YAACOV J. KRAVITZ, Ed.D.
Licensed Psychologist

101 Greenwood Ave. Suite 410
Jenkintown, PA 19046-2603

drk@dr-yjkravitz.com
215-635-3O11

Office Information

My office is located at
101 Greenwood Ave.
Suite 410
Jenkintown, PA 19046-2603

My business phone number: 215-635-3011.

Office Hours are by appointment only:
Monday: 10:00am - 7:00pm; Tuesday 10:00am - 7:00pm ; Thursday 10:00am - 5:00pm

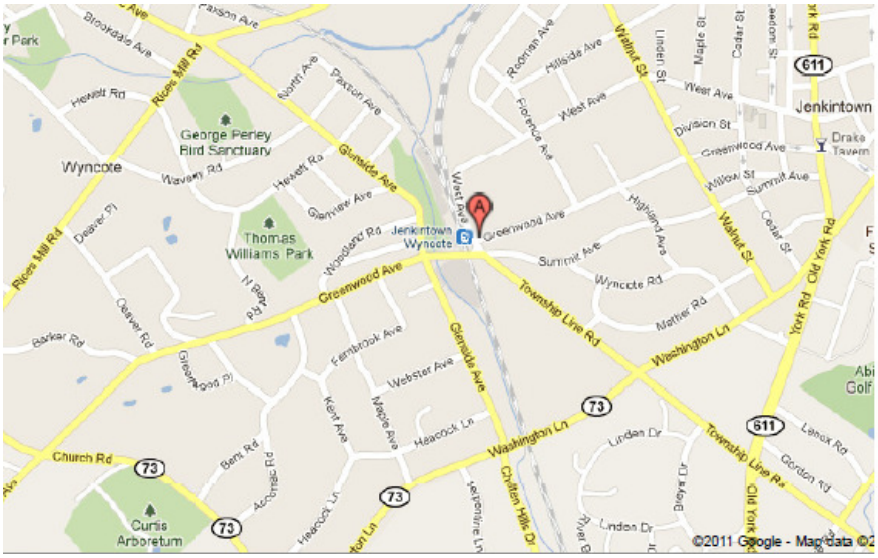
Directions and parking:

101 Greenwood Ave. is located at the intersection of Greenwood Ave., West Ave. and Township Line Road in Jenkintown. We are directly across the street from the SEPTA Regional Rail – Jenkintown Station.

There is a large parking lot on the east side of the building with direct access to the building. Please use the upper level.

There are parking spaces for individuals with disability tags in two locations:

1. off of Greenwood Ave at the corner of the building near the entrance to the lot
2. three spaces on the Upper Level (no wheel chair access on this level) turn left at the top of the ramp.



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Informed Consent: Information for individuals participating in a psychological assessment prior to surgery for a Spinal Cord Stimulator

1. Your Medical Doctor or surgeon has requested that you be evaluated to determine your eligibility to undergo surgery and have a Spinal Cord Stimulator or other device implanted. The evaluation may be required by your insurance company.
2. The purpose of the evaluation is to determine several factors relevant to your eligibility for the procedure:
    a. Are you able to understand, reason about and make an informed decision about the surgery?
    b. Do you have any psychological characteristics that indicate that you are not a good candidate for this procedure? Certain individuals may not benefit from the procedure because of psychological factors.
3. This psychologist serves as a consultant to your physician. Information that you disclose to this psychologist will be shared with the referring physician. That information may also be provided to your insurance company. This psychologist cannot control the release of information by another source once that information has been conveyed with your consent. Your physician and insurance company will use this information to make decisions about your treatment including whether or not you receive the SCS implant.
4. This psychologist may make recommendations to your physician about additional behavioral interventions that may be helpful to you in benefitting from the implant or that may be advisable in place of the implant. In certain cases you may be required to follow the recommendations prior to receiving the implant. You may also contact this psychologist to arrange a follow up session to discuss these recommendations.
5. This evaluation consists of two components: an interview and psychological testing. The testing consists of several paper and pencil assessments that you will be asked to complete.
6. The assessment may be covered by your insurance. Some insurance companies will cover the interview component of the assessment, but not psychological testing. You are responsible for payment for any services not covered by insurance as well as any deductibles or co-pays.

I have read and understand the above information. I consent to participate in the assessment with full knowledge of its purpose, use of information and the limits of confidentiality.

➔ Patient Signature _____ Date _____

Patient Name [please print] _____ Date of Birth _____

Yaacov Jeffrey Kravitz, Ed.D.

101 Greenwood Ave., Suite 410, Jenkintown, PA 19046 www.dr-yjkravitz.com 215-635-3O11

Patient Name_____ Sex_____ DOB_____

Address _____City_____ State_____Zip_____

Home Phone_____Work_____Cell_____

* Confidential messages may be left at (check any that apply) ___ Home Phone __work ____cell
* If you consent to the exchange of logistic information (eg, appointments) and educational information by e-mail please give your e-mail address _____ Initials ____
PLEASE NOTE THAT E-MAIL IS NOT SECURE AND I CAN NOT GUARANTEE ITS CONFIDENTIALITY.

