Do you smoke?	<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Have Previously	
<i>If yes,</i>				
How many packs/ day?	<input type="radio"/> <1	<input type="radio"/> 1-2	<input type="radio"/> >2	
How many years have you smoked?	<input type="radio"/> 1-4	<input type="radio"/> 5-10	<input type="radio"/> >11	
Do you consume alcohol?	<input type="radio"/> Yes	<input type="radio"/> No		
In the past did you consume alcohol?	<input type="radio"/> Yes	<input type="radio"/> No		
How often do you consume alcohol?	<input type="radio"/> Daily	<input type="radio"/> Social	<input type="radio"/> Never	
Do you exercise regularly?	<input type="radio"/> Yes	<input type="radio"/> No		
Working status:	<input type="radio"/> Full time	<input type="radio"/> Part Time	<input type="radio"/> Student	<input type="radio"/> Unemployed

Family History

Father	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease
Mother	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease
Siblings	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease
Grandparents	<input type="radio"/> Arthritis	<input type="radio"/> Cancer	<input type="radio"/> Diabetes	<input type="radio"/> Stroke	<input type="radio"/> Heart Trouble	<input type="radio"/> Lung Disease

Review of Systems

Constitutional

- Fatigue Yes No
- Weight change Yes No
- Fever Yes No

Neurological

- Migraine Headaches Yes No
- Numbness/ Tingling Yes No
- Seizures Yes No
- Dizziness Yes No
- Coordination Problems Yes No
- Neck Pain Yes No

Respiratory

- Shortness of Breath Yes No
- Chest Pain Yes No
- Trouble Breathing Yes No
- Wheezing/ Asthma Yes No
- Chronic Coughing Yes No
- Coughing up Blood Yes No

Cardiovascular

- Chest Pain Yes No
- Irregular Heartbeat Yes No
- High Blood Pressure Yes No
- Leg/Ankle swelling Yes No

Spine

- Severe Back Pain Yes No
- Spine Curvature Yes No
- Back Problems Yes No

Musculoskeletal

- Joint pain Yes No
- Joint stiffness Yes No
- Joint swelling Yes No

Gastrointestinal

- Nausea/ Vomiting Yes No
- Stomach Ulcer Yes No
- Diarrhea Yes No
- Blood in stool Yes No

Skin

- Rashes/sores Yes No
- Skin Cancer Yes No
- Itching/ Burning Yes No

Hematologic

- Anemia Yes No
- Easy Bruising Yes No
- Bleeding problem Yes No

Women ONLY:

- Are you pregnant or could possibly be pregnant?
 Yes No

Allergies

Are you allergic to any medications? Yes No

If yes, please list: _____

Are you allergic to food or environmental substances? Yes No

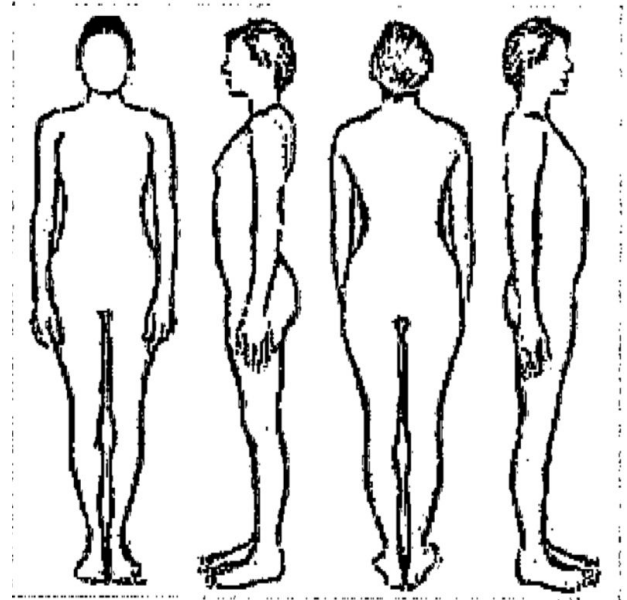
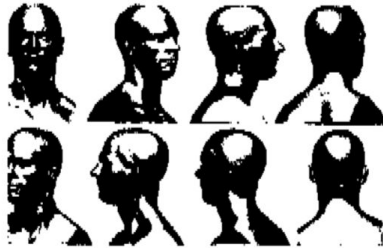
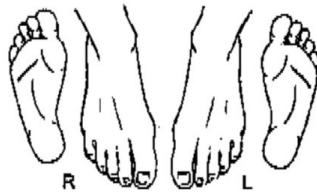
If yes, please list: _____

Hospitalization (Please list)	Surgeries (Please list surgery type and year)

Patient Signature _____ Date _____

New Patient Evaluation

Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.



