Pain Management and Anesthesiology of NJ

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THE FOLLOWING MULTI-PAGE QUESTIONNAIRE IS A VERY IMPORTANT TOOL THAT IS USED TO ASSESS YOUR PAIN CONDITION AS WELL AS THE APPROPRIATE TREATMENTS FOR YOUR PROBLEM.

1. PLEASE READ AND FILL'OUT EVERY SINGLE ITEM IN THIS PACKAGE, INCLUDING THE DEMOGRAPHIC AND FINANCIAL INFORMATION ON THE FIRST THREE PAGES. PLEASE ALSO INCLUDE YOUR SIGNATURE WHERE REQUESTED. FAILURE TO COMPLETE OR SIGN THIS FORM COULD RESULT IN A DELAY IN YOUR APPOINTMENT.

2. PLEASE BRING THE COMPLETED FORM ALONG WITH ANY PERTINENT FILMS, REPORTS, DOCTOR NOTES, ETC. FOR YOUR INITIAL CONSULTATION.

3. AN INFORMED PATIENT MAKES BETTER DECISIONS ABOUT TREATMENT OPTIONS OFFERED BY HIS OR HER PHYSICIAN.

THANK YOU VERY MUCH IN ADVANCE FOR YOUR COOPERATION.

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GENERAL INFORMATION

Name:_____ **Date:**_____ **Height**_____ **Weight**_____

Social Security Number:_____ **Date of Birth:**_____ **Age:**_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone: _____**Work Phone**: _____**Cell Phone**: _____

Employer's Name & Address: _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer & Work Number: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person Not Living With You: _____

Emergency Contact's Relation To You: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Claim Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID#: _____ Group: _____

Subscriber Relation To Patient: Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary Insurance Name: _____

Claim Address: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

ID# _____ Group: _____

Subscriber Relation To Patient: Self ☐ Spouse ☐ Child ☐ Other ☐

ACCIDENT/INJURY & LITIGATION INFORMATION

Is Your Condition Due To:

Work Related Injury or Accident (Workers Compensation)? Yes ☐ No ☐

Date of Injury/Accident: _____

Case Manager's Name: _____ Phone: _____ Fax: _____

Adjuster's Name: _____ Phone: _____ Fax: _____

WC Insurance Co. Name: _____ Claim # _____

Please describe the details of your work related injury or accident (what happened?):

_____

_____

_____

_____

_____

Automobile Accident? Yes ☐ No ☐ Date of Accident: _____

Please describe the details of your work related injury or accident (what happened?):

_____

_____

_____

_____

Other Type of Accident? Yes ☐ No ☐ Date of Accident: _____

Please describe the details of your work related injury or accident (what happened?):

_____

_____

_____

_____

Is litigation (Lawsuit) Pending? Yes ☐ No ☐

Attorney's Name: _____ Phone: _____

Attorney's Address: _____

Please describe the current status of your legal case or settlement:

_____

_____

_____

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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Pain Management and Anesthesiology of NJ to release any Information pertaining to my case, to my physician, insurance company, adjuster, or attorney of applicable in the case.

_____ _____

SIGNATURE OF PATIENT GUARDIAN DATE

_____ _____

INITIALS DATE

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PATIENT RECORD RELEASE FORM

PERMISO PARA REVELAR LOS EXPEDIENTES DE PACIENTE

DOCTOR'S OFFICE OR HOSPITAL
OFICINA DE HOSPITAL O DEL DOCTOR

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:
LE AUTORIZO Y SOLICITO POR ESTE MEDIO REVELAR A:

Pain Management and Anesthesiology of NJ

Complete medical records (including, but not limited to doctors notes, all radiological reports, Laboratory reports etc.) concerning my illness and/or treatment during: Mis expedients medicos (que incluyen, pero no limitado a las notas de los doctors, informes radiologicos, reports de Laboratorio etc,) referents a mi enfermedad y/o tratamiento durante:

PATIENT'S NAME (print): _____
NOMBRE DE PACIENTE

PATIENT'S SIGNATURE: _____
FIRM DE PACIENTE

DATE OF BIRTH: _____
FECHA DE NACIMIENTO

WITNESS: _____
TESTIGO

PMA of NJ

Advance Directive Patient Agreement

According to CMS directive 416.50 (a) (2) and the NJ State Law, every patient having a surgical procedure at **PMA of NJ** has the right to utilize an Advance Directive Document or create a new Advance Directive Document as per NJ State Law. If an individual does not have an Advance Directive Document or the paper work to complete an Advance Directive, it will be provided to you upon request by

PMA of NJ

The NJ Advance Directive is a document that protects the patient's right to refuse medical treatment that the patient does not want or to request treatment that they may want in the event that the patient loses the ability to make decisions themselves.

