THE CENTER FOR PAIN MANAGEMENT AT STONY BROOK
Patient Demographics

Name_____Date_____

Address _____

_____

Home Phone # _____Alternate Phone # _____

Date of Birth _____ SS# _____

**Emergency Contact name and phone_____

Primary Insurance _____ ID# _____

Insurance phone number _____

Policy Holder _____Relationship _____ DOB _____

Secondary Insurance Plan _____

ID#_____

Insurance phone number_____

Policy holder_____Relationship_____DOB_____

Workers Compensation

Employer at time of Injury: _____Date of Injury:_____

Employer Address:_____Phone#:_____

WC Insurance Carrier Name:_____

Address:_____

Adjustor Name and Phone#:_____

Social Security#:_____WCB#:_____Carrier Claim#:_____

No Fault

Policy Holder:_____Policy Number:_____

Date Of Accident:_____Claim#:_____

No Fault Insurance Carrier Name & Address:_____

Adjustor Name and Phone#:_____

Name: MR: Date:

P.O. Box 1559
Stony Brook, NY 11790

GUARANTEE OF PAYMENT

Many insurance companies, including managed care organizations, require prior written authorization for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations from your insurance company prior to receiving medical services. If you have not received prior approval for the service or authorization has been denied, you are fully responsible for all charges if your insurance company does not agree to pay. In addition, you will be responsible for all deductibles, co-insurance, co-payments, any service that is not covered by your insurance plan, and any service that your insurance company has determined not to be "medically necessary".

★ ★ ★ ★ ★ ★ ★ ★

I have read and understand this information. I understand that my insurance company may deny coverage and request that **Stony Brook Center for Pain Management** perform this medical service anyway. I agree to be personally and fully responsible for all charges. I understand that the provider named above is relying on this promise and is rendering services without requiring payment at the time of service based on such reliance.

X_____ X_____ _____

Patient or Legally Authorized Representative/Guarantor **SIGN** | Print Name | Date

_____ _____ _____

Witness | Print Name | Date

CLINICAL PRACTICE MANAGEMENT PLAN

Patient's Name: _____
Last First Middle

RELEASE OF INFORMATION

I hereby authorize and direct STONY BROOK ANAESTHESIOLOGY

_____ _____, University Faculty Practice Corporations having treated me, to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

X_____ _____
Signature of Patient or Authorized Representative Date

UNIFORM ASSIGNMENT

I hereby assign, transfer and set over to STONY BROOK ANAESTHESIOLOGY

_____ _____, University Faculty Practice Corporations sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care, to cover the cost of care and treatment rendered to myself or my dependent.

In addition, I also assign, transfer and set over to all of the other University Faculty Practice Corporations from which I may require medical care, sufficient monies and/or benefits to which I may be entitled. These other University Faculty Practice Corporations are as follows: Stony Brook Anaesthesiology, Stony Brook Dermatology, Stony Brook Family Medical Group, Stony Brook Internists, New York Spine and Brain Surgery, Neurology Associates of Stony Brook, University Associates of Obstetrics and Gynecology, Stony Brook Preventative Medicine Services, Stony Brook Ophthalmology, Stony Brook Orthopaedic Associates., Stony Brook Children's Services, Stony Brook Psychiatric Associates., Stony Brook Radiation Oncology, Stony Brook Radiology, Stony Brook Surgical Associates, and Stony Brook Urology.

X_____ _____
Signature of Patient or Authorized Representative Date

Account Representative:

CENTER PAIN MANAGEMENT PQRS MEASURE 2019

Patient Name: _____

Date of Service: _____

Please check the appropriate answers to the questions below:

1) Are you over 65 years of age [ ] Yes [ ] No

   if the answer yes please answer question #2

2) Have you designated a person to make your medical decisions should you be unable to do so?
   [ ] YES [ ]NO

If the answer to question 2 is **YES** please provide the contact person, name, and phone number below

Name_____ Phone#_____

Physician/Provider/NP Use Only

Please circle PQRS Measure #47 which applies:

1123F	Advance Care Planning discussed and documented, advance care plan or surrogate decision maker documented in the medical record
1123F-8P	Advance Care Planning not documented, reason not otherwise specified.
1124F	Advance Care Planning discussed and documented in the Medical Record, patient did not wish or was not able to name a surrogate decision maker or provide an advanced care plan. Patient's cultural and/or spiritual beliefs preclude the discussion.

[ ] I personally reviewed the above PQRS Measure based on information provided:

MD/NP Signature_____ DATE_____

Stony Brook Medicine

Center for Pain Management
New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (631) 638-0800 if you have any question on how to complete any section on this form.