Marital Status: ___ Minor ___ Single ___Married ___Divorced ___Widowed ____Separated

Employment: ____Full Time ____Part Time ___Minor ____Unemployed ____Disability

Employer Name:_____

Employer Address _____

If Student: ____ Full Time ____Part Time School Name: _____

Referred By: _____

Family Dr./Pediatrician: _____

Emergency Contact Person: _____Phone number _____

Responsible Party Name:_____ DOB _____

SS# _____Relationship to Patient _____

Address _____

Home Phone_____Work_____Cell_____

Employer: _____Address:_____

Primary Insurance Information: Must be completed fully in order to bill Insurance Co.:

Name of Insured: _____Relationship to Patient_____

Insured's DOB_____ _____

Insurance Company Name _____Phone_____

Address _____

ID# _____Group # _____Deductible._____

Are You covered for Out-Patient Psychotherapy:___Yes___No. Max.Benefit Amount _____

Are You covered under your:_____Basic Plan or _____ Major Medical Plan .

Secondary Insurance Information: Are You covered for Out-Patient Psychotherapy:___Yes___No

Name Of Insured: _____Relationship to Patient_____

Insured's DOB_____ Insured's S S# _____

Insurance Company Name _____Phone_____

Address _____

ID# _____Group # _____Deductible._____

Name_____ INTAKE QUESTIONNAIRE
Date _____ Yaacov Jeffrey Kravitz, Ed.D., Licensed Psychologist

Please complete these questions as fully and as accurately as you can. Case records are strictly confidential.

I. PERSONAL INFORMATION

Birth date: ____/_____/_____ Age:___ Sex____ Race_____

Religion_____ Church/Synagogue member: yes __ no __

Education: Years or grade completed_____ Degrees earned_____

Occupation_____ How long in present job?_____

Have you had any counseling and/or psychiatric care? yes[ ] No[ ] If yes, when and under what circumstances:

Name of Dr. or counselor	Approximate Dates	What problem were you treated for?		

Who referred you to this psychologist or this group? _____

IN EMERGENCY PLEASE NOTIFY:

Name_____ Relationship _____Phone _____

Address_____Zip_____

MARITAL INFORMATION

Present Marital Status: (check one): single [ ] engaged [ ] married [ ]
separated [ ] divorced [ ] widowed [ ] unmarried couple [ ]

How long in present status?_____

Present mate: First name_____ Age _____

Occupation_____ religion_____ Hobbies _____

Comments about mate _____

_____

Prior marriage length was _____years. From 19____ to 19____

Prior mate: First name_____

Occupation _____ religion_____ Hobbies_____

(comments about mate _____

Was this marriage broken by divorce [ ] or by the death [ ] of mate?

Give information about additional marriages on the reverse side of page.

CHILDREN:

First name: Sex Age Descriptive comments

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

_____ ___ ___ _____

Who is currently living in your household? _____

_____

Name_____ INTAKE QUESTIONNAIRE
Date _____ Yaacov Jeffrey Kravitz, Ed.D., Licensed Psychologist

FAMILY HISTORY

Parents (names) Mother _____ Father _____
Occupation_____ _____
Education _____ _____
Religion_____ _____
How do you get along? _____ _____
Parent's current marital status _____ _____
Current age or age at death _____ _____
If deceased, what was your age then? _____ _____
Comments _____ _____

Sisters and brothers in chronological order (include yourself)

First name Sex Age Descriptive comments

_____ ___ ___ _____
_____ ___ ___ _____
_____ ___ ___ _____
_____ ___ ___ _____

Give any other information about your family that seems important (include suicide, chemical abuse, diagnosed mental illness, etc.) _____
_____
_____

Is there any history of abuse in your life? Yes [ ] No [ ]
If yes, was it verbal [ ] emotional [ ] physical [ ] sexual [ ]

II. GENERAL CURRENT HEALTH data.

1) How much caffeine do you consume each day? (Give number of cups, size of typical cup, and amount of sugar per cup)
Coffee ___ cups _____ Oz/CUP _____ sugar
tea _____ cups _____ Oz/CUP _____ sugar
sodas/colas_____ Type _____

2) Cigarette use per day equals _____ cigarettes, or _____ packages.

a) Alcohol and drug consumption equals

Substance	Amount	How often ?	Age began	Last used
Wine				
Beer				
Hard liquor				
Drug(specify)				

4) List all known allergies (food, medications, environmental factors) including the reactions you experience. Please include any treatment and/or medications that you use to deal with your allergies:

5) What kind of exercise do you get? What is the frequency of your exercise?

What is the effect on you of this exercise?

How is most of your free time occupied?

6) What is your current height?_____Weight_____
In the last six months have you gained ___ weight or lost_ weight?
How much? ____ lbs. Reason

7) Describe your daily diet. Include foods, drinks, snacks:
Breakfast:

Lunch:

Dinner:

Snacks:

8) Please list any medical conditions that you have now or have had in the past:

Medical Condition	Approximate Dates	Name of Dr. or counselor

9)List all medications you currently take. Please include dosage and condition being treated.
Please list all current medications (prescription/non-prescription/vitamins/herbs/other):

Name of medication	Dosage	Date started	What is it for?

[Use reverse side or separate page for additional medications or conditions.]
What is the date of your last physical exam?_____

III. INFORMATION ABOUT CURRENT CONCERNS

Has life been satisfying to you? Explain.