Part I Proxy Declaration: This part allows the patient to name a health care representative to make decisions about their health care including decisions about life-sustaining treatments if they are no longer able to speak for themselves.

Part II NJ Instruction Declaration: This is the NJ State's living will. It allows the patient to state their wishes regarding health care decisions in the event that they can no longer make their own decisions.

The Advance Directive Document will go into effect at **PMA of NJ** when the operating surgeon/proceduralist makes the determination that the patient is no longer able to communicate their health care decisions.

These documents are legally binding only if the individual is a competent adult over the age of 18.

☐ **YES,** I have an Advance Directive Document that I would like **PMA of NJ** to follow on the day of my procedure. I will provide a copy to the facility.

☐ **NO,** I do not have an Advance Directive Document and I am not interested in obtaining one or using one on the day of my procedure.

☐ **I do not have an Advance Directive Document but I would like to have one provided to me by the facility. I** would like to follow its mandates on the day of my procedure and will provide a completed copy to **PMA of NJ.**

Printed Name _____ Date _____

Signature _____

Witness _____

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ASSIGNMENT OF BENEFITS

I Authorize and direct my insurer or payor to pay directly to the above, Pain Management and Anesthesiology of NJ, and the physicians, any or all benefits, that would otherwise be payable to me (or the patient, if signed by a responsible party), up to the amount of my bill, accruing to me in connection with my treatment at Pain Management and Anesthesiology of NJ.

I request that payment of authorized medicare, medigap or other health insurance policy benefits for services furnished to me by Pain Management and Anesthesiology of NJ be made on my behalf to Pain Management and Anesthesiology of NJ. In the event Payments are made to Pain Management and Anesthesiology of NJ and me as joint payees, I agree to cooperate with Pain Management and Anesthesiology of NJ to ensure that the center/practice receives all amount due to Pain Management and Anesthesiology of NJ.

I hereby authorize Pain Management and Anesthesiology of NJ to pursue any means necessary to collect all charges on my Account including follow up calls, appeals, arbitration, and civil suit, if allowable under law. In the event that Pain Management and Anesthesiology of NJ or physician elects to bring an appeal, lawsuit or petition for arbitration against the insurance carrier, I hereby assign to them my rights, title and interest under any insurance policy under which I am entitled to proceed for benefits, if allowable under law. This assignment shall allow an attorney of their choosing to bring suit or submit to arbitration their claim of any unpaid or underpaid bills for treatment rendered at Pain Management and Anesthesiology of NJ.

Patient or Responsible Party _____

(Signature)

Patient or Responsible Party _____

(Print Name)

Witness _____

Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) Is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically; on paper, or orally, are kept properly confidential. This, Act gives you, the patient, significant • new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misused personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information.

We may *use* and disclose your medical records for the following purposes only: treatment, payment, and health care operations.

- TREATMENT means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

  PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- HEALTHCARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities auditing functions, coat-management analysis and customer service. An example would be an internal quality assessment review.

We may also create and .distribute de-identifiable health information by removing all references to individually identifiable information.

We may contact you to provider appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written; request, except to the extent that we already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosure to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Pr4ctices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may 'request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office of the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice Or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer. For more information about HIPPA or to file a complaint: The US Dept of Health & Human Services, Office of Civil Rights, 200 Independence Ave, SW, Washington, D.C. 20201, phone 202-619-0257 toll free 1-877-696-6775.

Please acknowledge receipt of this information with your signature below. Thank you.