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

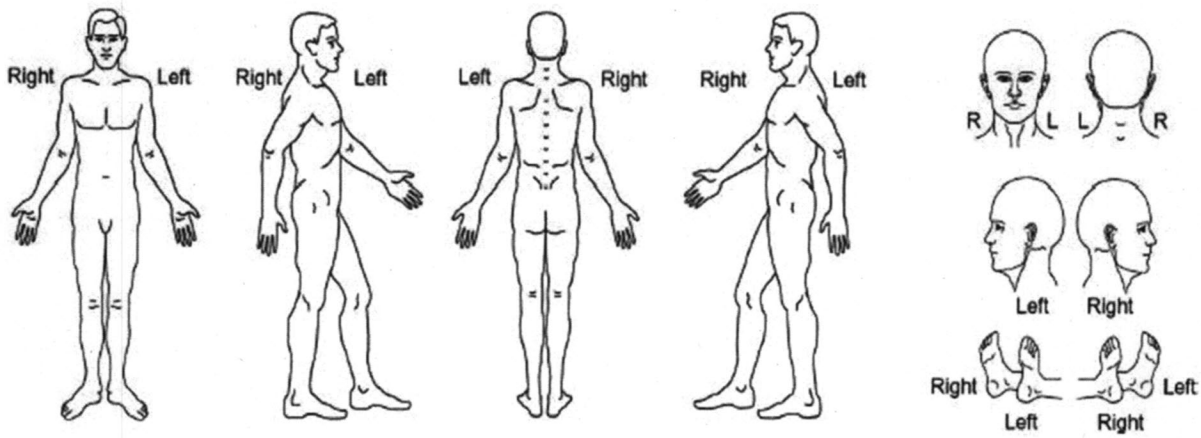
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately, when did this pain begin?_____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Describe the character of your pain (eg: dull, stabbing, throbbing, etc):

_____

What time of day is your pain at its worst? _____

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now_____ The Best It Gets_____ The Worst It Gets_____

What other factors worsen or affect your pain?

_____

What other factors relieve your pain?

_____

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc)

_____

What are the goals you wish to achieve with Pain Management? _____

_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐MRI of the: _____ Date: _____

☐X-Ray of the: _____ Date: _____

☐CT Scan of the: _____ Date: _____

☐EMG/NCV study of the: _____ Date: _____

☐Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief: ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other - _____

Which of these procedures listed above have helped with your pain? _____

_____

Please list the names of other Pain Physicians you have seen in the past?

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist	☐ Neurosurgeon	☐ Psychiatrist/Psychologist
☐ Chiropractor	☐ Orthopedic Surgeon	☐ Rheumatologist
☐ Internist	☐ Physical Therapist	☐ Neurologist

☐ Other _____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology
- ☐ Cancer – Type _____
- ☐ Cancer – Type_____
- ☐ Cancer – Type_____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders
- ☐ Presence of stent/pacemaker/ defibrillator

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ IBS/Crohns Disease

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neurological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Balance Disorder
- ☐ Head Injury
- ☐ Headaches
- ☐ Migraines

ENT
- ☐ Glaucoma
- ☐ Vertigo
- ☐ Hearing Problems
- ☐ Nosebleeds

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Psychological
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD/ADHD
- ☐ PTSD

Endocrinology
- ☐ Diabetes – Type_____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Other Diagnosed Conditions
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____ Date? _____

2) _____ Date? _____

3) _____ Date? _____

4) _____ Date? _____

5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐Arthritis ☐Cancer ☐Diabetes

☐Headaches/Migraines ☐High Blood Pressure ☐Kidney Problems

☐Liver Problems ☐Osteoporosis ☐Rheumatoid arthritis

☐Seizures ☐ Stroke

☐Other Medical Problems: _____

☐ I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ Daily use of alcohol ☐Never ☐ History of alcoholism ☐ Current alcoholism

Tobacco Use:

☐ Current user ☐ Former user ☐ Never used

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	**Dose**	**Frequency**
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication Name	**Dose**	**Frequency**
1)			
2)			
3)			
4)			
5)			

Only if any of your medications cause constipation, please answer these questions. If not, skip this section.

On average, how often do you have a bowel movement?
(Please check one)

☐ **More than 3 times per day**
☐ **Once per day**
☐ **Less than once per week**
☐ **2 to 3 times per day**
☐ **2 to 3 times per week**

Think back to when you started pain medicine. Did your bowel habits change? If so how?