Describe your pain:

<input type="checkbox"/> Throbbing	<input type="checkbox"/> Heavy
<input type="checkbox"/> Shooting	<input type="checkbox"/> Burning
<input type="checkbox"/> Stabbing	<input type="checkbox"/> Aching
<input type="checkbox"/> Sharp	<input type="checkbox"/> Tender
<input type="checkbox"/> Cramping	<input type="checkbox"/> Dull

What makes your pain worse?

<input type="checkbox"/> Bending	<input type="checkbox"/> Sexual Intercourse	<input type="checkbox"/> Coughing
<input type="checkbox"/> Lifting	<input type="checkbox"/> Standing a long time	<input type="checkbox"/> Sneezing
<input type="checkbox"/> Defecation	<input type="checkbox"/> Sitting a long time	<input type="checkbox"/> Other:

What makes your pain better?

<input type="checkbox"/> Ice	<input type="checkbox"/> Activity	<input type="checkbox"/> Bending Backwards
<input type="checkbox"/> Heat	<input type="checkbox"/> Bending Forward	<input type="checkbox"/> Medications
<input type="checkbox"/> Sitting	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Other:



Medication List (continue on back side if needed)

Medications & Directions	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Any use of recreational drugs? What kind and for how long? If yes, please include if you've joined any recovery programs. If in recovery, please include how long.

Social History

How much does your chronic pain limit your abilities to perform these activities?

PHYSICAL ACTIVITIES - Lower body

Walking

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Climbing stairs

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Bending

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Social History (continued)

PHYSICAL ACTIVITIES - Upper body

Reaching above

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Turning your head

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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PERSONAL & HOUSEHOLD CARE

Bathing or dressing

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Getting in and out of bed

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Performing housework

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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WORK

Concentrating at work

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Working with hands

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Performing tasks at work

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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SOCIAL ACTIVITIES

Visiting family & friends

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Getting out of house

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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Pursuing hobbies & friends

<input type="checkbox"/> Not at all	<input type="checkbox"/> Mildly	<input type="checkbox"/> Moderately	<input type="checkbox"/> Severely
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St. Charles Spine 558 St. Charles Drive #200 Thousand Oaks, CA 91360 (805) 379-2322				PATIENT/PROVIDER ASSESSMENT _____ Today's Date	
Name					
First <input type="radio"/> Male <input type="radio"/> Female		Last		MI	
Gender (Select One)		Height		Weight	
Primary Insurance		Patient ID / Member ID			
Please answer the following questions to the best of your ability.					

Mark Circle if Answer is Yes

<input type="radio"/> Are you pregnant?	<input type="radio"/> Do you have a pain or insulin pump?
<input type="radio"/> Do you have a pacemaker or defibrillator?	<input type="radio"/> Do you have any electrical or metal implants or sensors of any kind?

SECTION 1

Regarding your health

[1A] Have you ever been diagnosed with any of the following cardiovascular disease or symptoms?

<input type="radio"/> Do you have diabetes?	<input type="radio"/> Peripheral Vascular Disease (<i>PVD - Circulation disorders in blood vessels</i>)?
<input type="radio"/> Do you have, or had you had, gangrene?	
<input type="radio"/> Arteriovenous Fistula (Abnormal Connection between veins & arteries)?	<input type="radio"/> Embolism of the upper limb/limbs (<i>Artery obstruction in the arms</i>)?
<input type="radio"/> Diabetes Type I with circulatory disorders?	<input type="radio"/> Atherosclerosis of the Aorta? (Plaque build up in the Aortic Artery)
<input type="radio"/> Diabetes Type II with circulatory disorders?	
<input type="radio"/> Do you have or have you had chronic ulcer(s)? (Stage II, III, or IV).	<input type="radio"/> Do your hands and feet get cold easily?
<input type="radio"/> Have you ever experienced vision loss?	<input type="radio"/> Transient Cerebral Ischemia (TIA)? (<i>Mini Stroke</i>)
<input type="radio"/> Do you experience disturbance in your speech?	<input type="radio"/> Cerebrovascular Disease (CVA)? (<i>Stroke</i>)

[1B] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

<input type="radio"/> Do you have high cholesterol?	<input type="radio"/> Raynaud's Syndrome (<i>discoloration of fingers and/or toes when exposed to changes in temperature (cold or hot) or emotional event</i>)?
<input type="radio"/> Do you have hypertension (<i>high blood pressure</i>)?	
<input type="radio"/> Do you often experience abdominal pain?	
<input type="radio"/> Do you often feel fatigued (tired)?	<input type="radio"/> Beurger's disease (<i>inflammation of clotting in blood vessels in hands or feet</i>)?