Signature _____ Date _____

COMPREHENSIVE MEDICAL QUESTONAIRE

Referring Physician: _____ **Primary Care Physician:** _____

Please list the names of any healthcare professionals who have been involved in the evaluation and/or treatment(s) of your pain condition

(Please print names):

Orthopedic Surgeon: _____ Physiatrist/Rehabilitation specialist: _____

Spine Surgeon: _____ Chiropractor: _____

Neurologist: _____ Acupuncturist: _____

Neurosurgeon: _____ Pain Medicine specialist: _____

Rheumatologist: _____ Other: _____

Pain History

1. PLEASE DESCRIBE YOUR PAIN PROBLEM. Where is your pain? Where does the pain spread or radiate? (Example- "Low back pain that radiates down the back of my left leg to my heel":

_____

_____

_____

_____

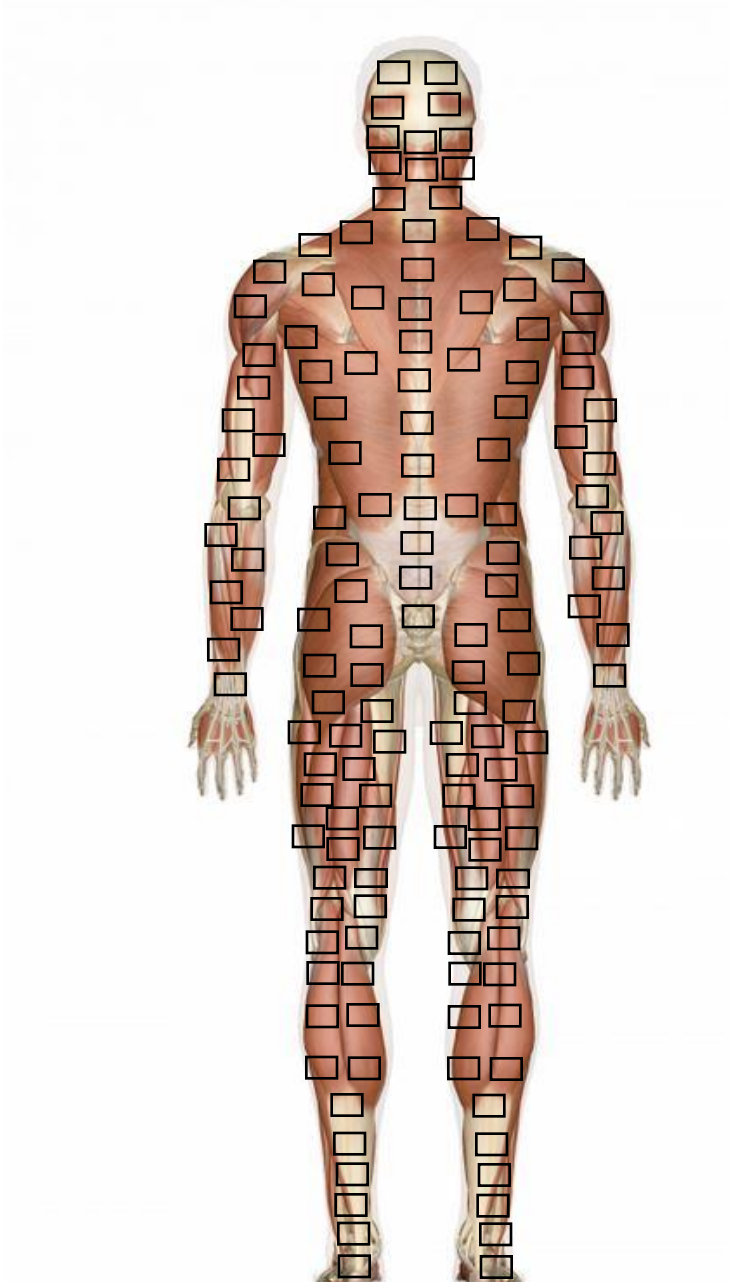
_____

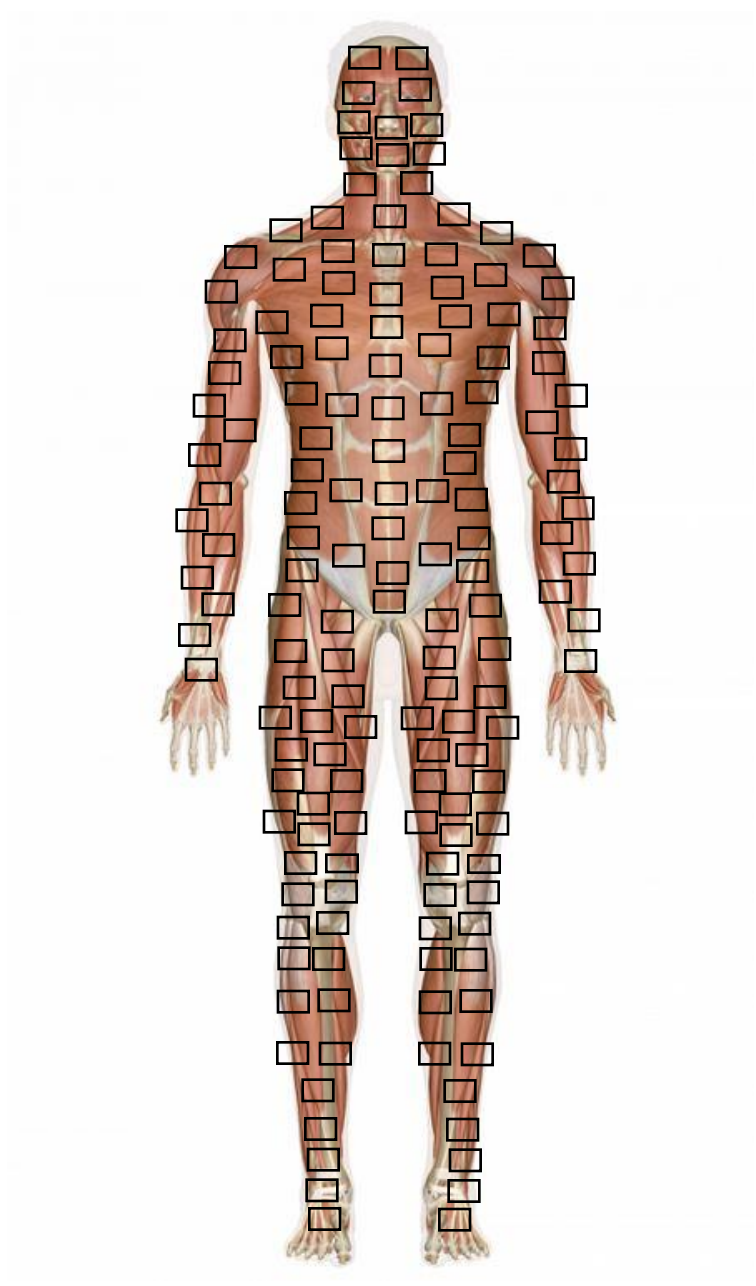
_____

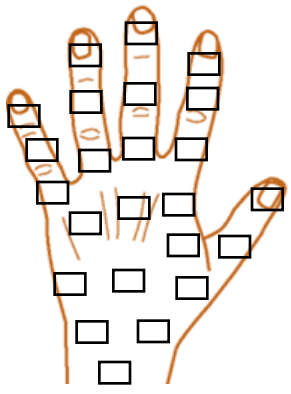
PLEASE USE DIAGRAM ON THE NEXT PAGE TO DEMONSTRATE WHERE YOUR PAIN IS.

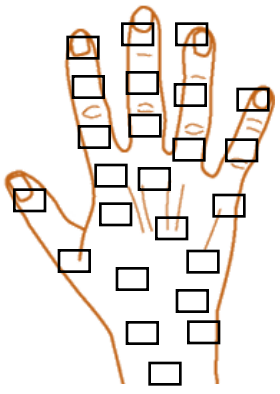
Date: _____ **Patient:** _____

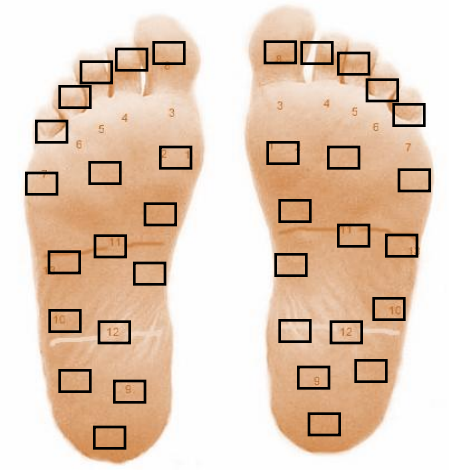
PLEASE USE THE DIAGRAM BELOW TO DEMONSTARTE WHERE YOUR PAIN IS LOCATED BY CHECKING THE AREAS THAT ARE PAINFUL.











