



Quest Center for Integrative Health
MEDICAL (ND, PCP, OMT) REGISTRATION FORM

DEMOGRAPHICS

Date: ___/___/___

Last Name First Name MI AKA

Address Apt # City State Zip Code

Home Phone # Work Phone # Cell/Message Phone # email address

Check the numbers we may leave a message on: [] Home number [] Work number [] Cell/Message number

Social Security Number Date of Birth Marital Status Gender Ethnicity

Employer Name Employer Phone Number Employer Address, City, State, Zip

Do you have a legal guardian? Yes [] No [] Parent/Guardian Name Parent/Guardian Phone Number

Parent/Guardian Address Apt # City State Zip Code

Would you like to be on our mailing list? Yes [] No []

EMERGENCY CONTACT INFORMATION

Name of Emergency Contact Person Home Phone Number Work Phone Number

Relationship Address Apt # City State Zip Code

MEDICAL INFORMATION

Primary Care Physician Clinic Name Address Phone Number

RED ALERTS

Medical Allergies Medical Problems Hospital of Choice

BILLING INFORMATION

Who do we bill to:

- [] Client/Patient (stop here - sign below)
[] Private Insurance* (fill out insurance portion and sign below)
[] OHP* (fill out insurance portion and sign below)
[] Medicare* (fill out insurance portion and sign below)
[] Veteran's Benefits* (fill out insurance portion and sign below)
[] Ryan White (stop here - sign below)
[] Client/Patient Bills Insurance (stop here - sign below)
[] Other Third Party (fill out and sign below)

* Please provide us with your insurance card in order that we make a photocopy for our records

Primary Insurance Carrier's Name Policy Holder's Name (if different than clients) Relationship to Insured

Insurance Carrier's Phone Number Policy ID/Subscriber # Group # Secondary Insurance Carrier's Name, if applicable

Claim # (for Motor Vehicle Accidents only) Claim's Adjuster (for Motor Vehicle Accidents only) Claim's Adjuster's Phone Number

Attorney's Name (if applicable) Attorney's Phone Number Attorney's Address

RYAN WHITE /HEP ENROLLMENT and ELIGIBILITY INFORMATION

Household Gross Monthly Income: \$ # in Household

I certify that the above information is true and accurate. Client/Patient's Signature (or Parent/Guardian) Date Page 1

Acknowledgement, Consent, Confidentiality, Office Policy and Rights and Responsibilities

I understand that **Project Quest** will use and disclose health information about me.

I understand that my health information may include information both created and received by **Project Quest**, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that **Project Quest** may use and disclose my health information in order to:

- Make decisions about, and plan for, my care and treatment.
- Refer to, consult with, coordinate among, and manage along with other healthcare providers for my care and treatment.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for, quality, cost-effective health care.

I understand that if applicable, my health information, both created and received by **Project Quest**, may be used within the context of mandatory and necessary reporting related, but not limited to, statistics, funding or grants, that may be required by local, state and/or federal agencies.

I also understand that I have the right to receive and review a written description of how **Project Quest** will handle health information about me. This written description is known as a *Notice of Privacy Practices* and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of **Project Quest**, and my rights regarding my health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time, and that I am entitled to receive a copy of any revised *Notice of Privacy Practices*. I also understand that a copy of the most current version of **Project Quest's** *Notice of Privacy Practices* in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some, or all of my health information not be used or disclosed in the manner described in the *Notice of Privacy Practices*, and I understand that **Project Quest** is not required, by law, to agree to such requests.

Client Confidentiality Agreement: As a client of Project Quest, you may learn of confidential information relating to both potential and existing clients within an alcohol and drug recovery environment, as well as any other services that Project Quest provides inside and outside a clinical setting. You may be exposed to protected health information, including, but not limited to, general and specific client-related information, personal information, financial information that is related to employment or disability, or other information not generally disclosed by Project Quest to the public. This information may be in written or verbal form, electronically generated or created by any other means of transmission. Unauthorized access, discussion, review, disclosure, transmission, alteration, dissemination, or destruction of such information, except as required to fulfill the responsibility of Project Quest, is absolutely prohibited.

Purpose: To ensure that personal and protected health information is safeguarded so that individuals are not afraid to seek health care or other services that Project Quest may provide. To also ensure that personal health information is protected during its collection, use, disclosure, storage and destruction within Project Quest.