Additional thoughts or comments:

Your Name _____ Date:_____

Situations Affecting Your Pain

I am interested in how different situations affect your pain.
For each of the following situations:

If it makes the pain **Worse** circle Worse on the line next to the item
If it makes the pain **Better** circle Better on the line next to the item
If you think that this situation is a trigger of a pain episode circle Trigger

If the situation has NO effect on your pain DO NOT CIRCLE any response.

1. Worry:	Worse	Better	Trigger
2. Tension:	Worse	Better	Trigger
3. Physical Exercise, Movement	Worse	Better	Trigger
(Standing, Lifting, Walking, Etc.):	Worse	Better	Trigger
4. Menstrual Cycle:	Worse	Better	Trigger
5. Relaxation:	Worse	Better	Trigger
6. Weekends:	Worse	Better	Trigger
7. Vacations:	Worse	Better	Trigger
8. Going To Work:	Worse	Better	Trigger
9. Concentration:	Worse	Better	Trigger
10. Reading:	Worse	Better	Trigger
11. Studying:	Worse	Better	Trigger
12. Listening To Lectures, Seminars, Talks, Etc.:	Worse	Better	Trigger
13. Noises:	Worse	Better	Trigger
14. Excitement:	Worse	Better	Trigger
15. Quarrels:	Worse	Better	Trigger
16. Anger:	Worse	Better	Trigger
17. Emotional Times:	Worse	Better	Trigger
18. Sunshine:	Worse	Better	Trigger
19. Hot Baths:	Worse	Better	Trigger
20. Precision Work:	Worse	Better	Trigger
21. Sex:	Worse	Better	Trigger
22. Annoyances:	Worse	Better	Trigger
23. Diet-Certain Food And/Or Drink:	Worse	Better	Trigger
24. Alcohol:	Worse	Better	Trigger
25. Fatigue:	Worse	Better	Trigger
26. Weather:	Worse	Better	Trigger
27. Sympathy & Attention:	Worse	Better	Trigger
28. Cold/Heat:	Worse	Better	Trigger
29. Other (Please specify)	Worse	Better	Trigger

SURGERIES, TREATMENTS AND METHODS FOR MANAGING YOUR PAIN

Name Date:

Please **list every Surgery, Treatment (injection, acupuncture, etc.) and other method** (lying down, relaxing, meditation, massage, hypnosis, distractions, keeping busy) you have used to manage your pain. Indicate how each has affected your pain in the short and long term. Also indicate how it has affected your quality of life.

Dates [from-to]	Type of Treatment or other method you have used to manage pain	Short-term effects on desired outcome	Long-term effects on desired outcome	Long-term effects on Quality of Life

WEST HAVEN-YALE MULTIDIMENSIONAL PAIN INVENTORY

BEFORE YOU BEGIN, PLEASE ANSWER 2 PRE-EVALUATION QUESTIONS BELOW:

1. Some of the questions in this questionnaire refer to your "significant other". A significant other is *a person with whom you feel closest.* This includes anyone that you relate to on a regular or infrequent basis. It is very important that you identify someone as your "significant other". Please indicate below who your significant other is (check one):

   __ Spouse __Partner/Companion __Housemate/Roomate
   __ Friend __Neighbor __Parent/Child/Other relative
   __ Other(please describe):

---

2. Do you currently live with this person? __YES __ NO

When you answer questions in the following pages about "your significant other", always respond in reference to the specific person you just indicated above.

A. In the following 20 questions, you will be asked to describe your pain and how it affects your life. Under each question is a scale to record your answer. Read each question carefully and then circle a number on the scale under that question to indicate how that specific question applies to you.

1. Rate the level of your pain at the present moment.

0	1	2	3	4	5	6
No pain						Very intense pain

2. In general, how much does your pain problem interfere with your day to day activities?

0	1	2	3	4	5	6
No intereference						Extreme interference

3. Since the time you developed a pain problem, how much has your pain changed your ability to work?

0	1	2	3	4	5	6
No change						Extreme change

___ Check here, if you have retired for reasons other than your pain problem

4. How much has your pain changed the amount of satisfaction or enjoyment you get from participating in social and recreational activities?