2. When did your pain begin? (Please be as specific as possible (example: “4 months ago”)

_____

_____

3. How did your pain begin? (please Check and describe below)

Date of accident/ Illness

☐Pain just Started By Itself _____

☐Injury or Accident at Work _____

☐Injury or Accident At Home _____

☐Motor Vehicle Accident _____

☐Following Surgery _____

☐Following Illness _____

☐Other Reason (Specify): _____

4. Pain Quality

HOW WOULD YOU DESCRIBE THE PAIN?

☐Burning ☐Sharp ☐Cutting ☐Throbbing

☐Cramping ☐Numbness ☐Dull

☐Aching ☐Pressure ☐Soreness

☐Pins and Needles ☐Shooting ☐Other _____

In general, during the past month has your pain been (Please Check One)

☐Worsening ☐Improving ☐Unchanged

5. Timing of Pain

How often do you have your pain? (Please check one)

☐Constantly (100% of the time)

☐Nearly constantly (60% of the time)

☐Intermittently (30% to 60% of the time)

☐Occasionally (Less than 30% of the time)

6. Which activities or body positions (e.g. walking, bending, et.) bring on or WORSEN your pain?

_____

_____

Which activities or body positions (e.g. sitting, lying down, etc.) seem to IMPROVE your pain?

_____

_____

7. Which symptoms are associated with your pain? (Check all that apply):

☐Weakness of arm (s) – Left/Right/Both

☐Weakness of leg (s) – Left/Right/Both

☐Numbness of arm (s) – Left/Right/Both

☐Numbness of leg (s) – Left/Right/Both

☐Weakness of arm (s) – Left/Right/Both

☐Loss of bladder or bowel control

☐Cool, pale skin

☐Discolored or mottled skin

☐Pain with only light touch

☐Depression

☐Weight gain (How many lbs. past 6 months? _____

☐Difficulty sleeping

☐Impotence

☐Decreased sex drive

8. RATE YOUR PAIN

(0-10 WHERE 0 IS NO PAIN AND A 10 IS THE WORST POSSIBLE PAIN)

I would rate my pain today a ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

I would rate my worst pain a ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

I would rate my pain when under control as a ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

I could accept or live with a level of pain at a ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

9. ACTIVITIES AND YOUR PAIN

During the past month, check the activities that you avoided/ or were affected because of the pain:

☐Performance at work

☐Doing yard work or shopping

☐Participating in recreation

☐Physically exercising

☐Performing household chores

☐Socializing with friends

☐Having sexual relations

☐Other _____

10. Which **TREATMENTS** have been used for your pain? (Check all that apply)

		Helpful?	When did you receive this treatment?
☐	Pain Killers	☐Yes ☐No	_____
☐	Anti-Inflammatory Meds	☐Yes ☐No	_____
☐	Muscle Relaxants	☐Yes ☐No	_____
☐	Bed rest	☐Yes ☐No	_____
☐	Physical Therapy	☐Yes ☐No	_____
☐	Exercise	☐Yes ☐No	_____
☐	TENS (electrical stimulation)	☐Yes ☐No	_____

PRIOR TREATMENTS (continued):

		Helpful?	When did you receive this treatment?
☐	Chiropractic Therapy	☐Yes ☐No	_____
☐	Traction	☐Yes ☐No	_____
☐	Cortisone Injections	☐Yes ☐No	_____
☐	Epidural Injections	☐Yes ☐No	_____
☐	Other Nerve Blocks	☐Yes ☐No	_____
☐	Surgery	☐Yes ☐No	_____
☐	Psychotherapy	☐Yes ☐No	_____
☐	Biofeedback	☐Yes ☐No	_____
☐	Other _____		

Please list any medications that you have taken in the past for your condition which has/have NOT helped to reduce or relieve your pain:

11. PATIENT MEDICAL HISTORY CONDITION

					Other
Endocrine	☐ None	☐ Diabetes: Insulin	☐ Diabetes: Non-Insulin	☐Thyroid	_____
Eyes	☐ None	☐Glaucoma:Narrow Angle	☐Glaucoma:Wide Angle		_____
Cardio	☐ None	☐High Blood Pressure	☐ Heart Attack	☐Valve Problem	_____
		☐Heart Surgery	☐Angina	☐Arrhythmia	_____
Circulation	☐ None	☐Peripheral Vascular	☐Chronic Edema	☐Varicose veins	_____
		Disease			_____
Neurological	☐ None	☐CVA/Stroke	☐Seizures		_____
Respiratory	☐ None	☐Emphysema	☐Asthma	☐COPD	_____
Gastrointestinal	☐ None	☐Ulcers	☐Heartburn/Reflux	☐Liver Problems	_____
Genitourinary	☐ None	☐Urination Problems	☐Kidney Stones	☐Erectile Dysfunction	_____
Musculoskeletal	☐ None	☐Arthritis	☐Joint Replacement		_____
Psychiatric	☐ None	☐Depression	☐Anxiety	☐Claustrophobia	_____
Hematologic	☐ None	☐Low Platelets	☐Bleeding	☐Poor Clotting	_____

12. Please List any operations you have had in the past:

Year	Type of Operation
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES:

13. Please list your ALLERGIES TO MEDICATIONS or OTHER DRUGS:

Name of Medication	Type or Reaction Experienced

14. Are you allergic to Iodine contrast dye (e.g. IVP Dye)? ☐Yes ☐No

If you answered yes, what type or reaction did you have? _____

CURRENT MEDICATIONS:

15. Please list the medications which you currently take strictly for pain:

Name of Medication	Dosage and Number of Pills Per Day

16. Please list the medications which you currently take for other medical conditions:

Name of Medication	Name of Medication

17. Do you take Aspirin? ☐Yes ☐No **If you answered yes, when was your last dose?** _____

23. Do you currently smoke cigarette? ☐Yes ☐No How Much _____

Alcohol: ☐Yes ☐No How Much _____

24. Have you ever ben diagnosed with or treated for drug or alcohol abuse? ☐Yes ☐No

If yes, When? _____ Please describe _____

WORK HISTORY

25. What is your employment status? (please check one)

☐Retired ☐Able to work but currently unemployed

☐Homemaker ☐Not working, on worker's Comp, leave from my job since _____

☐Student ☐Not working, on Disability since (date) _____

☐Working Part Time ☐Working Full Time (☐Light Duty)

26. What is (was) your occupation or job Title? (Please describe)

_____

_____

_____

27. Which of the following are regular requirements of your job? (Check all that apply to you)

☐Heavy lifting (over 30 pounds)

☐Light lifting (15-30 pounds)

☐Frequent stooping, Bending, Twisting

☐Standing for long periods of time (over one hour at a time)

☐Sitting for long periods of time (over one hour at a time)

☐Computer Work

☐Other Physical Requirements (describe) _____

28. How much work have you missed as a result of your pain problem? (check one)

☐None

☐I have missed _____ days of work due to my pain problem

☐ I have missed _____ weeks of work due to my pain problem

☐ I have missed _____ months of work due to my pain problem

☐Not applicable to my situation

☐Other: _____

29. Please use the following space to address any other issues related to your pain condition not already covered in this questionnaire. Your comments and concerns are welcomed:

_____

_____

30. REVIEW OF SYSTEMS: (please check the appropriate boxes) ☐**None**

Constitutional: ☐Weight loss ☐Fever ☐Chills ☐Night sweats Other _____

Skin: ☐Bleeding ☐Rashes ☐Moles ☐Sores Other _____

Eyes, Ears, Nose, Throat: Recent changes in: ☐Vision ☐Hearing ☐Smell ☐Taste Other _____

Respiratory: ☐Shortness of Breath ☐Wheezing ☐Productive cough Other _____

Cardiovascular ☐Chest pain ☐Palpitations ☐Murmur ☐Feet edema Other _____

Gastrointestinal: ☐Nausea/Vomiting ☐Diarrhea ☐Constipation ☐Abdominal pain Other _____

Genital-Urinary: ☐Bloody urine ☐Urinary discomfort ☐Abnormal discharge Other _____

Musculoskeletal: ☐Cramps ☐Joint pain/Swelling ☐Morning stiffness ☐Weakness Other _____

Central Nervous System: ☐Convulsion ☐Dizziness ☐Problem Sleeping Other _____

Female: Are you pregnant? ☐No ☐Yes, Last menstrual period - Date _____ Other _____

Male: Last Prostate exam - Date_____, PSA – Date _____, Results _____, Other _____

HOW WERE YOU REFFERED TO THIS OFFICE?

☐Doctor ☐Patient ☐Friend ☐Yellow Pages ☐Advertisement Other: _____