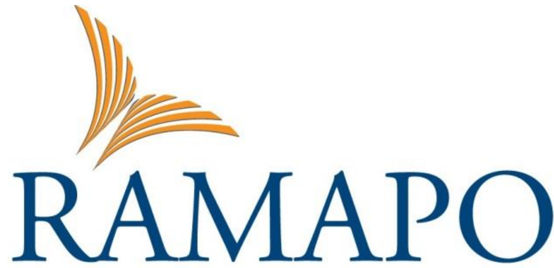


100 Route 59 Suite 111 Suffern, New York 10901
845-357-5745-Phone 845-357-5751-Fax

Pain Questionnaire

Name:____ Date:____________________________

Date of Birth:______________ Age:__________ Weight:_____________ Height:__________

Referring Physician:_________________________ Primary Care Physician:__________________

1. Date you first noticed your pain:____
2. Where is your pain located?____
3. Does your pain travel anywhere?_____ If yes, where?________________________________

____

4. Under what circumstances did your pain begin?

a) The pain just began, no reason. b) A work related injury c) A car accident

d) Following surgery e) Following illness f) Other

5. If your pain is work related, please list:

Employer:__________________________________ Date of Injury:_____________________
Type of Work:_______________________________ Occupation: ______________________

What is your present employment status:
a) Full Time b) Part Time c) Retired d) Short Term Disability e) Permanent Disability

Briefly describe the incident:____

____

____

What is your present employment status?____

6. If your injury resulted from a car accident, briefly describe the accident:___________________

____

____

7. Please indicate on the diagram where your pain occurs by shading the painful areas.

Front View **Back View**

R L L R

8. Use the following scale to indicate the severity of your pain.

0 1 2 3 4 5 6 7 8 9 10

No Pain Unbearable Pain

At the present time ________ At its usual level ________

At its worst level ________ At its least severe level ________

9. Is your pain worse at any particular time of day?_______________________________________

10. Since your pain began, has it:

a) Increased b) Decreased c) Remained the same

11. Would you describe your pain as:

a) Burning b) Sharp c) Aching
d) Throbbing e) Shooting f) Other

12. Is your pain associated with any of the following?

a) Numbness b) Tingling c) Pins & Needles sensation d) Muscle spasm
e) Lying down f) Coldness g) Skin discoloration h) Sweating
i) Bowel or bladder problems

13. Do any of the following make your pain feel WORSE?

a) Coughing b) Sneezing c) Sitting d) Standing
e) Lying Down f) Walking g) Physical activity h) Sexual activity
i) Bending forward or backward j) Twisting k) Other

14. Do any of the following make your pain feel BETTER?

a) Relaxation b) Sitting c) Standing d) Lying down
e) Alcoholic drinks f) Heat g) Cold h) Walking
i) Medicine j) Other

15. Please list ALL PAIN MEDICATIONS you are currently taking:

____

____

____

16. How long does the medicine last? _______________ hours.

17. On average, does the medicine you take:

a) Always take the pain away b) Usually take the pain away
c) Does not take the pain away at all

18. Have you had any of the following?

a) X-rays b) Cat scan c) MRI scan d) Bone scan e) EMG study f) Myelogram
g) Other If so, when and where? ____

____

____

19. Have you ever had any of the following treatments for your pain? (check all that apply)

a) Physical therapy | b) Occupational therapy | c)TENS
d) Chiropractic therapy | e) Acupuncture | f) Heat therapy
g) Bed rest | h) Traction | i) Hypnosis
j) Biofeedback | k) Relaxation therapy | l) Psychotherapy
m) Other | If yes, when? ____

____

____

20. Please list all the physicians you have seen for your pain and when you saw them: ________

____

____

____

21. Have you had any kind of injections or nerve blocks for your pain? __YES / NO__.

What kind?____

When?____

By whom?____

22. Have you ever been hospitalized or had an operation for your pain? __YES / NO__.

If yes, list the admitting physician and type of surgery:_______________________________

____

23. Is there anything else about your pain we should know?_____________________________

____

____

____

Medical History

High Blood Pressure	Yes	No	Rheumatoid Arthritis	Yes	No
Heart Disease / Heart Attack	Yes	No	Diabetes	Yes	No
Congestive Heart Failure	Yes	No	Thyroid Disease	Yes	No
Heart Valve Problems	Yes	No	Bleeding Disorders / Anemia	Yes	No
Irregular Heart	Yes	No	Asthma / Emphysema / COPD	Yes	No
Stroke / TIA	Yes	No	Sleep Apnea	Yes	No
Seizures	Yes	No	Liver Disorder	Yes	No
Kidney Problems	Yes	No	Pacemaker or AICD	Yes	No
Cardiac Stents	Yes	No	Currently on Blood Thinners	Yes	No
Drug Abuse	Yes	No	Depression / Anxiety	Yes	No
Smoking	Yes	No	Alcohol Abuse	Yes	No