0	1	2	3	4	5	6
No change						Extreme change

5. How supportive or helpful is your spouse (significant other) to you in relation to your pain?

0	1	2	3	4	5	6
Not at all supportive						Extremely supportive

6. Rate your overall mood during the past week.

0	1	2	3	4	5	6
Extremely low mood						Extremely high mood

7. On the average, how severe has your pain been during the last week?

0	1	2	3	4	5	6
Not at all severe						Extremely severe

8. How much has your pain changed your ability to participate in recreational and other social activities?

0	1	2	3	4	5	6
No change						Extreme change

9. How much has your pain changed the amount of satisfaction you get from family-related activities?

0	1	2	3	4	5	6
No change						Extreme change

10. How worried is your spouse (significant other) about you in relation to your pain problem?

0	1	2	3	4	5	6
Not at all worried						Extremely worried

11. During the past week, how much control do you feel that you have had over your life?

0	1	2	3	4	5	6
Not at all in control						Extremely in control

12. How much suffering do you experience because of your pain?

0	1	2	3	4	5	6
No suffering						Extreme suffering

13. How much has your pain changed your marriage and other family relationships?

0	1	2	3	4	5	6
No change						Extreme change

14. How much has your pain changed the amount of satisfaction or enjoyment you get from work?

0	1	2	3	4	5	6
No change						Extreme change

__ Check here, if you are not presently working.

15. How attentive is your spouse (significant other) to your pain problem?

0	1	2	3	4	5	6
Not at all attentive						Extremely attentive

16. During the <u>past week</u>, how much do you feel that you've been able to deal with your problems?

0	1	2	3	4	5	6
Not at all						Extremely well

17. How much has your pain changed your ability to do household chores?

0	1	2	3	4	5	6
No change						Extreme change

18. During the <u>past week</u>, how irritable have you been?

0	1	2	3	4	5	6
Not at all irritable						Extremely irritable

19. How much has your pain changed your friendships with people other than your family?

0	1	2	3	4	5	6
No change						Extreme change

20. During the <u>past week</u>, how tense or anxious have you been?

0	1	2	3	4	5	6
Not at all tense or anxious						Extremely tense or anxious

B.

In this section, we are interested in knowing how your significant other (this refers to the person you indicated above) responds to you when he or she knows that you are in pain. On the scale listed below each question, **circle a number** to indicate <u>how often</u> your significant other generally responds to you in that particular way <u>when you are in pain</u>.

1. Ignores me.

0	1	2	3	4	5	6
Never						Very often

2. Asks me what he/she can do to help.

0	1	2	3	4	5	6
Never						Very often

3. Reads to me.

0 1 2 3 4 5 6
Never Very often

4. Expresses irritation at me.

0 1 2 3 4 5 6
Never Very often

5. Takes over my jobs or duties.

0 1 2 3 4 5 6
Never Very often

6. Talks to me about something else to take my mind off the pain.

0 1 2 3 4 5 6
Never Very often

7. Expresses frustration at me.

0 1 2 3 4 5 6
Never Very often

8. Tries to get me to rest.

0 1 2 3 4 5 6
Never Very often

9. Tries to involve me in some activity

0 1 2 3 4 5 6
Never Very often

10. Expresses anger at me.

0 1 2 3 4 5 6
Never Very often

11. Gets me some pain medications.

0 1 2 3 4 5 6
Never Very often

12. Encourages me to work on a hobby.

0	1	2	3	4	5	6
Never						Very often

13. Gets me something to eat or drink.

0	1	2	3	4	5	6
Never						Very often

14. Turns on the T.V. to take my mind off my pain

0	1	2	3	4	5	6
Never						Very often

C.

Listed below are 18 common daily activities. Please indicate <u>how often</u> you do each of these activities by <u>circling</u> a number on the scale listed below each activity. Please complete <u>all</u> 18 questions.

1. Wash dishes.

0	1	2	3	4	5	6
Never						Very often

2. Mow the lawn.

0	1	2	3	4	5	6
Never						Very often

3. Go out to eat.

0	1	2	3	4	5	6
Never						Very often

4. Play cards or other games.

0	1	2	3	4	5	6
Never						Very often

5. Go grocery shopping.

0	1	2	3	4	5	6
Never						Very often

6. Work in the garden.

0	1	2	3	4	5	6
Never						Very often

7. Go to a movie.

0 1 2 3 4 5 6
Never Very often

8. Visit friends.

0 1 2 3 4 5 6
Never Very often

9. Help with the house cleaning.

0 1 2 3 4 5 6
Never Very often

10. Work on the car.

0 1 2 3 4 5 6
Never Very often

11. Take a ride in a car.

0 1 2 3 4 5 6
Never Very often

12. Visit relatives.

0 1 2 3 4 5 6
Never Very often

13. Prepare a meal.

0 1 2 3 4 5 6
Never Very often

14. Wash the car.

0 1 2 3 4 5 6
Never Very often

15. Take a trip.

0 1 2 3 4 5 6
Never Very often

16. Go to a park or beach.

0	1	2	3	4	5	6
Never						Very often

17. Do a load of laundry.

0	1	2	3	4	5	6
Never						Very often

18. Work on a needed house repair.

0	1	2	3	4	5	6
Never						Very often

WEST HAVEN-YALE MULTIDIMENSIONAL PAIN INVENTORY
For Significant Others

Please give this Questionnaire to the person who you indicated was your "Significant Other" in the WEST HAVEN-YALE MULTIDIMENSIONAL PAIN INVENTORY.

To the Significant Other: Please complete this questionnaire for the person who has designated you as their "Significant Other," and who is requesting treatment for pain.

