Today's Date:_____

Patient Information

Patient Information

First Name: _____Last Name:_____ Date of Birth: _____

Marital Status: _____ Sex: _____ Social Security #: _____

Street: _____ City: _____ St: ____ Zip Code: ____

Home Phone: _____ Cell: _____ Work: _____

Emergency Contact Information

Name: _____ Date of Birth: _____ Sex: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Insurance Information

Policy Holder's Name: _____ Date of Birth: _____

Insurance Carrier: _____ Effective Date: _____

Policy #: _____ Group #: _____

Claim Address: _____

Pharmacy Name: _____ Pharmacy #: _____

Physician Information

Primary Physician: _____ Phone #: _____

Street: _____ City: _____ State: _____ Zip Code: _____

Referring Physician: _____ Phone #:_____

Street: _____ City: _____ State: _____ Zip Code: _____

Specialty: _____

Workers Compensation/ No Fault Info

Insurance Carrier: _____ Date of Injury: _____

Claim representative: _____ Contact #: _____

Policy #: _____ Claim #: _____

Claim Address: _____

INITIAL VISIT INFORMATION

DATE ___/___/_____

Your Name: _____

Referred By: _____

Circle one

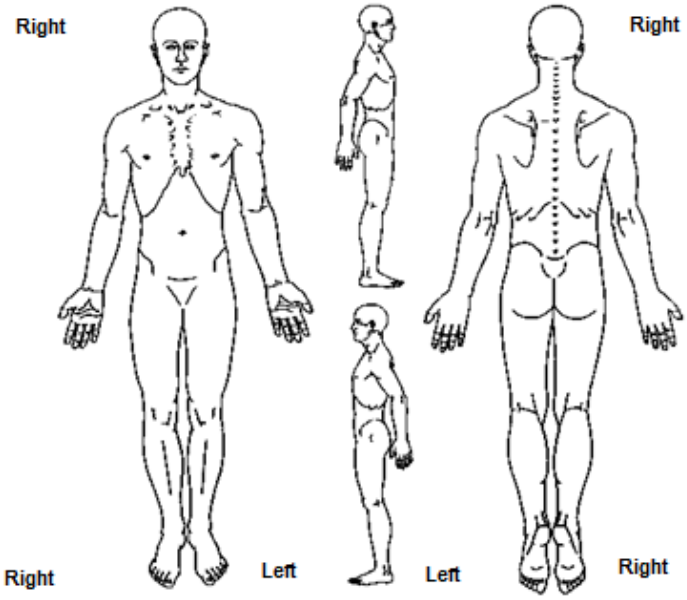
Height: _____ Weight: _____ Sex: M F Age: _____

Pain Rating Today

1 2 3 4 5 6 7 8 9 10

WHERE is your pain located?

Using these pictures, shade with a pen or pencil the parts of your body that are affected by pain. Use an "X" to indicate specific trigger or tender points.



When / How long ago did your pain start?

_____ **Years** _____ **Month(s)**

_____ **Week(s)** _____ **Day(s)**

Any Specific Date? _____ /_____ / _____

How would you describe this pain as?

- ☐ **Throbbing**
- ☐ **Shooting**
- ☐ **Stabbing**
- ☐ **Sharp**
- ☐ **Cramping**
- ☐ **Hot-burning**
- ☐ **Aching**
- ☐ **Heavy**
- ☐ **Tender**
- ☐ **Splitting**
- ☐ **Tiring-Exhausting**
- ☐ **Sickening**
- ☐ **Fearful**
- ☐ **Punishing-cruel**

Describe event(s) related to the start of your pain.

_____

_____

_____

_____

_____

_____

_____

Check additional symptoms you are experiencing?

- ☐ **Tingling (pins-needles)**
- ☐ **Pain EVEN with bed-rest**
- ☐ **Cold / Hot skin**
- ☐ **Changes in skin color**
- ☐ **Chills / Night Sweats**
- ☐ **Sensitive areas to touch**
- ☐ **Repeated infections**
- ☐ **Uncontrolled loss of bowel**
- ☐ **Uncontrolled loss of urine**
- ☐ **Weight loss (10-15 pounds in 2 weeks or less)**
- ☐ **Weakness**
- ☐ **Numbness**
- ☐ **Imbalance**
- ☐ **Swelling**
- ☐ **Fever**
- ☐ **Cramps**
- ☐ **Difficulty in walking**

