Meskin Counseling Services

812 Dolphin Circle, Encinitas, CA 92024
2707 Congress St Suite 2-1, San Diego CA 92009
(760) 940-0880 FAX (760) 930-9157

Patient's Name: ____________________________________

Date of Injury: _________________

Attorney Name: ____________________________________

Therapist Name: ____________________________________

I do hereby authorize any insurance company, attorney, third part, group medical plan med-pa or other parties to pay directly to Dr. Harve Meskin such sums for medical services rendered to me by reason of plaintiff's claim for personal injury which occurred on or about__________ . I do further assign and irrevocably grant a lien to Dr. Meskin for any sums now due or to become due me as a result of any settlement, judgment or verdict arising from said accident/incident.

l understand that I am fully responsible for the services rendered to me arising out of this accident/incident, that my obligation shall be extinguished by the lien or that my payment of the obligation is not contingent or in any way dependent upon any settlement or judgment which may be awarded to me. I waive and relinquish any right which | may have to rescind or to seek the rescission of this agreement and further agree that this settlement shall be binding upon all of my Successors, agents, assignees and attorneys.

This lien cannot be changed. A photocopy of this lien is considered as valid as the original.

Dated: _________________

Patient's Signature: ____________________________________

The undersigned being attorney of record for the above patient does hereby agree to all terms of the above. Attorney agrees to withhold such sums from any settlement and judgment or verdict before disbursement of funds to myself or patient/client, as may be necessary to adequately protect said doctor named above.

Dated: _________________

Attorney's Signature: ____________________________________

Attorney: Please sign, date and return the original copy to the doctor's Office. Please keep a copy for your records.

DATE: _______________

NAME: ____

ADDRESS: ____City:__________Zip:__________

SS# ________________________________ Home Phone: ____________________________________

DOB: _________________ Work Number: _________________ Cell: _________________

AGE: _____ SEX: _____ E-Mail: ____

MARITAL STATUS: (Please check) MARRIED DIVORCED SINGLE PARTNERS SEPARATED

EMPLOYMENT: EMPLOYER: ____

Town/City: : ____

(Name of company at the time of the injury, if a Workers' Compensation case.)

Date of injury: _________________ Job Title: _________________ how long? ____ Wages: _________

Job Duties: ____

____

____

ILLNESSES:

	CHILDHOOD	**ADULT**
1.	____________________________________ Date/Age	____________________________________ Date/Age
2.	____________________________________ Date/Age	____________________________________ Date/Age
3.	____________________________________ Date/Age	____________________________________ Date/Age

Cosmetic Surguries:

____

____

PSYCHIATRIC HISTORY: Please list all treating doctors/counselors, dates, and the reasons for seeing them.

1.	____________________________________ Reason	____________________________________ Date
2.	____________________________________ Reason	____________________________________ Date
3.	____________________________________ Reason	____________________________________ Date

SOCIAL HISTORY: Please list all your past and present activities, interests and hobbies.

____
____
____
____
____

Which activities have changed or been stopped due to the injury? ______________________________
____
____

MILITARY? YES NO Branch: ______________________________

LEGAL: (check all that apply) DUI's FELONIES MISDEMEANORS CHILD CUSTODY LAWSUITS BANKRUPCY REPOS WORKERS' COMP CLAIMS

WORK HISTORY OR ATTACH RESUME: Please list name of company, job title and dates of employment in order since you left school.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Please check off the symptoms that you are experiencing. Also, let us know how often you are experiencing these feelings.