When you know your partner is in pain (or experiencing increased pain), how are you likely to respond? Mark how frequently you are likely to do each of the following:

1. Express sympathy

0 1 2 3 4 5 6
Never Very often

2. Ask what I can do to help.

0 1 2 3 4 5 6
Never Very often

3. Leave the room.

0 1 2 3 4 5 6
Never Very often

4. Express irritation at him/her.

0 1 2 3 4 5 6
Never Very often

5. Take over his/her job or duties.

0 1 2 3 4 5 6
Never Very often

6. Talk to him/her about something else to take him/her mind off the pain.

0 1 2 3 4 5 6
Never Very often

7. Express my frustration at him/her.

0 1 2 3 4 5 6
Never Very often

8. Try to get him/her to rest.

0 1 2 3 4 5 6
Never Very often

9. Try to involve him/her in some activity

0 1 2 3 4 5 6
Never Very often

10. Express anger at him/her.

0 1 2 3 4 5 6
Never Very often

11. Gets him/her some pain medication.

0 1 2 3 4 5 6
Never Very often

12. Encourage him/her to work on a hobby.

0 1 2 3 4 5 6
Never Very often

13. Get him/her something to eat or drink.

0 1 2 3 4 5 6
Never Very often

14. Turn on the T.V. to take his/her mind off my pain

0 1 2 3 4 5 6
Never Very often

15. Give him/her a massage.

0 1 2 3 4 5 6
Never Very often

16. Try to comfort him/her by listening to his/her complaints.

0 1 2 3 4 5 6
Never Very often

17. Tell him/her not to exert himself/herself.

0 1 2 3 4 5 6
Never Very often

Pain Scale (PIPS)

Below you will find a list of statements. Please rate how true each statement is for you by circling a number next to it.

1 Never true	2 Very rarely true	3 Seldom true	4 Sometimes true	5 Often true	6 Almost always true	7 Always true

1. I would do almost anything to get rid of my pain	1 2 3 4 5 6 7
2. I do not do things that are important to me to avoid feeling my pain	1 2 3 4 5 6 7
3. When I am in pain, I stay away from other people	1 2 3 4 5 6 7
4. It is important that I learn to control my pain	1 2 3 4 5 6 7
5. It is important to understand what causes my pain	1 2 3 4 5 6 7
6. I feel angry about my pain	1 2 3 4 5 6 7
7. I say things like "I don't have any energy", "I am not well enough", "I don't have time", "I don't dare", "I have too much pain", "I feel too bad" or "I don't feel like it"	1 2 3 4 5 6 7
8. I avoid doing things when there is a risk it will hurt or make things worse	1 2 3 4 5 6 7
9. I avoid scheduling activities because of my pain	1 2 3 4 5 6 7
10. I put a lot of effort into fighting my pain	1 2 3 4 5 6 7
11. It is not me that controls my life, it is my pain	1 2 3 4 5 6 7
12. I need to understand what is wrong in order to move on	1 2 3 4 5 6 7
13. Because of my pain, I no longer plan for the future	1 2 3 4 5 6 7
14. I postpone things on account of my pain	1 2 3 4 5 6 7
15. I cancel planned activities when I am in pain	1 2 3 4 5 6 7
16. I interrupt activities if it starts to hurt or becomes worse	1 2 3 4 5 6 7

PCS

Client No.: _____ Age: _____ Sex: M(__) F(__) Date: _____

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

0 – not at all **1** – to a slight degree **2** – to a moderate degree **3** – to a great degree **4** – all the time

When I'm in pain …

1 ☐ I worry all the time about whether the pain will end.

2 ☐ I feel I can't go on.

3 ☐ It's terrible and I think it's never going to get any better.

4 ☐ It's awful and I feel that it overwhelms me.

5 ☐ I feel I can't stand it anymore.

6 ☐ I become afraid that the pain will get worse.

7 ☐ I keep thinking of other painful events.

8 ☐ I anxiously want the pain to go away.

9 ☐ I can't seem to keep it out of my mind.

10 ☐ I keep thinking about how much it hurts.

11 ☐ I keep thinking about how badly I want the pain to stop.

12 ☐ There's nothing I can do to reduce the intensity of the pain.

13 ☐ I wonder whether something serious may happen.

