



Naga S. Bushan, M.D. | J. Michael Calmes, M.D. | José Del Giudice, M.D.
Theerapol Prasertsuntarasai, M.D. | Autumn Beasley, F.N.P.

Dear _____,

Welcome to the Arthritis & Osteoporosis Associates, L.L.P. family! Our mission is to provide quality and compassionate medical care for patients of the South Plains with rheumatic diseases. As our patient, we put *you* first and realize that our purpose is to improve *your* life. Please do not hesitate to ask any questions regarding procedures, policies, or forms that must be completed for your visit.

An appointment has been scheduled with Dr. Calmes for you on

_____ at _____.

Please complete the attached questionnaire and bring it with you on the date of your appointment. Please **DO NOT MAIL** the questionnaire back to us. If you are unable to keep this appointment please contact our office within 24 hours of your appointment time. Broken appointments prevent other patients from receiving timely care. If you fail to keep this appointment you may be billed \$75.00.

Please bring all X-Ray, CT, MRI films, labs and progress notes from any physician that pertains to this visit. The doctor will review these films and reports at the time of your visit.

1. All insurance co-pays and deductibles are due at the time of service. This will range from \$500 to \$1500. This estimate DOES include labs, x-rays, injections performed in our office.
2. All private pay patients will be required to pay in full at the time of service. This will range from \$500-\$1500. This estimate DOES include labs, x-rays, injections performed in our office.
3. We will not file any non-contracted insurance. Patient is responsible for payment in full at the time of service. Please contact the office if you have any questions regarding your insurance plan. If your insurance plan requires a referral from you Primary Care Physician, you are responsible for obtaining the referral before your appointment. If your referral is not received prior to your appointment, you will be asked to reschedule.
4. **If your care requires lab work and/or x-rays, it is possible that you may receive a separate bill from our lab vendor or x-ray vendor since all tests are not done in our practice.**
5. Please bring someone to interpret if you cannot speak English. If you are a nursing home resident, a family member or nursing home attendant must accompany and stay with you through the duration of the appointment.

Thank you for your cooperation and understanding and for choosing Arthritis & Osteoporosis Associates. We look forward to caring for you.

Signature _____ Date: _____



Naga S. Bushan, M.D. | J. Michael Calmes, M.D. | José Del Giudice, M.D.
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To Our Patients:

The physicians of Arthritis & Osteoporosis Associates, Dr. Bushan, Dr. Calmes, Dr. Del Giudice, and Dr. Prasertsuntarasai wish to inform you that they do not attend or consult patients in the hospital. We will, of course, be available to consult by phone with the attending physician and other consultants regarding the hospital care of our patients for continuity of medications and to discuss our patients' rheumatologic diagnosis. One of our physicians will always be on telephone call to advise you regarding problems or emergencies that may arise after hours or on weekends. We do advise each of you to have a personal primary care physician to direct your hospital needs and coordinate appropriate consultations in the hospital.

The face of rheumatology practice is changing nationwide and the trend is for practicing rheumatologists to focus on the outpatient care of our patients. We continue to strive to provide state of the art care of your rheumatic diseases in our outpatient clinic and our time and energies need to be directed toward the care of our office patients. We are adding new technologies in our practice with addition of musculoskeletal ultrasound. We continue to have a very active clinical research department participating in several clinical trials involving new and exciting therapies for the diseases we treat.

As always, we continue to be committed to providing quality care for our patients and are dedicated to making your experience in our outpatient clinic a pleasant experience. We thank you for your loyalty as we partner in your medical care.

Sincerely,

Naga Bushan, M.D.

Jose Del Giudice, M.D.

Michael Calmes, M.D.

Theerapol Prasertsuntarasai, M.D.

***Please note: This office DOES NOT prescribe Schedule III narcotics including Hyrdocodone*
It is the repsonsibility of the patient to know his/her insurance benefits. Please call your insurance
company if you are unsure of your benefit coverage prior to confirming an appointment.**

Arthritis & Osteoporosis Associates, L.L.P.
J. Michael Calmes, M.D.