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

- ☐ **Constantly (80-100% of time)**
- ☐ **Frequently (50-80% of the time)**
- ☐ **Intermittently (25-50% of the time)**
- ☐ **Occasionally (less than 25% of the time)**

Consider "0" being 'NO PAIN' and "10" being the "WORST IMAGINABLE PAIN", then circle the number which represents the intensity of

YOUR AVERAGE daily pain

0 1 2 3 4 5 6 7 8 9 10

YOUR WORST daily pain

0 1 2 3 4 5 6 7 8 9 10

YOUR LEAST daily pain

0 1 2 3 4 5 6 7 8 9 10

How do the following affect your pain?
(please check the ones applicable to your condition)

	Increases my pain	Reduces my pain
Standing	☐	☐
Sitting	☐	☐
Lying Down	☐	☐
Walking	☐	☐
Exercise / Moving the Affected Part	☐	☐
Relaxation	☐	☐
Coughing or Sneezing	☐	☐
Urination or Bowel Movement	☐	☐

Check the treatments you have tried for your pain and then complete the appropriate column at the right to the best of your ability.

	Excellent Relief	Moderate Relief	No Relief
Bed rest	☐	☐	☐
Exercise	☐	☐	☐
Heat or Ice	☐	☐	☐
Physical therapy	☐	☐	☐
Traction	☐	☐	☐
TENS Machine	☐	☐	☐
Chiropractor	☐	☐	☐
Acupuncture	☐	☐	☐
Relaxation Techniques	☐	☐	☐
Nerve block or Injections	☐	☐	☐
Surgery	☐	☐	☐

What activities are you having difficulty with due to your pain?

- ☐ **Going to work**
- ☐ **Performing household chores**
- ☐ **Recreational Activities**
- ☐ **Lifting anything**
- ☐ **Bending**
- ☐ **Driving**
- ☐ **Exercising**
- ☐ **Self Care**
- ☐ **Sitting**
- ☐ **Sleeping**

REVIEW OF SYSTEMS: Please review the list below. If you currently have these problem(s), please check the box ❑ next to them.

GENERAL
- ☐ Weight gain
- ☐ Weight loss
- ☐ Decreased energy
- ☐ Fever

SKIN
- ☐ Rash
- ☐ Itching
- ☐ Color Change
- ☐ Excessive Sweating

HEAD-ENT
- ☐ Headache
- ☐ Dizziness
- ☐ Fainting
- ☐ Blurry Vision
- ☐ Sensitivity to Light
- ☐ Hearing Loss
- ☐ Ringing in Ears
- ☐ Nose Bleeds
- ☐ Bleeding Gums

GASTROINTESTINAL
- ☐ Poor appetite
- ☐ Painful swallowing
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Nausea / Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Blood in stool

RESPIRATORY
- ☐ Shortness of breath
- ☐ Painful breathing
- ☐ Cough
- ☐ Sputum ___
- ☐ Cough with blood
- ☐ Wheezing

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Palpitations
- ☐ Swelling in legs
- ☐ Poor circulation in legs
- ☐ Varicose veins
- ☐ Blood clots in legs

NEUROLOGIC
- ☐ Seizures
- ☐ Fainting
- ☐ Tremors
- ☐ Weakness
- ☐ Tingling
- ☐ Numbness
- ☐ Memory loss
- ☐ Coordination loss
- ☐ Difficulty in Walking

GENITOURINARY
- ☐ Difficult urination
- ☐ Flank or pubic pain
- ☐ Urgency or frequency
- ☐ Urine Incontinence
- ☐ Night time urination
- ☐ Passage of stones
- ☐ Dark or bloody urine
- ☐ Erectile dysfunction
- ☐ Abnormal vaginal bleeding

PSYCHIATRIC
- ☐ Hallucinations
- ☐ Depression
- ☐ Irritability
- ☐ Tension or anxiety
- ☐ Suicidal thoughts
- ☐ Suicidal attempts

MUSCULOSKELETAL
- ☐ Painful muscle(s)
- ☐ Painful joint(s)
- ☐ Muscle cramps
- ☐ Decrease in muscle size
- ☐ Joint stiffness
- ☐ Joint swelling / redness

ENDOCRINE
- ☐ Increase Thirst
- ☐ Cold intolerance

HEMAT - LYMPHATIC
- ☐ Easy Bruising
- ☐ Bleeding tendency

SELECT / LIST YOUR MEDICAL HISTORY:

- ☐ High Cholesterol
- ☐ Asthma
- ☐ Hypertension
- ☐ Acid Reflux
- ☐ Hepatitis
- ☐ Osteoporosis
- ☐ Bleeding Disorder
- ☐ Hypothyroidism
- ☐ COPD / Emphysema: ___
- ☐ Heart Disease: _____
- ☐ Kidney Disease: _____
- ☐ Diabetes: _____
- ☐ Osteoarthritis: _____
- ☐ Depression / Anxiety

_____

_____

_____

DOCUMENT ANY SURGICAL PROCEDURES THAT YOU EVER HAD (if possible, by dates):

_____

_____

_____

_____

_____

ALLERGIES: ☐ I HAVE NO ALLERGIES

Drug	Reaction
_____	_____
_____	_____

- ☐ Dye
- ☐ Iodine
- ☐ Shellfish
- ☐ Latex
- ☐ Any specific food item: _____

LIST ALL MEDICATIONS YOU ARE TAKING

Please list any medications you are currently taking, with their doses and number of times taken per day. Include "over the counter" drugs and herbal supplements. Use the back of this sheet if necessary.

_____

_____

_____

_____

_____

_____

ARE ANY OF YOUR FAMILY MEMBERS SUFFERING FROM THE FOLLOWING?

Select all that apply:	Relationship to you:
☐ Cancer	_____
☐ Diabetes	_____
☐ Kidney disease	_____
☐ Chronic Pain	_____
☐ Alcohol Abuse	_____
☐ Illegal drug Abuse	_____
☐ Prescription drug Abuse	_____

PERSONAL: (Check the ones applicable to you)

PRESENT WORK STATUS

- ☐ I am Working: Occupation: _____
- ☐ I am on Disability OR have a pending application
  Reason for Disability: _____
- ☐ I am on Worker's Compensation

LEGAL ISSUES

- ☐ I have a pending litigation related to my pain
- ☐ ATTORNEY _____

LIVING STATUS

- ☐ I live alone
- ☐ I live with my spouse
- ☐ I live with a Domestic Partner / Friend / Kid(s)

PERSONAL HABITS

- ☐ I use Tobacco: Cigarettes per day: _____
  For how long? _____
- ☐ I use Alcohol: How often? _____
- ☐ I have a history of street drugs use
  Which ones? _____
  Last use _____
- ☐ I have been addicted to prescription drugs in past
- ☐ I have been treated for alcohol/ drug abuse in past
- ☐ I have been sexually abused in past

GENERAL CONSENT

1. Consent for General Treatment. I agree to the healthcare services by North American Partners in Pain Management, LLP and members of its staff. This includes, but is not limited to, routine diagnostic procedures, administration of medication and routine medical care.

2. No Representation of Guarantees. I am aware that the practice of medicine is not an exact science and I agree that no oral or written guarantee has been given to me regarding the diagnosis, treatment and medical care that I may receive while I am a patient at North American Partners in Pain Management, LLP.

3. Uses and Disclosures of PHI. We will use your protected health information (PHI) for purposes of providing treatment, obtaining payment for treatment and conducting health care operations. Your PHI will be used or disclosed only for these purposes unless we have obtained your authorization or if it is otherwise permitted by HIPAA Privacy Regulations or State law. I agree that North American Partners in Pain Management, LLP may request and use my prescription medication history from other healthcare providers or third party benefit payers for treatment purposes. North American Partners in Pain Management, LLP may elect to use a health information organization or similar entity to facilitate the electronic exchange of health information. If, in the judgment of my physician, the use of my patient information will benefit medical education, knowledge or research, I hereby grant my consent for this purpose, provided that it is specifically understood that I shall not be identified by name in any resulting publication or presentation. Disclosures of your PHI for the purposes described in this Notice may be made in writing, orally or by facsimile. You may ask us not to use or disclose certain parts of your PHI for the purposes of treatment, payment or health care operations.

4. Infectious Diseases. You are hereby notified pursuant to the Needlestick Safety and Prevention Act (NSPA), that you may be tested for the presence of HIV, HIV antibody, Hepatitis B and Hepatitis C without your consent if any health professional sustains a needle stick, mucous membrane or open wound exposure to your blood or other body fluid while in our facility. This test is permitted for your protection, as well as the protection of the physicians, nurses and other employees of North American Partners in Pain Management, LLP as well as other healthcare professionals.

5. Personal Property. I agree that North American Partners in Pain Management, LLP has no responsibility for loss of clothing, money, valuables, dentures, glasses or other personal items and understand that arrangements should be made by me to safeguard items during my stay.