	Always 100%	**Continuous** 67-100%	**Frequent** 34-66%	**Occasionally** 0-33%
Crying/Tearfulness :	__________	__________	__________	__________
Over/Under Sleeping:	__________	__________	__________	__________
Under/Over Eating:	__________	__________	__________	__________
Short Temper:	__________	__________	__________	__________
Memory Loss:	__________	__________	__________	__________
Easily Frustrated:	__________	__________	__________	__________
Suicidal/Homicidal:	__________	__________	__________	__________
Sadness:	__________	__________	__________	__________
Fatigue:	__________	__________	__________	__________
Poor Self Esteem:	__________	__________	__________	__________
Feeling Hopeless:	__________	__________	__________	__________
Poor Concentration:	__________	__________	__________	__________
Inability to make Decisions:	__________	__________	__________	__________
Anxiety Attacks at Night:	__________	__________	__________	__________
Restiessness:	__________	__________	__________	__________
Panic Attacks:	__________	__________	__________	__________
Lack of interest in sex:	__________	__________	__________	__________
Poor Motivation:	__________	__________	__________	__________
Flashbacks:	__________	__________	__________	__________
Nightmares:	__________	__________	__________	__________
Isolation:	__________	__________	__________	__________

Name________________________________

SINCE YOUR ACCIDENT/INJURY DO YOU

Was someone you care about involved in the incident too? ____yes ____no
Do you have unwanted memories of the incident? ____yes ____no
Nightmares or bothersome memories of the incident? ____yes ____no
Flashbacks or intrusive thoughts about the incident? ____yes ____no
Do you get upset if you see or hear something similar to the incident? ____yes ____no
Can you drive through or go back to the incident site? ____yes ____no
Do you have anxiety being in a car as a passenger or driver? ____yes ____no
Do you avoid talking about the incident? ____yes ____no
Do you try to avoid thinking about what happened? ____yes ____no
You have trouble recalling the incident? ____yes ____no
Is the world less safe now than before the incident? ____yes ____no
Do you blame yourself for the incident? ____yes ____no
Feel guilty even though you know that it was not your fault? ____yes ____no
Feel ashamed due to the incident? ____yes ____no
Have you become socially isolated? ____yes ____no
Do you think about dying more now than before the incident? ____yes ____no
Do you feel detached from those around you? ____yes ____no
Do you have problems expressing positive emotions? ____yes ____no
Are you more irritable since the incident? ____yes ____no
Do you feel suicidal or engage in self-destructive behaviors? ____yes ____no
Are you hyper-alert? ____yes ____no
Are you easily startled? ____yes ____no
Do you have poor concentration? ____yes ____no
Do you cry or become tearful more easily? ____yes ____no
How long have you felt this way? _________________________
How many hours of sleep are you **currently** getting?_____ How many **before** the injury?_____
Has your appetite changed?_____ gained/lost how many pounds?________
Did you hit your head in the accident? ____yes _____ no
Were you knocked out? ____yes ______no
Memory loss? ____yes _____some _____no
Are you easily frustrated? ____yes ____no
Self-esteem? ____less ___the same ____better
Do you feel hopeless? ____yes ____no
Have you lost interest in intimate relations? ____yes ____no
Have you had any previous traumas? ____yes ____no
Explain________________________________

PCL-5 Stress Scale

Name:
Date:

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem and then select one of the options to indicate how much you have been bothered by that problem in the past month. The options include not at all, a little bit, moderately, quite a bit, and extremely.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Study ID: ________________________________ **Hospital #:**____________________________

DO NOT WRITE ABOVE THIS LINE

Name: __________________________________ **Date:** ______________ **Time:** _____________

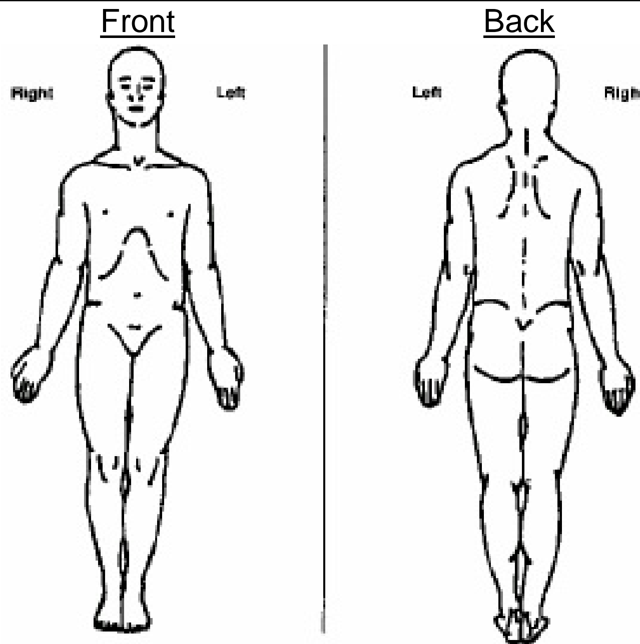
Brief Pain Inventory (Short Form)