…Total

IMAGE-SP
Pain Drawing

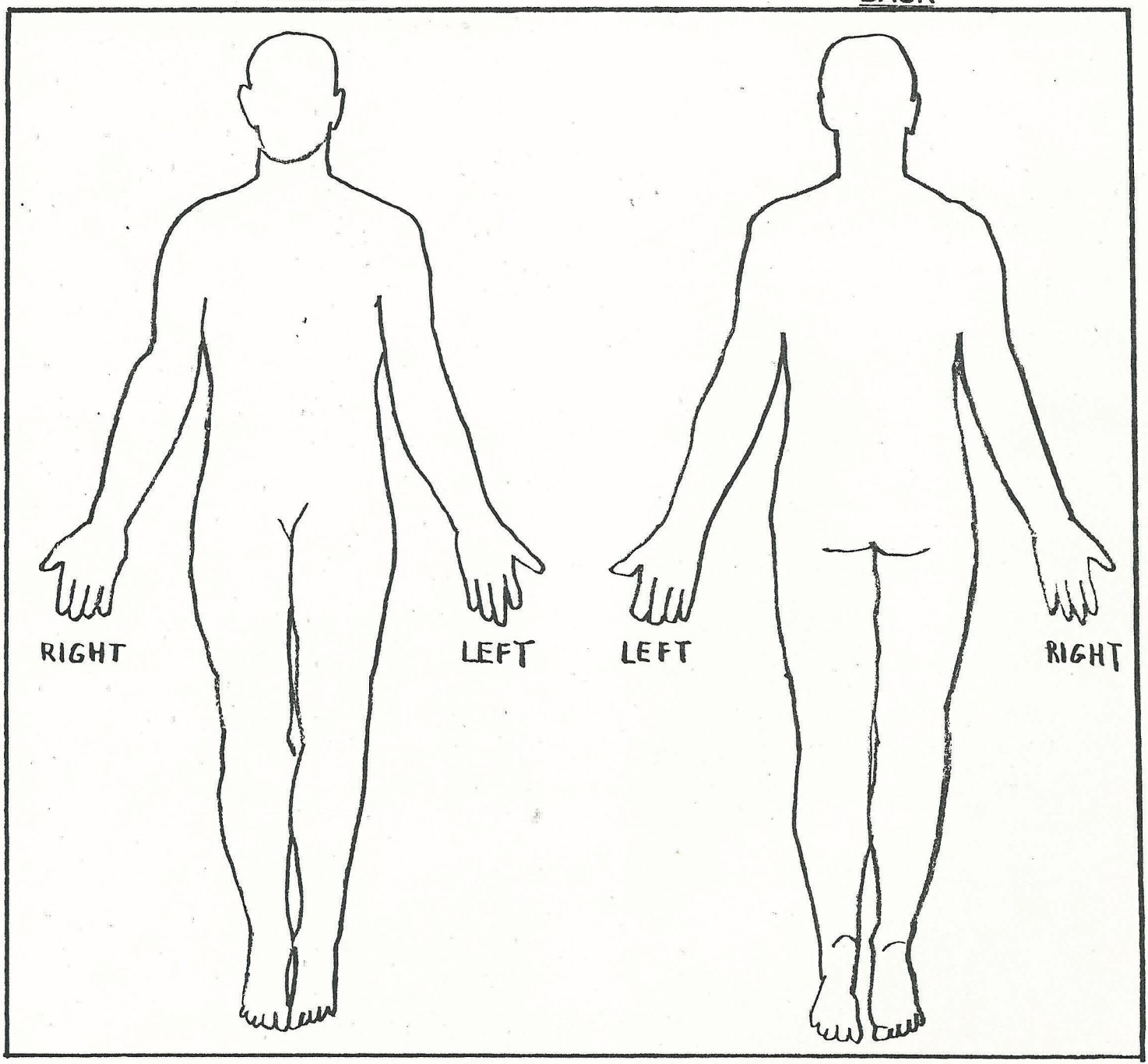
Name: _____
Date: _____

By David Selby, M.D., C. E. McCoy, Ed.D., and G. Frank Lawlis, Ph.D.

Draw the location of your pain on the body outlines and mark how bad it is on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
AAAA AA	= = = = = = = = = =	OOOO OO	. . . .	///// ////	x x x x x x x

Percentage of pain in back _____ Percentage of pain in legs _____



NO PAIN ——— INTOLERABLE PAIN

MARK YOUR PAIN ESTIMATE

Name:_____ Date: _____

Some of the words below describe your average pain. The words are arranged in groups or categories. Circle ONLY those words that best describe it. Leave out any category (group) that is not suitable. Use only a single word in each appropriate category (group,) the one that best applies.

What Does Your Pain Feel Like?

A
1. Flickering
2. Quivering
3. Pulsing
4. Throbbing
5. Beating
6. Pounding

B
1. Jumping
2. Flashing
3. Shooting

C
1. Pricking
2. Boring
3. Drilling
4. stabbing
5. Lancinating

D
1. Sharp
2. Cutting
3. Lacerating

E
1. pinching
2. Pressing
3. Gnawing
4. Cramping
5. Crushing

F
1. Tugging
2. Pulling
3. Wrenching

G
1. Hot
2. Burning
3. Scalding
4. Searing

H
1. Tingling
2. Itchy
3. Smarting
4. Stinging

I
1. Dull
2. Sore
3. Hurting
4. Aching
5. Heavy

J
1. Tender
2. Taut
3. Rasping
4. Splitting

K
1. Tiring
2. Exhausting

L
1. Sickening
2. Suffocating

M
1. Fearful
2. Frightful
3. Terrifying

N
1. Punishing
2. Gruelling
3. Cruel
4. Vicious
5. Killing

O
1. Wretched
2. Blinding

P
1. Annoying
2. Troublesome
3. Miserable
4. Intense
5. Unbearable

Q
1. Spreading
2. Radiating
3. Penetrating
4. Piercing

R
1. Tight
2. Numb
3. Drawing
4. Squeezing
5. Tearing

S
1. Cool
2. Cold
3. Freezing

T
1. Nagging
2. Nauseating
3. Agonizing
4. Dreadful
5. Torturing

PLEASE CONTINUE ON THE REVERSE SIDE OF THIS PAGE.

1. How does your pain change with time? Which words or words would you use to describe the pattern of your pain? **Circle the number** of the most appropriate words.

1. continuous steady constant 2. rhythmic periodic intermittent 3.brief momentary transient

How Strong is Your Pain? People agree that the following 5 words (mild, discomforting, distressing, horrible, excruciating) represent pain of increasing intensity. To answer each question below **circle** the number of the most appropriate word following the question.