_____ _____

(Patient Signature) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA)

I have received a copy of the Joint Notice of Privacy Practices. The Joint Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Joint Notice may be changed at any time. I may obtain a revised copy of the Joint Notice by calling the clinic or by requesting one at an office visit.

If personal representative's signature appears below, please describe their relationship to the patient next to the signature.

_____ _____

(Patient Signature) (Date)

Rev 2021

North American Partners in Pain Management, LLP- Release and Assignment

I hereby assign al medical and /or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Blue Shield, HMOs and commercial insurance to North American Partners in Pain Management, LLP.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to North American Partners in Pain Management, LLP, for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agencies any information needed to determine these benefits or the benefits payable for related services.

North American Partners in Pain Management, LLP bills only for the professional component of these services, you may receive bills from other providers or facilities for this service.

I understand that I am financially responsible for all charges for the hospital and for anesthesia if these services are used.

I understand that I am financially responsible for all charges whether or not covered by said insurance.

I authorize release of any information required to secure payment on my behalf.

I the undersigned am aware that there may be a $50.00 late cancellation fee for any appointment or procedure that is not cancelled at least twenty-four hours in advance.

_____ _____

(Patient Signature) (Date)

Rev 2021

North American Partners in Pain Management Payment Policy

Patients without insurance are expected to pay the full amount at the time of service. All other payment arrangements require prior approval, please call 1 (877) 940-0240 to speak to a billing representative.

If you have health insurance coverage, we will be glad to assist you in filing a claim with your insurance carrier. We will need you to provide us with the following information: insurance company name, address, policy and group numbers, the name of the guarantor, and a completed claim form if required by your carrier. Any insurance you may have is essentially a contract between you and the carrier. You are ultimately personally responsible for payment for the services that are rendered to you.

If your insurance does not cover the service in full, you are responsible to pay the balance in full within 30 days of receipt of your statement.

If your claim is automobile or liability related injury and is pending litigation, please understand our office cannot become a third party to any pending settlement. Payment in full is expected at the time of service.

Workers Compensation claims will be filed directly to your insurance carrier. If your claim is denied by Workers Compensation, we will bill your health insurance. You must provide your health insurance information before your first visit.

Insurance co-payments are due at the time of service. Please refer to your insurance card to obtain the amount due.

If your insurance carrier requires a referral, it is your responsibility to obtain the referral from your Primary Care Physician before your appointment is made.

Authorization and Assignment of Benefits

I hereby authorized North American Partners in Pain Management, LLP and affiliated physicians to furnish information to my insurance carriers concerning my illness and treatments. In addition, I hereby authorize all payment for medical services rendered to myself or my dependent payable to North American Partners in Pain Management, LLP. I understand that I am responsible to the provider for all charges, including those not covered by my insurance carrier, and I may be charged for telephone consultations with affiliated physicians and nurses. Furthermore, all payment plans must be authorized prior to my appointment.

_____ _____

(Patient Signature) (Date)

Rev 2021

Non-secure Communication Authorization

I consent to allow North American Partners in Pain Management, LLP to use unsecured email and mobile phone text messaging to communicate with me the following information

- Appointment Reminders
- Assessment form Notifications
- Educational Opportunities
- Office Communications or Notifications
- Other Official Business stemming from your relationship with this office

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

(Patient Signature) (Date)

Treatment Agreement

All patients receiving controlled substances from this office are required to follow the rules outlined by this agreement. These rules are required by law to ensure that these medications are used safely.

I will not obtain controlled substances from any other providers without permission from this office.

It is my responsibility to take my medications as prescribed, and to maintain an accurate count to ensure that I will not run out of medication before my next scheduled appointment.

If I travel away from the office, and will not be able to return before my prescription runs out, I will find another provider to prescribe the medication until I can return to the office.

If I relocate, it is my responsibility to find a provider to continue my treatment.

I understand that these medications will only be prescribed by a face-to-face office visit.

I understand that the office will not refill the prescriptions after office hours or on days that the office is not seeing patients.

I agree to follow the labeling instructions on my medications, including not sharing prescription medications with others; no ingesting alcohol while taking medications; and keeping all medications out of the reach of children.

I have received information on New York State Public Health Law Section 3397(4).

I am aware that I am subject to random urine drug screening.

I am aware that I run the risk of addiction by taking controlled substances for any length of time.

I have read the above-mentioned items, and my signature states I will comply with them. I understand that the office reserves the right to terminate care for violations of this agreement.

_____ _____

(Patient Signature) (Date)

Rev 2021