Patient Information

Last Name: _____ First Name: _____ Middle Initial: _____
Social Security #: _____ Birthdate: _____ AGE: _____ Sex: Male Female
Current Address: _____ State: _____ Zip: _____
Home #:(_____) _____ Work#:(_____) _____ Cell #:(_____) _____
RELATIONSHIP TO PERSON RESPONSIBLE FOR PAYMENT: Self Spouse Child Other: _____
Primary Care Physician: _____ Referring Physician: _____
Patient's Marital Status: Minor Single Married Separated Divorced Widowed
Status: Employed Student Employer/School: _____ Phone#:(_____) _____
Spouse's Name: _____ Spouse's Employer: _____
IN CASE OF AN EMERGENCY, PLEASE CONTACT: _____ Phone #:(_____) _____

IF SOMEONE OTHER THAN PATIENT IS RESPONSIBLE FOR PAYMENT, COMPLETE THIS SECTION:

Last Name: _____ First Name: _____ Middle Initial: _____
Social Security #: _____ Birthdate: _____ Sex: Male Female
Permanent Address: _____ State: _____ Zip: _____
Home #:(_____) _____ Cell #:(_____) _____
Employed: Yes No Employer: _____ Phone #:(_____) _____
Marital Status: Minor Single Married Separated Divorced Widowed

MEDICAL INSURANCE/MEDICARE/MEDICAID INFORMATION:

Type of Medical Insurance: Private Insurance Medicare Medicaid Workers Comp Other: _____
Name of Policy Holder: _____ Social Security #: _____
Insurance Company Name: _____ Phone #:(_____) _____
ADDRESS: _____ State: _____ Zip: _____
Identification #: _____ GROUP NAME/#: _____
Medicare #: _____ Medicaid #: _____
Employer Plan? Yes No Birthdate: _____ Sex: Male Female
Do you have a secondary form of insurance? Yes No Company Name: _____
Phone #:(_____) _____ ID#: _____ Group #: _____

Arthritis & Osteoporosis Associates, L.L.P.
J. Michael Calmes, M.D.

Patient Financial Agreement

PATIENT NAME: _____ **D.O.B.:** _____

Arthritis & Osteoporosis Associated, L.L.P. appreciates the confidence you have shown in choosing us to provide for your medical needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. You are responsible for payment in full. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for the balance in full.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer.

I have read the above policy regarding my financial responsibility to *Arthritis & Osteoporosis Associates, L.L.P.* for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to *Arthritis & Osteoporosis Associates, L.L.P.* the full and entire amount of the bill incurred by me or the above name patient; or, if applicable any amount due after payment has been made by my insurance carrier.

PATIENT SIGNATURE: _____ **DATE:** _____

GUARANTOR SIGNATURE: _____ **DATE:** _____

(If guarantor is not the patient)

CO-PAY POLICY

Some health carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time service is rendered for the patient to pay at EACH VISIT. Thank you for your cooperation in this matter.

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____

MEDICARE AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to *Arthritis & Osteoporosis Associates, L.L.P.* for any services furnished to me by their providers. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap or Medicare Advantage benefits be made either to me or on my behalf to *Arthritis & Osteoporosis Associates, L.L.P.* for any services furnished to me by their providers. I authorize any holder of Medicare information about me to release to my Medigap insurance carrier any information needed to determine these payable for related services.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

Patient Financial Agreement (continued)

MEDICAID/PCCM

If the referring physician on my monthly Medicaid card changes, it is my responsibility to obtain the required referral for my appointment with *Arthritis & Osteoporosis Associates, L.L.P.* If I fail to obtain my required referral I understand that my appointment will be rescheduled with no exceptions.

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____

SELF-PAY

I do not have health insurance and will be responsible for services rendered here at *Arthritis & Osteoporosis Associates, L.L.P.* I agree to pay *Arthritis & Osteoporosis Associates, L.L.P.* the full and entire amount of treatment given to me or to the above named patient at each visit.

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____

REFERRAL POLICY

As described in my contract with my insurance company, if a referral is required for my visit to an *Arthritis & Osteoporosis Associates, L.L.P.* specialist, I am responsible for obtaining the referral. If I fail to obtain my required referral, I understand that my appointment will be rescheduled with no exceptions.

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____

CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours prior to canceling your appointment.

I understand if I no show for two consecutive ne patient appointments or no show for four follow-up appointments, I will be discharged form medical care.

Arthritis & Osteoporosis Associates, L.L.P. will notify you in writing via certified mail if you are discharged from medical care.

I have read and understood the above information and I agree to the terms described.

PATIENT/GUARANTOR SIGNATURE: _____ **DATE:** _____

Arthritis & Osteoporosis Associates, LLP.