[1C] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

<input type="radio"/> Type I Diabetes with neurological symptoms?	<input type="radio"/> Type II Diabetes with neurological symptoms?
<input type="radio"/> Do you ever have pain in your arms and/or legs?	<input type="radio"/> Reflex Dystrophy (Chronic Pain in Limbs after injury, stroke or heart attack)?
<input type="radio"/> Do you ever notice a disturbance in the sensation of your skin (Tingling or numbness)?	
<input type="radio"/> Peripheral Neuropathy (a result of damage to your peripheral nerves, often causes weakness, numbness, and pain, usually in your hands and feet)?	<input type="radio"/> Reflex Sympathetic Dystrophy (marked by burning pain, swelling, and motor and sensory disturbances especially of an extremity after an injury)?
<input type="radio"/> Edema (swelling in arms and/or legs)?	<input type="radio"/> Idiopathic Peripheral Neuropathy? When the cause can't be determined, it's called idiopathic neuropathy. Includes numbness, tingling and pain in legs and/or feet.
<input type="radio"/> Degenerative Disease?	

[1D] Have you ever been diagnosed with any of the following cardiovascular conditions or symptoms?

<input type="radio"/> Hypotension (very low blood pressure)?	<input type="radio"/> Dizzy and/or light headed when you stand up?
<input type="radio"/> Rapid Heart Rate (Tachycardia)?	<input type="radio"/> Do you experience hyperhidrosis (Excessive sweating)?

SECTION 2

Regarding your personal and family health history.

<input type="radio"/> Do you smoke or have you ever smoked?	<input type="radio"/> Has anyone in your immediate family (blood relatives) passed away from Sudden Cardiac Death Syndrome (SCD)?
<input type="radio"/> Has anyone in your immediate family (blood relatives) been diagnosed with cardiovascular disease (CVD), or have had a heart attack?	<input type="radio"/> Do you have a history of CVA or TIA (Stroke or mini stroke)?

NOTICE OF HIPAA AND PRIVACY PRACTICES: This office protects your privacy as well as optimize your quality of care through access to your healthcare data. As part of your privacy, we will never share your information with a third party for marketing purposes. However, HIPAA guidelines allow sharing of general information for statistical reasons, such as a government health department or official third party. Your information may be used within this office or practice or with other healthcare professionals for training and educational purposes pursuant to HIPAA guidelines.

Patient Signature	Provider Signature
FOR OFFICE USE ONLY	Continuous BP (XXX/XX mmHg) BP1: _____ BP2: _____ BP3: _____

The Pittsburgh Sleep Quality Index (PSQI)

Name: _____

Date: _____

Instructions: The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions during the past month.

1. When have you usually gone to bed? _____
2. How long (in minutes) has it taken you to fall asleep each night? _____
3. When have you usually gotten up in the morning? _____
4. How many hours of actual sleep do you get at night? (This may be different than the number of hours you spend in bed) _____

Please check the appropriate blank below.

5. During the past month, how often have you had trouble sleeping because you...

	Not during the past Month (0)	Less than once a week (1)	Once or twice a week (2)	Three or More times a week (3)
a. Cannot get to sleep within 30 minutes	a. _____	_____	_____	_____
b. Wake up in the middle of the night or early morning	b. _____	_____	_____	_____
c. Have to get up to use the bathroom	c. _____	_____	_____	_____
d. Cannot breathe comfortably	d. _____	_____	_____	_____
e. Cough or snore loudly	e. _____	_____	_____	_____
f. Feel too cold	f. _____	_____	_____	_____
g. Feel too hot	g. _____	_____	_____	_____
h. Have bad dreams	h. _____	_____	_____	_____
i. Have pain	i. _____	_____	_____	_____
j. Other reason(s), please describe, include how often you have had trouble sleeping because of this reason(s):	j. _____	_____	_____	_____

6. During the past month, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

6. _____

7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?

7. _____

8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?

8. _____

Very good (0)	Fairly good (1)	Fairly bad (2)	Very bad (3)
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9. During the past month, how would you rate your sleep quality overall?

9. _____

Physician Determined Global PSQI Score: _____