_____

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to

Medication Name	Allergic Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: ☐Fevers ☐Chills ☐Sweats ☐Weakness ☐Fatigue ☐Decreased Activity ☐Malaise ☐Unexplained weight gain ☐Unexplained weight loss ☐Low sex drive ☐Difficulty sleeping

Eyes: ☐Blurriness ☐Double vision ☐Visual disturbance ☐Pain

Ears/Nose/Throat/Neck: ☐Hearing problems ☐Ear pain ☐Sinus problems ☐Sore throat ☐Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ☐Chest pain ☐Palpitations ☐Swelling in feet ☐Shortness of breath during sleep ☐Bleeding disorder ☐Blood clots ☐Fainting

Gastrointestinal: ☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation ☐Heartburn ☐Abdominal pain

Genitourinary/Nephrology: ☐Painful urination ☐Blood in urine ☐Change in urine stream ☐Unusual discharge ☐Flank pain ☐Urinary incontinence

Musculoskeletal: ☐Back pain ☐Neck pain ☐Joint pain ☐Muscle pain ☐Muscle cramp ☐ Muscle spasm ☐Gait disturbances ☐Joint stiffness ☐Joint swelling ☐Trauma

Integumentary: ☐Rash ☐Itching ☐Lesions ☐Bruising

Neurological: ☐Abnormal balance ☐Confusion ☐Numbness ☐Tingling ☐Dizziness ☐Headaches ☐Loss of coordination ☐Memory loss ☐Seizures ☐Tinnitus ☐Tremors ☐Vertigo

Psychiatric: ☐Feeling anxious ☐Depressed mood ☐Suicidal thoughts ☐Hallucinations ☐Stress problems ☐Suicidal planning ☐Thoughts of harming others

Opioid Risk Tool Patient Form

Mark each box that applies.

	Female	Male
1. Family History of Substance Abuse:		
Alcohol	☐	☐
Illegal Drugs	☐	☐
Prescription Drugs	☐	☐
2. Personal History of Substance Abuse:		
Alcohol	☐	☐
Illegal Drugs	☐	☐
Prescription Drugs	☐	☐
3. Age (mark box if between 16-45)	☐	☐
4. History of Preadolescent Sexual Abuse	☐	☐
5. Psychological Disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar, Schizophrenia	☐	☐
Depression	☐	☐

PHQ-4

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed, or hopeless	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

A C 2 C 0 3 0

Stony Brook Medicine

Stony Brook, NY 11794

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ADULT PATIENT NEEDS ASSESSMENT

Communication:

Do any of the following apply to you?

- ☐ Impaired Vision
- ☐ Impaired Hearing
- ☐ Reading or Speaking Problems
- ☐ Pain
- ☐ Concerns about your illness
- ☐ None of the above
- ☐ Other _____

What is your primary language? _____

Do you have difficulty understanding English? ☐ Yes ☐ No

Can you read English? ☐ Yes ☐ No

What language do you prefer when receiving information? _____

Culture:

Do you have any Cultural / Religious / Spiritual Practices that are important for us to know to provide your health care?

☐ Yes ☐ No If Yes, please describe: _____

_____

Learning Preference:

How do you prefer to learn?

☐ Reading ☐ Person explaining to me ☐ Seeing/pictures ☐ Demonstration ☐ Video/Television

Is there anyone you would like to have with you during your teaching? If so, whom? _____

Domestic Concerns:

Have you been a victim of mental or physical abuse? ☐ Yes ☐ No

Do you feel that you are currently in danger at home? ☐ Yes ☐ No

Falls Risk:

Do you have a fear of falling? ☐ Yes ☐ No

Have you fallen in the last 12 months? ☐ Yes ☐ No

If you answered "YES" to either of these two questions, please notify staff immediately.

Nutrition Screen:

Have you noticed a decrease in appetite within the last month? ☐ Yes ☐ No

Have you had an unexplained weight loss (over 10 lbs.) over the past 3–6 months? ☐ Yes ☐ No

Please describe your appetite: ☐ Good ☐ Fair ☐ Poor ☐ Other _____

Patient / Designee Signature: _____ Date: _____

Practitioner Signature: _____ ID#: _____ Date: _____ Time: _____

Stony Brook Medicine

Name: _____ DOB: _____

COMMUNICATION CONSENT

It is the policy of Stony Brook Anesthesiology not to release confidential information other than face to face without authorization to do so by alternative methods. Any information that will be provided will be released only to the authorized person(s) listed below.

I authorize Stony Brook Anesthesiology and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Telephone: ☐ Yes ☐ No _____-_____-_____

Voicemail: ☐ Yes ☐ No

E-mail: ☐ Yes ☐ No _____

*An invitation to join the Stony Brook patient portal will be sent to your e-mail.

If you would like to have information released to someone other than yourself, please complete the following list of authorized people:

1. Name: _____ Rel:_____ Tel: _____-_____-_____
2. Name: _____ Rel:_____ Tel: _____-_____-_____
3. Name: _____ Rel:_____ Tel: _____-_____-_____

*Patient Signature: _____ Date: _____