Definitions: Protected Health information is defined as all information recorded or exchanged that relates to an individual's health, or health care history, including genetic information, about the individual, or the individual's family.

Protected health Information is described as the following:

Patient Name	E-Mail Addresses	Vehicle or Other Device Serial Numbers
Patient Address	Social Security Number	Web URL's
City & County of Residence	Medical Record Number	Internet Protocol Addresses (IP)
Zip Code	Health Plan Beneficiary Number	Finger or Voice Prints
Names of Relatives & Employers	Account Numbers	Photographic Images
Birth Date	Telephone & Fax Numbers	

Protected Health Information also includes conduct or behavior that may be a result of illness or the effect of treatment.

Policies: In accordance with this policy, you agree to protect and not to disclose confidential information. You agree that you have the responsibility to respect the confidentiality of the clients of Project Quest.

Consent to treatment: I hereby voluntarily consent to the provision of medical and/or mental health care services at Project Quest Integrative Health Center as may be deemed medically advisable or necessary. I request that my health care practitioner(s) provide any care they think is necessary and consistent with my instructions except _____. I understand this care may include tests, examinations, medical and minor surgical treatment and related anesthesia. I acknowledge that the health care practitioners treating me may be independent contractors or employees of Project Quest. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care practitioner(s) during each visit. I understand that if special procedures or operations are needed, my health care provider will discuss this with me and my additional consent will be required. I understand that I have the right to participate in the development and periodic review of my individualized treatment plan, be informed of my diagnosis (after the assessment has been completed) and the purpose of any prescribed medication and potential side effects of the medication. I understand that some of Project Quest practitioners are involved in teaching and I consent to having student practitioners and others involved with my care. I understand that I may revoke my consent at any time, but action taken by Project Quest before that time will remain covered by this authorization.

Medical records policy: Your medical records are the property of Project Quest. Information may be shared among practitioners of Project Quest for purposes such as treatment or other health care operations, including quality assurance activities, utilization review activities, and peer review. If you are referred to practitioners outside of Project Quest, any necessary information may be shared with them as well, in order to facilitate and coordinate your health care. In addition, we will provide necessary documentation to your insurance company for purposes of claims review and payment. All of this is done pursuant to your consent, as indicated by your signature at the bottom of this page.

Consent to release information: I consent to allow Project Quest to release my confidential health information for purposes of treatment, payment and health care operations. In particular, I consent to the release of my confidential health information for the following purposes: (1) for the diagnosis, treatment and/or evaluation of any health condition, including the sharing of information by and among Project Quest practitioners and outside health care practitioners; (2) as required by my insurance carrier for the purposes of reviewing and paying claims for services rendered by Project Quest practitioners; (3) for the performance of quality assurance, utilization review, and/or peer review activities; (4) for the determination of eligibility under my insurance health plan; (5) as required by any governmental agency or any entity responsible for processing or paying my claims for medical benefits, including Worker's Compensation claims; and (6) as otherwise authorized by law. I understand that I may revoke my consent at any time, but action taken by Project Quest before that time will remain covered by this consent. I understand that information from my medical record may be reviewed or released while I am receiving care or after discharge and this information will be held confidential except as allowed by law.

Office Policy:

General: You are free to receive health care from any practitioners of your choice, either within or outside of Project Quest. As a patient of Project Quest, you will have the opportunity and choice to see one of our medical and mental health practitioners, according to your identified health care needs. Practitioners at Project Quest are either independent contractors with, or employees of, Project Quest. Each practitioner is solely responsible for any health care decisions and recommendations he or she may make. While all practitioners will be practicing within the scope of their individual licenses, some of the treatments they discuss with you may be considered experimental, new, or "alternative". You are solely responsible for deciding which treatment you will choose, although your practitioner(s) will assist you in reaching an informed decision. No guarantee is made as to the results that may be obtained from their examination or treatment.

After hours care: We recommend that you maintain a relationship with a primary care physician who can provide emergency care, since at this time, **Project Quest does not offer emergency services, or after hours care.** If an emergency arises, contact your primary care provider, call 911 or go to the nearest emergency room. If you have an urgent mental health issue, call the mental health crisis line at 503-988-4888, or call our on-call mental health therapist line at 503- 702-8409.

Cancellation policy: We request 48 hours notice if you must cancel your appointment; appointments scheduled for Monday must be cancelled by Friday. Last minute cancellations may incur a missed visit fee of \$35. This fee does not apply to Medicaid clients, in accordance with OAR 309-016-0105. Patients who miss two or more appointments will need to be seen on a same day only basis – i.e., we will not reserve an appointment for you, but you may call in the morning to see if any appointments are available for that day.