Comments or other Medical Illnesses: ____

____

Operations, Procedures or Hospitalizations and dates:__________________________________

____

____

____

Allergies to medications, food or latex reaction:_______________________________________

____

____

____

Current Medications, Dose and Frequency:____

____

____

____

____

Are you: ____Right Handed ____Left Handed ____Ambidextrous

Do you have a health Care Proxy?	Yes ___	No ___
Do you have a living will?	Yes ___	No ___
Can you take care of yourself?	Yes ___	No ___
Can you eat, dress or use the toilet?	Yes ___	No ___
Can you walk indoors around the house?	Yes ___	No ___
Can you walk one or two blocks?	Yes ___	No ___
Can you do light housework?	Yes ___	No ___
Can you do heavy work around the house?	Yes ___	No ___
Can you shop for yourself?	Yes ___	No ___

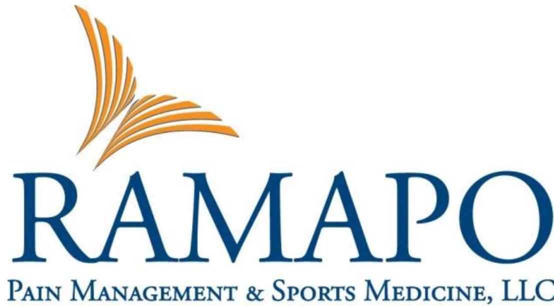
Would you accept a blood transfusion if medically necessary? Yes ___ No ___

Please answer the questions below using the following scale:

0 = never; 1 = seldom; 2 = sometimes; 3 = often; 4 = very often

1. How often do you have mood swings? ____
2. How often do you smoke a cigarette within an hour after you wake up? _________________
3. How often have you taken medication other than the way it was prescribed? _____________
4. How often have you used illegal drugs (eg. Marijuana, cocaine) in the past five years? ________
5. How often in your life have you had legal problem or been arrested? ___________________

Signature: _______________________________________ Date: _______________________



100 Route 59 Suite 111 Suffern, New York 10901
845-357-5745-Phone 845-357-5751-Fax

PATIENT INFORMATION SHEET

Patient Name:____ Date of Birth:____________________

Gender: Male___ Female___ Race:_____________ Ethnicity:__________ Social Security # : ____________________

Current Address: ____ Apt. # : _________

City: ______________________________ State: _______________________ Zip Code: ____________________

E-mail Address: ____________________________________ Primary Language Spoken in Home: _____________

Home Phone # : (________) _________ ____________ Cell Phone # : (________) _________ ____________

Marital Status: S____ M____ D____ W____ Occupation: _______________________________

Primary Care Physician (PCP): __________________________ PCP Phone # : (________) _________ ____________

Guardian's Name (if minor): ____

Patient's Employer: _________________________________ Work Phone # : (________) _________ ____________

Employer's Address: ____

Spouse's Name: _________________________________ Spouse's Phone # : (________) _________ ____________

Spouse's Employer: _______________________ Address: ____

If full-time student, indicate school currently attending: ____

Primary Insurance Carrier: ____

Policy # : ________________ Group # : _______________ Phone # : (________) _________ ____________

Address: ____

Guarantor's Name: _________________________________ Relationship to Patient: _________________________

Guarantor's SSN: _________________________________ Guarantor's Date of Birth: _________________________

Employer: ________________________________ Employer's Phone Number: (________) _________ ____________

Secondary Insurance Carrier: ____

Policy # : ________________ Group # : _______________ Phone # : (________) _________ ____________

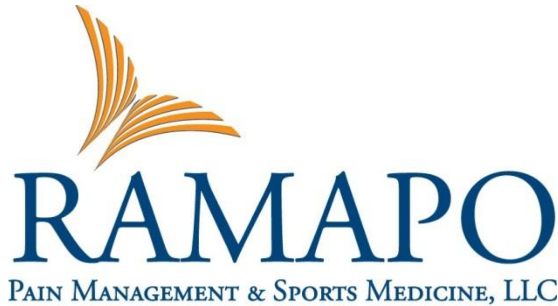
Address: ____

Guarantor's Name: _________________________________ Relationship to Patient: _________________________

Guarantor's SSN: _________________________________ Guarantor's Date of Birth: _________________________

Employer: ________________________________ Employer's Phone Number: (________) _________ ____________

Signed: ____ Date: __________________________



100 Route 59 Suite 111 Suffern, New York 10901

845-357-5745-Phone   845-357-5751-Fax

Insurance Assignment & Release, Consent to Treat,Consent to use and disclose Protected Health Information (PHI) and Receipt of Notice of Privacy Practices (HIPAA).