Consent for Use and Disclosure of Health Information:

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (check all that apply)

Home Telephone: _____

Leave a detailed message

Leave a message with call back
number only

Work Telephone: _____

Leave a detailed message

Leave a message with call back
number only

Written Communication:

Mail to home address

Mail to work/ office address

Other: (spouse,child,etc.)

(Please list names of individuals we have
consent to speak with regarding your care)

Fax to this number: _____

Acknowledgment of Receipt of Notice of Privacy Practices:

You have the right to read our Notice of Policy Practices before you sign this consent. Our notice provides description of our treatment, payment activities and healthcare operations, and the uses and disclosures we may make of your protected health information, and of other important information concerning your protected health information. A copy of our Notice is available in our office. We reserve the right to change our privacy practices as described in our Notice. If we change our privacy practices, we will make a copy of the revision available. Which will contain the changes.

AGREEMENT AS TO GOVERNING LAW AND FORUM:

The Patient and healthcare provider rendering or providing health care to patient agree: (1) that all health care rendered shall be governed exclusively and only by Texas Law and in no event shall the law of any other state apply to any healthcare rendered to patient: and (2) in the event of a dispute any lawsuit, action of cause action which in any way relates to the healthcare provided to patient shall only be brought in a Texas District Court in the county of where all or substantially all of the healthcare was provided or rendered and in no law and forum selection provisions of this paragraph are mandatory and are not permissive.

By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

SIGNATURE: _____ DATE: _____
(PATIENT OR PERSONAL REPRESENTATIVE)

PRINT NAME: _____

RELATIONSHIP TO PATIENT (if signed by personal representative): _____

Arthritis & Osteoporosis Associates, L.L.P.

J. Michael Calmes, M.D.

Patient History Form (Rheumatology)

Date of appointment: ___/___/___ Time of appointment: _____ Birth Place: _____
 Last name: _____ First name: _____ MI: _____ DOB: ___/___/___
 Address: _____ City: _____ State: _____ Age: _____ Sex: Male Female
 Home #:(_____) _____ Work #:(_____) _____ Cell #:(_____) _____
 Marital Status: Never married Married Divorced Separated Widowed
 Spouse/Significant Other: Alive/age: _____ Deceased/age: _____ Major illness: _____

Education (circle highest level attended):

Grade School 7 8 9 10 11 12

College 1 2 3 4

Graduate School: _____

Occupation: _____

Number of hours worked/average per week: _____

Referred by: Self Family Friend

Doctor Other health profession

Name of person making referral: _____

Primary Care Physician: _____

Do you have an orthopedic surgeon? Yes No

If yes, name: _____

Describe briefly your present symptoms: _____

Date symptoms began: ___/___/___

Previous treatment for this problem (include physical therapy, surgery & injections; medications to be listed later) _____

Please list the names of other practitioners you have seen for this problem: _____

RHEUMATOLOGIC (ARTHRITIS) HISTORY

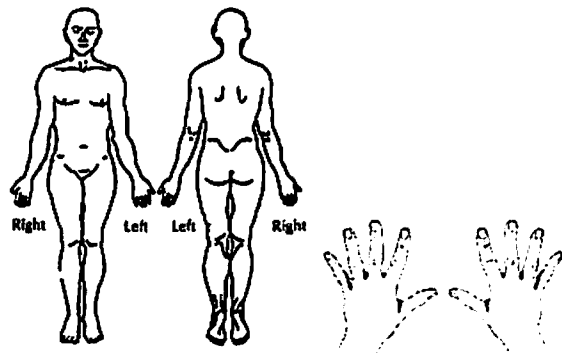
At any time have you or a blood relative had any of the following? (check if yes)

Yourself		Relative/Relation	Yourself		Relative/Relation
<input type="checkbox"/>	Arthritis (unknown type)		<input type="checkbox"/>	Lupus or SLE	
<input type="checkbox"/>	Osteoarthritis		<input type="checkbox"/>	Rheumatoid Arthritis	
<input type="checkbox"/>	Gout		<input type="checkbox"/>	Ankylosing Spondylitis	
<input type="checkbox"/>	Childhood Arthritis		<input type="checkbox"/>	Osteoporosis	

Other arthritis conditions: _____

Date: _____ Initials: _____

Please shade all the locations of your pain over the past week on the body figures and hands.