Insurance billing and payment for services: If you choose to have us bill insurance for you, we require that your deductible be met and that your co-payment or your portion of the bill be paid at the time of each visit. In the event that your insurance carrier determines that the services provided to you are not a covered benefit under your health care plan, you are responsible for the total amount due, as well as any applicable co-payment or deductible. A \$20 fee will be charged for any returned checks. You may choose to purchase any recommended nutritional supplements, health care products, books, etc. at this location or elsewhere. In most cases, non-prescription pharmacy items are not covered by insurance and you will need to provide payment for these items at the time you receive them. **You are responsible for updating us on any changes** in your insurance carrier or policy status, as well as any changes in your address, telephone number, name, or other relevant information. Your signature below authorizes payment to be made directly to Project Quest or its practitioners of all insurance or health plan benefits.

Medicare: At this time, most Project Quest practitioners are not authorized participating providers in the Medicare program and, therefore are unable to bill for or accept direct payment from Medicare. **If while you are a patient at Project Quest, you become eligible for Medicare, you must immediately inform the receptionist of this.**

Workers Compensation: At this time, Project Quest practitioners are not accepting any worker's compensation claims. You must notify your practitioner and Project Quest receptionist if your visit is due to an injury covered by Worker's Compensation.

Past due accounts: For accounts over 30 days past due, a monthly rebilling fee of \$15 on the unpaid amount will be charged. You will be charged any necessary collection cost, including attorney's fees or collection agency fees, both at trial and on appeal, and whether or not a lawsuit is filed.

By signing below, I agree that I have read and fully understand the terms and conditions outlined herein regarding the office policy and use and/or disclosure of my health information. I understand and accept the policies listed in this agreement. I have reviewed and understand the permitted disclosures and give my consent to use my health information as named above. I have asked questions about anything not clear to me, and I am satisfied with the answers I have received. I also certify that the information given to me is correct and I have read and consent to the terms of this policy, including payment for these services. I am the patient, or authorized as the patient's agent or representative to execute the above and accept the terms on behalf of the patient, and I assume individually all financial responsibility by signing below. I understand I may revoke this consent at any time I also acknowledge that a copy of the Notice of Privacy Practices will be provided to me upon my request.

CLIENT RIGHTS AND RESPONSIBILITIES

You Have The Right To:

1. Be treated with respect and courtesy.
2. Be given information about your rights and mental health needs and treatment.
3. Be free from restraint or seclusion. Restraint or seclusion cannot be used to punish you. It cannot be used to force you to do something you don't want to do. Your provider cannot restrain or seclude you to get back at you. Your provider can't use restraint or seclusion to make things easier for them.
4. Participate in choosing a mental health provider without a referral from your therapist or doctor.
5. Participate in planning and decisions about your treatment.
6. Talk to your provider and expect that what is said will be kept confidential.
7. Request your medical records and transfer to another provider.
8. Get mental health care without a long delay and be told if your appointment is being cancelled.
9. Receive information about all mental health services provided by Project Quest.
10. Consent to care before it begins or refuse care and talk with your provider about what this might mean for you.
11. File a grievance or complaint, free from retaliation, and receive assistance when needed in submitting a grievance or complaint.
12. Request a Department of Human Resources hearing.
13. Receive mental health care regardless of age, race, religion, national origin, gender, or sexual orientation.
14. Receive emergency mental health care 24 hours a day, 7 days a week.
15. Change your primary mental health provider for a good reason.
16. Receive notices in a form that you can read and have these forms explained to you.
17. Have someone to help you talk to your provider if you need language interpretation, or are hearing or speech impaired.
18. Have a friend, family member or advocate go with you during your appointment.
19. Get a written copy of these rights and responsibilities, a description of your benefits and directions for making routine and urgent appointments.
20. Get services that accurately summarize your current problems.
21. Have Project Quest maintain written records in your chart that document your services, progress, and referrals.
22. Receive, in writing, a 30-day notice prior to any of your services being cancelled, reduced or changed.
23. Be informed in a timely manner of any appointment cancellations.
24. Have in writing your wishes for treatment. This is called a Declaration for Mental Health Treatment or an Advance Directive for physical health treatment.
25. Have the right to refuse services, including any specific procedure without suffering punitive consequences. If adverse consequences are expected to result from such refusal, that fact must be explained verbally to you and if appropriate, you guardian.
26. To have access to and communicate privately with any public or private rights protection program or rights advocate.
27. Informed consent to fee-for-service. The amount of payment of any fees will be disclosed to you in writing and agreed to by you and/or your guardian.
28. Alternative format. Information and materials shall be provided to you in written form or in an alternative format or language appropriate to your needs.
29. Care which is demonstrated to be culturally competent with both awareness and sensitivity to cultural differences.
30. Care which is demonstrated to be gender appropriate with both awareness and sensitivity to gender differences.
31. Mandatory abuse reporting. Providers are required to report incidents of abuse when your provider comes in contact with and has reasonable cause to believe that you have suffered abuse.
32. The Americans with Disabilities Act as stated by law.