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

☐ Yes ☐ No

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.

Front Back



3. Please rate your pain by marking the box beside the number that best describes your pain at its worst in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Pain As Bad As You Can Imagine

4. Please rate your pain by marking the box beside the number that best describes your pain at its least in the last 24 hours.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Pain As Bad As You Can Imagine

5. Please rate your pain by marking the box beside the number that best describes your pain on the average.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Pain As Bad As You Can Imagine

6. Please rate your pain by marking the box beside the number that tells how much pain you have right now.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain Pain As Bad As You Can Imagine

7. What treatments or medications are you receiving for your pain?

8. In the last 24 hours, how much relief have pain treatments or medications provided? Please mark the box below the percentage that most shows how much relief you have received.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No Relief Complete Relief

9. Mark the box beside the number that describes how, during the past 24 hours, pain has interfered with your:

A. General Activity

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere Completely Interferes

B. Mood

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere Completely Interferes

C. Walking ability

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere Completely Interferes

D. Normal Work (includes both work outside the home and housework)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere Completely Interferes

E. Relations with other people

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere Completely Interferes

F. Sleep

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere Completely Interferes

G. Enjoyment of life

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Does Not Interfere

Name:
Date:

Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by putting a checkmark in the corresponding space in the column next to each symptom. Please check only ONE per row.

	Not at all	Mildly, but it didn't bother me much	Moderately – it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding / racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot / cold sweats	0	1	2	3

Name:
Date:

	None or a little	Some of the time	Good part of the time	Most or all of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night PT				
5. I eat as much as! used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that other would be better off if I were dead				
20. I still enjoy the things I used to do				

Epworth Sleepiness Scale

Name: ____

Date: ____________________

Your age: (Yr) ______ Your sex: Male ______ Female ______

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired?

This refers to your usual Way of life in recent times.

Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:--

0 = would never doze

1 = Slight chance of dozing

2 = Moderate chance of dozing

3 = High chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	

DATE: ______________ NAME: ____

Questions Concerning Activities of Daily Living

Please fill out this form carefully and mark only one box for each question.

1. How well can you perform personal self-care activities including washing, dressing, using the bathroom, etc.?

- ☐ I can look after myself normally without having extra discomfort
- ☐ I can look after myself normally but have extra discomfort
- ☐ It is uncomfortable to look after myself and I am slow and careful
- ☐ I need some help but I manage most of my personal self-care
- ☐ I need help every day in most aspects of my personal self-care
- ☐ I do not get dressed, I wash with difficulty and I stay in bed or lay down most of the day

2. How well can you lift and carry?

- ☐ I can lift and carry heavy objects without having extra discomfort
- ☐ I can lift and carry heavy objects but I get extra discomfort
- ☐ I can lift and carry heavy objects only if they are conveniently positioned
- ☐ I can only lift and carry light to medium objects if they are conveniently positioned
- ☐ I can only lift very light objects
- ☐ I cannot lift or carry anything at all

3. How well can you walk?

- ☐ I am able to walk the same distance I could before my injury
- ☐ My injury and discomfort prevents me from walking more than 1 mile
- ☐ My injury and discomfort prevents me from walking more than 1/2 mile
- ☐ My injury and discomfort prevents me from walking more than 1/4 mile
- ☐ Because of my injury and discomfort I walk only a limited distance or I use a cane, crutches or walker
- ☐ Because of my injury and discomfort I am in bed most of the time or use a wheelchair