2. Which word describes your pain right now? 0. No Pain

1. mild 2. discomforting 3.distressing 4. horrible 5.excruciating

3. Which word describes it when it is least?

1. mild 2. discomforting 3.distressing 4. horrible 5.excruciating

4. Which word describes it when it is worst?

1. mild 2. discomforting 3.distressing 4. horrible 5.excruciating

5. Which word describes your average pain – how it feels most of the time?

1. mild 2. discomforting 3.distressing 4. horrible 5.excruciating

6. Which word describes the worst toothache you ever had?

1. mild 2. discomforting 3.distressing 4. horrible 5.excruciating

7. Which word describes the worst headache you ever had?

1. mild 2. discomforting 3.distressing 4. horrible 5.excruciating

8. Which word describes the worst stomach-ache you ever had?

1. mild 2. discomforting 3.distressing 4. horrible 5.excruciating

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7 __. 8__. 9__. 10__. Worst Disability

Signature_____ Please Print_____

Date _____

YAACOV J. KRAVITZ, Ed.D.,Licensed Psychologist
101 Greenwood Ave., Suite 410, Jenkintown, PA 19046 www.dr-yjkravitz.com 215-635-3O11

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. A HIPAA Notice of Privacy Practices (the Notice) is attached to this Agreement .It is very important that you read these documents carefully. We can discuss any questions you have about the procedures. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. I will then be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

TREATMENT SESSIONS We will usually schedule one session of 45 to 60 minutes duration per week at a time we agree on, although some sessions may be longer or more frequent. If you miss a scheduled appointment**,** you will be expected to pay a cancellation fee of $70 for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. This fee will be waived by Dr. Kravitz if he and you agree that the situation was an emergency.

PROFESSIONAL FEES My hourly fee for individual therapy is $130 for a 45 minute session; $160 for a 60 minute session; and $175 for an initial assessment. I charge $150 for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services may include, but are not limited to report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. [Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding, with a minimum of 4 hours, payable in advance.] Other services are often not eligible for insurance reimbursement and are your responsibility.

CONTACTING ME Due to my work schedule, I am often not immediately available by telephone. While I am in my office, I probably will not answer the phone if I am with a patient. When I am unavailable, my telephone is answered by an answering machine that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays when calls will be returned on the next work day. If you are difficult to reach, please inform me of some times when you will be available. In serious emergencies only you can call my cell at 267-626-9115. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY - Please see the attached Notice of Privacy Practices for details.

BILLING AND PAYMENTS You will be expected to pay for each session at the time it is held, unless you have insurance coverage that requires another arrangement. All insurance co-pays or private rate payments must be made at the time of the visit. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. If you have questions about the coverage, call your plan administrator. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. It may be necessary to seek approval for more therapy after a certain number of sessions.

In addition if your insurance carrier denies payment for any reason, you assume responsibility for the cost of the sessions. This agreement shall remain in effect for one year or throughout the course of treatment, whichever is longer.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS, AND THAT YOU AGREE AND CONSENT TO PARTICIPATE IN BEHAVIORAL HEALTH CARE SERVICES OFFERED AND PROVIDED BY DR. YAACOV J. KRAVITZ. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

I understand that I may revoke this authorization to release information at anytime by written notice to Dr. Kravitz and my insurance carrier.

Name (please print) _____ Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. **Your signature on the Patient-Psychotherapist Agreement provides consent for those activities, as follows**:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share your protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- I also may have contracts with accountants, billing services and lawyers. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.
- You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, and, sometimes, additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child who I am evaluating or treating is an abused child, the law requires that I file a report with the appropriate government agency, usually the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.

- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep information about you in two sets of professional records. One set constitutes your Clinical Record (Protected Health Information). It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to me by others confidentially, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. [I am sometimes willing to conduct this review meeting without charge.] In most circumstances, I am allowed to charge a copying fee of at least $0.20 per page and for certain other expenses. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information supplied to me confidentially by others), which I will discuss with you upon request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for refusing to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights or any complaints with you.

If there is a breach of your confidentiality, then I must inform you as well as Health and Human Services. A breach means that information has been released without authorization or without legal authority unless I (the covered entity) can show that there was a low risk that the PHI has been compromised because the unauthorized person did not view the PHI or it was de-identified. If you are self-pay, then you may restrict the information sent to insurance companies.

Most uses and disclosures of psychotherapy notes and of protected health information for marketing purposes and the sale of protected health information require an authorization. Other uses and disclosures not described in the notice will be made only with your written authorization. You must sign an authorization (release of information form) for releases unless it is for purposes already mentioned in this Privacy Notice (such as mandated reporting of child abuse, reporting of elder abuse, reporting of impaired drivers, etc.). You have a right to receive a copy of your Protected Health Information in an electronic format or (through a written authorization) designate a third party who may receive such information.

EFFECTIVE DATE and CHANGES TO THIS NOTICE

This Notice is effective on September 7, 2009. Revised 9/3/2014, 1/28/2015. I may change this notice at any time. If I change this notice I will make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this notice I will post the revised notice on my web site (www.dr-yjkravitz.com). You may also request a written copy. This form is educational only and does not constitute legal advice and covers only federal, not state law.