Patient History Form (continued)

SOCIAL HISTORY

Do you drink caffeinated beverages? Yes No
 Cup/glasses per day: _____

Do you smoke? Yes No Past How long? _____

Do you drink alcohol? Yes No # per week? _____

Has anyone ever told you to cut down on your drinking?
 Yes No

Do you use drugs for reasons that are not medical?
 Yes No If yes please list: _____

Do you exercise regularly? Yes No
 Type: _____

Amount per week: _____

How many hours of sleep do you get at night? _____

Do you get enough sleep at night? Yes No

Do you wake up feeling rested? Yes No

Previous operations:

PAST MEDICAL HISTORY

Do you now or have you ever had: (check if yes)

<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Asthma
<input type="checkbox"/> Goiter	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Nervous breakdown	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Headaches	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Colitis
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Stomach ulcers	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Tuberculosis

Other significant illness (please list):

	Type	Year	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Any previous fractures? Yes No Describe: _____

Any other serious injuries? Yes No Describe: _____

Family History:

	Age	If Living Health	Age of Death	If Deceased Cause
Father				
Mother				

Number of siblings: _____ Number of living: _____ Number or deceased: _____

Number of children: _____ Number of living: _____ Number of deceased: _____ List ages of each: _____

Health of children: _____

Do you know of any blood relative who has or had: (check and give relationship)

<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Heart disease _____	<input type="checkbox"/> Rheumatic Fever _____	<input type="checkbox"/> Tuberculosis _____
<input type="checkbox"/> Leukemia _____	<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Epilepsy _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Bleeding tendency _____	<input type="checkbox"/> Asthma _____	<input type="checkbox"/> Goiter _____
<input type="checkbox"/> Colitis _____	<input type="checkbox"/> Alcoholism _____	<input type="checkbox"/> Psoriasis _____	<input type="checkbox"/> Osteoporosis _____

Are you receiving disability? Yes No

Are you applying for disability? Yes No

Do you have a medically related lawsuit pending? Yes No

Date: _____ Initials: _____

Arthritis & Osteoporosis Associates, L.L.P.
J. Michael Calmes, M.D.

Systems Review

As you review the following list, please check any of the problems which have significantly affected you.

Date of last mammogram: ___/___/___ Date of last eye exam: ___/___/___ Date of last chest X-ray: ___/___/___

Date of last TB test: ___/___/___ Date of last bone densitometry: ___/___/___

Constitutional

- Recent weight gain/amount: _____
- Recent weight loss/amount: _____
- Fatigue
- Weakness
- Fever
- Eyes**
- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Feels like something in eyes
- Itching eyes

Ears/Nose/Mouth/Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Loss of smell
- Dryness in nose
- Runny nose
- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty swallowing

Cardiovascular

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- High blood pressure
- Heart murmurs

Respiratory

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing (asthma)

Gastrointestinal

- Nausea
- Vomiting of blood
- Stomach pain relieved with food
- Jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools
- Heartburn

Genitourinary

- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy, "smoky" urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to urinate
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble

For women only

- Age when periods began: _____
- Periods regular? Yes No
- How many days apart? _____
- Date of last period: ___/___/___
- Date of last pap: ___/___/___
- Bleeding after menopause?
 Yes No

Number of pregnancies: _____

Number of miscarriages: _____

Musculoskeletal

- Morning stiffness
Lasting how long? ___ min ___ hrs
- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling

List joints affected in the last 6 mo.

Integumentary

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Tightness
- Nodules/bumps
- Hair loss
- Color changes of hands or feet in the cold

Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands and/or feet
- Memory loss
- Night sweats

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

Endocrine

- Excessive thirst

Hematologic/Lymphatic

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Blood transfusion/when? _____

Allergic/Immunologic

- Frequent sneezing
- Increased susceptibility to infection

Date _____ Initials _____

Arthritis & Osteoporosis Associates, L.L.P.
J. Michael Calmes, M.D.

Medications

Drug allergies: Yes No to what? _____

Type of reaction: _____

Current medications (list any medications you are currently taking including over-the-counter medications)

Name of drug	Dose (include strength & # of pills per day)	How long have you taken this medication?	Helped A lot	Helped Some	Helped Not at all

Past Medications: Please review this list of medications. As accurately as possible, try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication and list any reactions you may have had.

Drug Names	Length of time	Has this helped?			Reactions
		A lot	Some	Not at all	

Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)

Ansald (flurbiprofen)					
Daypro (oxaprozin)					
Meclomen (meclofenamate)					
Tolectin (tolmetin)					
Voltaren (diclofenac)					
Arthrotec (diclofenac + misorostil)					
Disalcid (salsalate)					
Motrin (ibuprofen)					
Trilisate (choline magnesium trisalicylate)					
Clinoril (sulindac)					
Aspirin					
Dolobid (diflunisal)					
Feldene (piroxicam)					
Nalfon (fenoprofen)					
Lodine (etodolac)					
Vioxx (rofecoxib)					
Celebrex (celecoxib)					
Indocin (indomethacin)					
Naprosyn (naproxen)					
Oruvail (ketoprofen)					
Mobic (meloxicam)					
Relafen (nabumetone)					

Pain Relievers

Tylenol (acetaminophen)					
Codeine (Tylenol #3)					
Norco, Lortab (hydrocodone)					
Ultram, Ultracet (tramadol)					

Date: _____ Initials: _____

Medications (continued)

Disease Modifying Antirheumatic Drugs (DMARDs) or Immunosuppressive Drugs:

Auranofin (ridaura-gold pills)					
Myochrysine (gold shots)					
Plaquenil (hydroxychloroquine)					
Cuprimine/Depen (penicillamine)					
Rheumatrex (methotrexate)					
Arava (leflunomide)					
Imuran (azathioprine)					
Azulfidine (sulfasalazine)					
Atabrine (quinacrine)					
Cytosan (cyclophosphamide)					
Sandimmune/Neora (cyclosporine)					
Enbrel (etanercept)					
Humira (adalimumab)					
Simponi (golimumab)					
Cimzia (certolizumab)					
Remicade (infliximab)					
Orencia (abatacept)					
Actemra (tocilizumab)					
Benlysta (belimumab)					
Prosorba Column					

Osteoporosis Medications:

Premarin (estrogen)					
Fosamax (alendronate)					
Actonel (residronate)					
Didronel (etidronate)					
Evista (raloxifene)					
Fluoride					
Miacalcin (calcitonin injections)					
Boniva (ibandronate)					
Prolia (denosumab)					
Reclast (zoledronic acid)					
Forteo (teriparatide)					

Gout Medications:

Benemid (probenecid)					
Colcrys (colchicine)					
Zyloprim/Lopurin (allopurinol)					
Uloric (febuxostat)					
Krystexxa (pegloticase)					

Others:

Prednisone (cortisone)					
Hyalgan/Synvisc/Supartz					

Have you participated in any clinical trials for new medications? Yes No

If yes, list: _____

Date: _____ Initials: _____

ARTHRITIS & OSTEOPOROSIS ASSOCIATES, L.L.P.
Rapid 3 Assessment Questionnaire

Name: _____ DOB: ____/____/____ Date: ____/____/____

This questionnaire is designed to receive information from you to provide a record of your current health status. Please answer each question even if you do not believe it is related to your condition. There are no wrong answers.

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

Over the last week, were you able to:	Without ANY Difficulty	SOME Difficulty	MUCH Difficulty	UNABLE To DO
Dress yourself, including tying shoelaces and doing buttons?	__0	__1	__2	__3
Get in and out of bed?	__0	__1	__2	__3
Lift a full cup or glass to your mouth?	__0	__1	__2	__3
Walk outdoors on flat ground?	__0	__1	__2	__3
Wash and dry your entire body?	__0	__1	__2	__3
Bend down to pick up clothing from the floor?	__0	__1	__2	__3
Turn regular faucets on and off?	__0	__1	__2	__3
Get in and out of a car, bus, train, or airplane?	__0	__1	__2	__3
Walk two miles or three kilometers, if you wish?	__0	__1	__2	__3
Participate in recreational activities/sports as you would like, if you wish?	__0	__1	__2	__3
Get a good night's sleep?	__0	__1.1	__2.2	__3.3
Deal with feelings of anxiety or being nervous?	__0	__1.1	__2.2	__3.3
Deal with feelings of depression or feeling blue?	__0	__1.1	__2.2	__3.3

2. How much pain have you had because of your condition over the past week?

Please indicate below how severe your pain has been:

No Pain	Pain as bad as it could be
0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10	

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate below how you are doing:

Very Well	Very Poorly
0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10	

Score: 1. FN ____ 2. PN ____ 3. PTGE ____ RAPID3 ____