4. What is the most strenuous level of activity that you can do for the least 2 minutes

- ☐ Very heavy activity
- ☐ Heavy activity
- ☐ Moderate activity
- ☐ Light activity
- ☐ Very light activity
- ☐ Extremely light to no activity

5. How well can you climb one flight of stairs?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you still perform the activity)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

6. How well can you sit for 30 minutes to an hour?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity)

7. How well can you sit for two hours?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity)

8. How well can you stand or walk 30 minutes to an hour?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity)

9. How well can you stand or walk for two hours?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity)

10. How well can you reach and grasp something off a shelf at eye level?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

11. How well can you reach and grasp something off a shelf overhead?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

12. Do you have any difficulty with pushing and pulling activities?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

13. Do you have any difficulty with gripping, grasping, holding and manipulation of objects with your hands?

- ☐ No difficulty (and you can easily perform the activity) -
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity. or someone else helps you with it)

14. Do you have any difficulty with repetitive motions such as typing on a computer?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it) _

15. Do you have any difficulty with forceful activities with your arms and hands? -

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

16. Do you have difficulty with kneeling, bending or squatting?

- ☐ No difficulty (and you can easily perform the activity)
- ☐ Some difficulty (but you can still perform the activity well enough)
- ☐ A lot of difficulty (but you can still do the activity)
- ☐ Unable (you cannot do this activity or someone else helps you with it)

17. Do you have any difficulty with sleeping?

- ☐ I have no trouble sleeping because of my injury and discomfort
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless) since my injury
- ☐ My sleep is mildly disturbed (1-2 hours sleepless) since my injury
- ☐ My sleep is moderately disturbed (2-3 hours sleepless) since my injury
- ☐ My sleep is greatly disturbed (3-5 hours sleepless) since my injury
- ☐ My sleep is completely disturbed (5-7 hours sleepless) since my injury

18. In regards to sexual activity since and because of your injury:

- ☐ It is not a problem and there has not been a change because of my injury
- ☐ It is a little less frequent because of my injury
- ☐ It is much less frequent because of my injury
- ☐ No sexual functioning because of my injury

19. In regards to you pain at the moment:

- ☐ I have no pain at the moment
- ☐ My pain is mild at the moment
- ☐ My pain is moderate at the moment
- ☐ My pain is severe at the moment
- ☐ My pain is the worst imaginable at the moment

20. In regards to your pain most of the time:

- ☐ I have no pain most of the time
- ☐ My pain is very mild most of the time
- ☐ My pain is moderate most of the time
- ☐ My pain is fairly severe most of the time
- ☐ My pain is the worst imaginable most of the time

21. How much do your injury and/or pain interfere with your ability to travel?

- ☐ None
- ☐ Some or a little of the time
- ☐ A lot or most of the time
- ☐ All of the time. I can’t travel

22. How much do your injury and/or pain interfere with your ability to engage in social activities?

- ☐ None
- ☐ Some or a little of the time
- ☐ Most of the time
- ☐ All of the time. I can't engage in social activities

23. How much do your injury and/or pain interfere with your ability to engage in recreational activities??

- ☐ None
- ☐ Some or a little of the time
- ☐ Most of the time
- ☐ All of the time. I can't engage in recreational activities

24. How much do your injury and/or pain interfere with concentrating and thinking?

- ☐ None
- ☐ Someone a little of the time
- ☐ A lot or most of the time
- ☐ All of the time- I can't concentrate or think very clearly

25. How much has your injury and/or pain caused emotional distress with depression or anxiety?

- ☐ None (no depression or anxiety from the injury or discomfort)
- ☐ Some or a little of the time (mild depression or anxiety from the injury or discomfort)
- ☐ A lot or most of the time (moderate depression or anxiety from the injury or discomfort)
- ☐ All of the time (severe depression or anxiety from the injury or discomfort)