CONSENT FOR RELEASE OF MEDICAL RECORDS AND CONFIDENTIAL INFORMATION

This form when completed and signed by you, authorizes Dr. Kravitz to release protected information from your clinical record to the person you designate.

I, (patient Name)_____, (Birth date): _____ authorize my psychologist, Yaacov Jeffrey Kravitz, Ed.D. and/or his administrative and clinical staff, to

_____Disclose or release only to

_____obtain from

_____

(Person/Organization to/from whom information is to be disclosed/obtained) (phone number)

_____

(Street address, city, state, .zip code)

records and information relevant to the mental health professional services that I have received from him. Such release or disclosure shall be limited to the following specific types of information: (Provide a description of the information that you want disclosed. Your description should be as specific and detailed as possible.)

_x_ History and evaluation _____

_x_ Test results (Specify) _____

__ Other _____

I am requesting this release of information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

Assessment for Spinal Cord Stimulator trial

It is understood that information disclosure may be made through written documents, telephone conversation, or other electronic means.

I issue this authorization with knowledge of the contents of the material or communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence

By signing this consent to release confidential information / medical records, I am expressly consenting to release of information / medical records that may contain information concerning alcohol abuse, drug abuse, psychiatric treatment, or HIV-related information.

I hereby hold harmless the above named practitioner from any liability relevant to the release of the confidential information or privileged information.

The patient signing this form has the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

This authorization is valid today, and remains in effect until

(*fill in expiration date)* _____ or event _____.

If no date is specified authorization remains in effect for six (6) months from today.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Patient's Signature _____ Date _____

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided: _____

CONSENT TO RELEASE INFORMATION TO YOUR PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, assessment results, progress, and/or medication if necessary. I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date has been specified.

I, _____ _____ _____ . For the purpose of
(patient name-print) (pt D.O.B.) (pt. Social Security #)

coordinating care, and [indicate any additional reasons for information to be released] _____ authorize Yaacov Jeffrey Kravitz, Ed.D., to release information indicated in the "consent" portion of this form to (indicate your Primary Care Physician or other Physician to whom information is to be released):

PCP Name: _____

PCP Phone: _____ **PCP Fax**_____

PCP Address:_____
(Street) (City) (State) (Zip)

In addition to the physician named above, please release relevant information to the following physician:

Physician's Name: _____

Physician's Phone: _____ **PCP Fax**_____

Physician'sAddress:_____
(Street) (City) (State) (Zip)

CONSENT

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire twelve (12) months from the date of signature, unless another date is specified. I have read and understood the above information and give my consent:

PATIENT, PLEASE CHECK ONE OF THE FOLLOWING !!!!!!!!

1) To release any applicable mental health/substance abuse information to my primary care physician.
2) To release only medication information to my primary care physician.
3) I do not give my consent to releasing any information to my primary care physician.

_____
Patient signature (patients over 18) (Date)

_____
Witness (Date)

Yaacov Jeffrey Kravitz, Ed.D.
Licensed Psychologist
215-635-3011 (office)
101 Greenwood Ave., Suite 410
Jenkintown, PA 19046
Affiliate of Growth Opportunities Center

YAACOV J. KRAVITZ, Ed.D.
Licensed Psychologist

101 Greenwood Ave, Suite 410
Jenkintown, PA 19046

drk@dr-yjkravitz.com
215-635-3O11

Advance Notice of Non-Covered Service

Your insurance company (Independence Blue Cross, Keystone, Personal Choice, Aetna) does not cover Psychological Testing for the purpose of screening patients for Spinal Cord Stimulator Implantation or an intrathecal pain pump.

Based on review of current psychological literature these tests are considered to be the standard of care and are included in all assessments.

I have been notified by my psychologist that my insurance will deny payment for the testing services specified above. I agree, as indicated by my signature below, to pay for these services that are not covered or for which payment is not allowed by my insurance company.

Patient's Signature_____ Date_____

Jeffrey Kravitz, Ed.D., Licensed Psychologist

Assignment of insurance benefits and Release of Information for Insurance Purposes

Client's Name:_____ Date of Birth _____

Home Address _____

_____

Specific Information To Be Released: Protected Healthcare Information

- Purpose for Releasing Information: Establishes reasons for providing insurance coverage of mental health services and for additional authorization of services.]

I understand that my records are protected under Section 5100.34 of the Pennsylvania Mental Health Procedures Act and the Pennsylvania Drug and Alcohol Abuse Control Act, and under the federal regulations governing Confidentiality of Drug and Alcohol Abuse Patients Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____

(Specification of date, event, or condition upon which this consent expires)

Assignment of Insurance Benefits

I request that payment of authorized insurance benefits be made on my behalf to Jeffrey H. Kravitz, Ed.D. for any services rendered to me by that provider. I understand that I am liable for any balance not covered by my insurance. I understand that certain psychological services and tests may not be covered by my insurance and that if payment is refused I will be responsible for payment of related fees. I authorize Dr. Kravitz and his staff to release to or obtain from:
[Please check or write in your insurance provider's name.]

_____ Pennsylvania Blue Cross - Blue Shield.

_____ Aetna

_____ _____

and its agents any information needed to determine these benefits payable for related services.

Beneficiary Signature _____ Date _____