CARROLL HEALTH GROUP
A LifeBridge Health Partner

General Surgery

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Adult Screening Form

Patient Name: _____ DOB: _____ Age: _____

Because we recognize that many issues in today's society are not openly discussed, Carroll Health Group General Surgery is routinely asking our patients to answer the questions below. The purpose of asking these questions is to help us give you the best care possible.

If your answer to any of the following questions is YES, please put a mark in this box ☐

In the past year, have you been threatened, or felt controlled by your spouse, partner, or caretaker?
Have you or your partner, spouse, or caretaker ever used physical force when you were arguing?
Has your partner, spouse, or caretaker ever destroyed things that you care about?
Are you ever afraid of your spouse, partner, or caretaker?

I do **NOT** wish to answer this question.
Signature: _____
Date:

Do you experience pain or suffering?
Never ☐
Some of the time ☐
Most of the time ☐
All of the time ☐

Are you currently taking medication(s) or using some type of treatment for pain relief? ☐ Yes ☐ No

Are you currently enrolled in a Pain Management Program?
☐ Yes ☐ No
If yes, who do you see for Pain Management?

_____

_____

_____

How would you rate the severity of your pain?
Rate your pain by circling the number that best describes your pain.

0 1 2 3 4 5 6 7 8 9 10

0 = No Pain
10 = Worst Pain

Reviewed by: _____ Date: _____