You Have The Following Responsibilities:

1. Choose a mental health provider.
2. Help you provider get your old mental health records or fill out new ones.
3. Honestly share your concerns about your mental health needs.
4. Ask questions about things you do not understand.
5. Help decide your treatment plan and approve the plan before it starts.
6. Treat your provider and Project Quest staff with respect and courtesy.
7. Keep appointments and be on time. Call your provider when you are going to be late or can't keep the appointment.
8. Bring your insurance or medical card with you whenever you need care.
9. Use only your selected provider for mental health needs. You may get service from someone else in an emergency.
10. Tell your provider if you change your address or phone number.

These rights and responsibilities are in accordance with OAR 309-032-0555

Notice of Privacy Practices:

_____ I acknowledge that I have received a written copy of Project Quest's Notice of Privacy Practices.
Patient's Initials

_____ I acknowledge that I have read and received a copy of Quest Center's Client Rights and Responsibilities.
Patient's Initials

Client's Printed Name

Client's Signature

_____/_____/_____
Date Signed

Page 4

Name _____ Today's Date _____
Last First Middle

CURRENT PROBLEM

In your own words, please describe the main health issue that brings you to this office _____

Regarding today's primary area(s) of concern, describe your symptoms initially and their progression, including their current status _____

What types of therapy have you tried for this problem?

acupuncture naturopathy physical therapy osteopathy chiropractic massage yoga medications/herbs/vitamins/homeopathy
manual lymph drainage Other (describe) _____

Are your symptoms: improving worsening staying the same

Please describe what makes your condition better or worse: _____

At which of the following places have you been seen or evaluated for this condition (list date, address, and outcome for each):

Emergency room urgent care primary care physician other _____

Please list all x-rays, CT scans, MR1 scans, etc. you have had for this problem(s) and dates:

Year	Type	Place Rendered	Results
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any broken bones, torn ligaments, or other major injuries? No Yes If yes, describe: _____

Have you ever had (please check all that apply): "the wind knocked out of you" blackout concussion seizure head trauma

If so, please describe, including dates: _____

List all traumas not covered above. (All traumatic history is relevant, not just recent trauma. Please include previous car accidents and injuries with dates): _____

Do you have any residual pain or limitations from these events? No Yes If yes, describe: _____

Have you ever been evaluated for arthritis or other bone, joint, or connective tissue disorders? no yes If yes, describe: _____

GENERAL MEDICAL HISTORY

Allergies: Please list any medications you are allergic to and type of reaction

Medications: List current medications (please include dosage and frequency — you may attach a separate list if you prefer)

Prescription (include any birth control pills or hormonal replacement therapy) _____

Over the counter _____

Name _____ Today's Date _____
 Last First Middle

Vitamins, herbs, and other natural products _____

Name of most recent primary care provider _____ Phone Number _____ Date of last visit _____

Are you up to date on health maintenance (physicals, PAP's, mammograms, prostate and colon checks, etc.) no yes

Medical History (include date of onset):

anemia	diabetes	gallstones	high Cholesterol	peptic ulcers
arthritis	emphysema	gout	kidney problems	psoriasis
asthma	epilepsy	heart disease	liver disease	stroke
blood clots	esophageal reflux	hepatitis	osteoporosis	thyroid problems
cancer	fibromyalgia	high blood pressure	pancreatitis	other

Past or current serious illness(es) or disease(s) other than above _____

Surgical History

Major Hospitalizations & Surgeries (Please list all procedures, complications (if any) and dates):

Year	Operation/Illness	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Has any family member ever had any of the following?