1. Insurance Assignment and Release:

I certify that I have insurance coverage with ______________________________ and __________________________, and assign directly to Ramapo Pain Management all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurances. I authorize the use of my signature on all insurance submissions.

Ramapo Pain Management may use my health care information and may disclose such information to the above named insurance company (or companies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Medicare/Medigap Authorization:

I request that payment of authorized Medicare benefits and if applicable, any Medigap benefits, be made either to me or on my behalf to Ramapo Pain Management for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to be released to The Center of Medicare and Medical Services, my Medigap insurer and their agents any information needed to determine these benefits or benefits for related services.

2. Patient Consent to Treat:

I, the undersigned patient, consent to the administration of pain management treatments and related procedures as deemed necessary by the physicians of Ramapo Pain Management, including those which are in addition to or different from those initially contemplated, when such procedures are deemed necessary or advisable by the provider in the course of the surgery or procedure.

3. Patient Consent for Use and Disclosure of PHI:

I, the undersigned patient, give my consent to Ramapo Pain Management to use or disclose my PHI to carry-out treatments, payments or health care operations. These individuals and entities can release, use or disclose my PHI to other physicians, certified registered nurse anesthetists, anesthesia assistants, anesthesia staff, nursing staff, nurse practitioners, physician assistants, radiology personnel and other such entities or persons as are deemed related to treatment, payment and health care operations, as determined at the sole discretion of the provider, anesthesia group and their respective agents.

4. Permission to Release Medical Records to Providers:

If another provider who is involved with treatment, payment or health care operations relating to my request of my medical records, I consent to the release of my entire medical records maintained by the provider to those other providers.

5. Permission to Release Billing Information Over the Telephone:

I agree, as part of consent for payment operations, that the provider, its group and their billing personnel, billing agents or management company can disclose billing information to any person that calls the provider with billing questions after the provider inquires as to the identity of the calling person and the calling person provides my correct social security number or health plan number.

6. Permission to Call and Leave Voice Mail Messages:

I agree that the provider, its agents or its representatives may call and leave a voice mail message at my home or other number I provide them with regarding my medical appointments, billing or payment issues or other information related to treatment, payment or health care operations.

7. Permission to Discuss PHI with Third Party:

I agree that the provider may discuss my PHI with any person that accompanies me to a visit or procedure or is present with me when the provider is present. The provider may rightly assume that if another person is with me, I have no objection of disclosure of my PHI to that person. I also agree that the provider may discuss my PHI with any person who identifies themselves as active in my mental, physical, emotional or spiritual care. I also agree that the provider, her/his anesthesia group, and their agents may disclose my PHI to employers who arrange and pay, directly or indirectly, for my medical treatment.

8. Permission to Discuss PHI with Public Agencies:

I agree the provider, her/his pain management group and their agents may, upon request by the following entities, disclose my PHI to public health agencies, law enforcement and the FDA.

9. Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have been provided, from the provider, a copy of a separate document, entitled, “Notice of PRIVACY Practices” which set forth this provider’s privacy practices and my rights regarding privacy of my PHI.

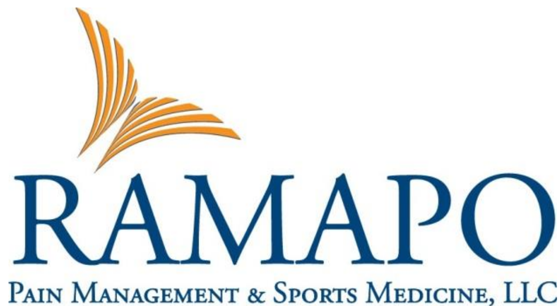
Signature of Beneficiary, Guardian or Personal Representative

---

Please Print Name of Beneficiary, Guardian or Personal Representative

---

Date **Relationship to Beneficiary**



100 Route 59 Suite 111 Suffern, New York 10901
845-357-5745-Phone 845-357-5751-Fax

Pain Management Agreement

The purpose of the agreement is to prevent misunderstanding about certain medications you may be taking for pain management. This is to help both you and your doctor comply with the law regarding controlled pharmaceuticals.

- I understand this agreement is essential to the trust and confidence necessary in the doctor/patient relationship and that my doctor will render treatment based on the agreement.
- I understand that if I break this agreement, my doctor will stop prescribing these pain control medications.
- In this case, my doctor will taper off the medication over a period of several days, as necessary to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medication is working to relieve the pain.
- I will not use any illegal controlled substances including marijuana, cocaine, etc.
- I will not share, sell or trade my medications with anyone.
- I will not attempt to obtain any controlled medications, including opiates, controlled stimulants or antianxiety medications from another doctor.
- I will safeguard my medication from loss or theft. Lost or stolen medications will not be replaced.
- I agree that refills of my prescriptions for pain medications will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.
- I authorize my doctor and the pharmacy to fully cooperate with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my pain medications.
- I authorize my doctor to provide a copy of this agreement to my pharmacy. I agree to waive any special privilege or right of privacy or confidentiality with respect to the authorization.
- I agree that I will submit to a blood or urine test if requested by my doctor to determine compliance with my program of pain control medication.
- I agree that I will use my medication at a rate no greater than prescribed. The use of my medication at a greater rate will result in my being out of medication for a period of time and termination of this document and/or treatment from this office.

Pharmacy Use:

I agree to use ____ Pharmacy.

Located at ____.

Telephone Number (______) ______ - ________ for filling prescriptions for all of my pain medicine.

I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

A copy of this agreement is entered into on the ____ day of ___________, 20_____.

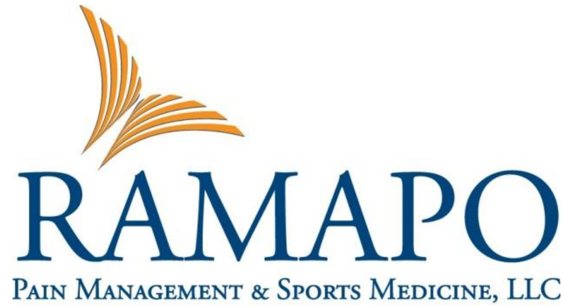
Patient Name: ____
(please print)

Patient Signature: ____

Physician Signature: ____

Witnessed By: ____

Patient Name:___________________________________



100 Route 59 Suite 111 Suffern, New York 10901
845-357-5745-Phone 845-357-5751-Fax

Disclosure of Ownership

To Our Patients:

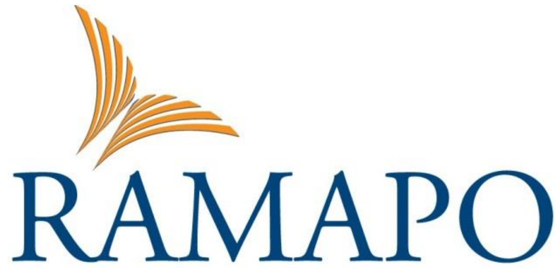
Public Law of the State of New Jersey mandates that a physician, chiropractor or podiatrist must inform their patients of any significant financial interest they may have in a healthcare service.

Accordingly, we wish to inform you that your doctor has financial interest in the Rockland and Bergen Surgery Center. Your physician has become an owner as a result of their commitment to quality healthcare and to provide better service to their patients.

The patient has been informed whether any of the services or facility fees associated with the referral will be considered to be reimbursed at an “out-of-network” level by the patient’s insurance carrier or other third party payer.

You may of course seek treatment at a healthcare service of your choice. A listing of alternative healthcare service providers can be found in the classified section of your telephone directory under the appropriate heading.

____ _________________________
Patient’s Signature Date



100 Route 59 Suite 111 Suffern, New York 10901
845-357-5745-Phone 845-357-5751-Fax

Sleep Health Disorder Checkup

Are you currently taking pain medication?	Yes ___	No ___
Have you been told you snore loudly?	Yes ___	No ___
Have you been told that you stop breathing at night?	Yes ___	No ___
Are you often tired during the day?	Yes ___	No ___
Is controlling your blood pressure difficult?	Yes ___	No ___
Do you awaken with shortness of breath?	Yes ___	No ___
Do you fall asleep while reading or watching TV?	Yes ___	No ___
Do you have trouble concentrating?	Yes ___	No ___
Have you been diagnosed with Sleep Apnea?	Yes ___	No ___

If you answered yes to three (3) or more questions, please let you clinician know

Name : ___________________________ Signature : _________________________

Contact # : ________________________