Cancer	No	Yes	Who?
Heart Disease	No	Yes	Who?
High Blood Pressure	No	Yes	Who?
Stroke	No	Yes	Who?
Diabetes	No	Yes	Who?
Psychiatric Problems	No	Yes	Who?
Tuberculosis	No	Yes	Who?

Review of Systems (check anything you have experienced significant problems with in the past and list date of onset; circle any current issues):

allergies (nasal/eye symptoms/postnasal drip) _____ sinus problems _____ double vision or blind spots _____ flashing lights _____
 ear pain/aching/pressure _____ shortness of breath _____ pain with breathing _____ palpitations _____ leg swelling _____
 leg pain with walking _____ difficulty swallowing _____ nausea _____ vomiting _____ diarrhea _____ constipation _____
 abdominal pain _____ bloody or black, tarry stools _____ leakage or loss of control of stool _____ difficulty pushing out stool _____
 urinary leakage _____ difficulty initiating urination _____ difficulty with urinary flow _____ sexual difficulties _____
 paralysis _____ speech disturbance _____ muscle weakness _____ tremor _____ restless legs _____ abnormal gait _____
 muscle wasting _____ joint pain _____ thoughts/attempts of hurting self _____ extractions or root canals _____ orthodontia _____
 TMJ problems _____ muscle pain _____ teeth clenching or grinding _____ severe menstrual pain _____
 Other _____

Women:

Date of last menstrual period: _____ Are you currently overdue or is there any chance that you could now be pregnant? No Yes

Name _____ Today's Date _____
Last First Middle

Are you currently breastfeeding? no yes

Number of pregnancies: _____ Number of deliveries _____ Any problems with pregnancies or deliveries? no yes Describe _____

Lifestyle

Caffeine (coffee, tea, cola, etc) - number of cups each day _____

Tobacco (cigarettes, pipe, chew, etc.) - daily amount _____

Alcohol (wine, beer, liquor) - amount and frequency _____

How often do you exercise? _____ What type(s) of exercise do you do? _____

Social History

Relationship Status: Single Married Committed relationship Separated Divorced Spouse/partner deceased

Number of Children: _____ Ages of Children : _____

Highest grade or degree completed in school _____ If any college level studies, what was your focus? _____

Occupation

Describe your occupation and work duties _____

What are your regular work hours? (Include number of hours per day and days per week) _____

Miscellaneous

Is there any other information that you think would be important for your practitioner(s) to know? _____

Activities of Daily Living

This questionnaire has been designed to give us information as to how your pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the ONE BOX that applies to you. We realize you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Name _____ Today's Date _____

PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain
- I do not normally change my way of washing or dressing even though it causes some pain
- Washing and dressing increase the pain but I manage not to change my way of doing it
- Washing and dressing increase the pain and I find it necessary to change my way of doing it
- Because of the pain I am unable to do some washing and dressing without help
- Because of the pain I am unable to do any washing and dressing without help

LIFTING

- I can lift heavy weights without extra pain
- I can lift heavy weights but it causes extra pain
- Pain prevents me from lifting heavy weights off the floor
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned (e.g. on a table)
- Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
- I can only lift very light weights at the most

WALKING

- I have no pain on walking
- I have some pain on walking but it does not increase with distance
- I cannot walk more than one mile without increasing pain
- I cannot walk more than ½ mile without increasing pain
- I cannot walk more than ¼ mile without increasing pain
- I cannot walk at all without increasing pain

SITTING

- I can sit in any chair as long as I like
- I can only sit in my favorite chair as long as I like
- Pain prevents me from sitting more than one hour
- Pain prevents me from sitting more than half-hour
- Pain prevents me from sitting more than 10 minutes

STANDING

- I can stand as long as I want without pain
- I have some pain on standing but it does not increase with time
- I cannot stand for longer than one hour without increasing pain
- I cannot stand for longer than half-hour without increasing pain
- I cannot stand for longer than 10 minutes without increasing pain
- I avoid standing because it increases pain straight away

SLEEPING

- I get no pain in bed
- I get pain in bed but it does not prevent me from sleeping well
- Because of pain my normal night's sleep is reduced by less than ¼
- Because of pain my normal night's sleep is reduced by less than ½
- Because of pain my normal night's sleep is reduced by less than ¾
- Pain prevents me from sleeping at all

SOCIAL LIFE

- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
- Pain has restricted my social life and I don't go out very often
- Pain has restricted my social life to my home
- I have hardly any social life because of the pain

TRAVELING

- I get no pain whilst traveling
- I get some pain whilst traveling but none of my usual forms of travel make it any worse
- I get extra pain whilst traveling but it does not compel me to seek alternative forms of travel
- I get extra pain whilst traveling which compels me to seek alternative forms of travel
- Pain restricts all forms of travel
- Pain prevents all forms of travel except that done lying down

CHANGING DEGREE OF PAIN

- My pain is rapidly getting better
- My pain fluctuates but overall is definitely getting better
- My pain seems to be getting better but improvement is slow at present
- My pain is neither getting better nor worse
- My pain is gradually worsening
- My pain is rapidly worsening

HOUSEHOLD ACTIVITIES

(check if you have pain with the activity and comment on degree)

- vacuuming _____
- washing floors _____
- washing dishes _____
- laundry _____
- making bed _____
- other _____

WORK

- I can work doing my normal activities without pain or difficulty
- I can work doing my normal activities but it is painful and difficult
- I can work ____ hrs. a day without altering my normal activities
- I cannot perform my normal work activities due to pain and difficulty,
- I cannot work at present due to pain and difficulty

LEISURE

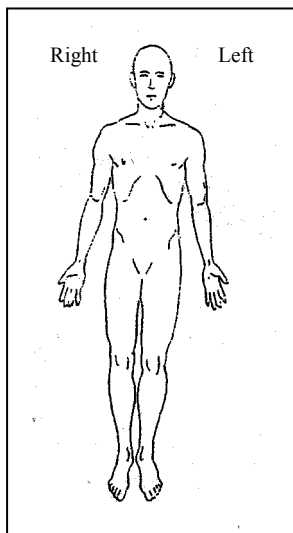
- I can participate in all my sports and leisure activities without pain
- I can participate in all my sports and leisure activities but with pain
- I can participate in _____ (list activity) but modified or for less time than usual due to pain.
- I cannot participate in _____ (list activity) due to pain

PAIN DIAGRAM

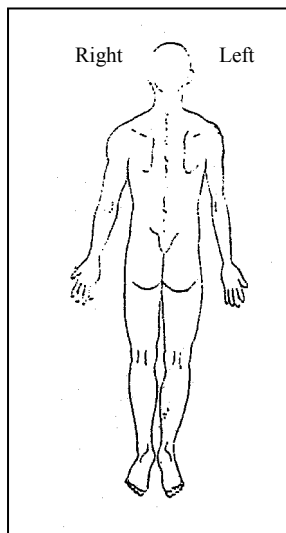
Please use these diagrams to mark all areas of current pain and indicate the severity of this pain using the following pain scale:

- 0 = none
- 1-2 = aware of pain, but tolerable without medication
- 3-4 = aware of pain, barely tolerable without medication
- 5-6 = pain medication necessary to participate in normal activities, feel anti-social
- 7-8 = pain medication helps reduce pain, but normal activities are still difficult to perform
- 9-10 = pain is excruciating, pain medications do not help me to function. Pain is incapacitating.

Front

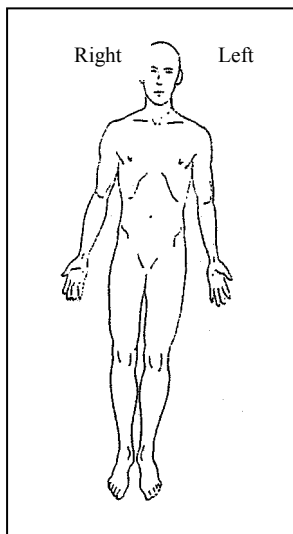


Back

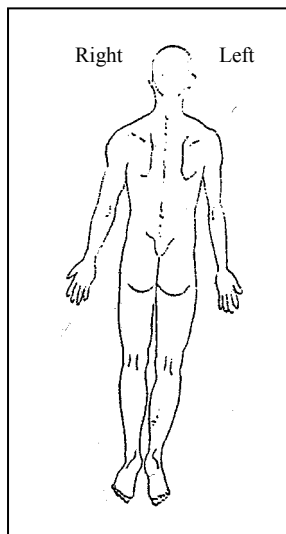


Please indicate in these diagrams any areas where you may have "funny feelings" such as numbness (N), tingling (T), pins and needles (P), or burning sensations (B). (Write the word to show where you have this feeling(s)).

Front



Back



Comments about pain patterns:
