Pain Rehab of Western New York, PLLC
1515 KENSINGTON AVENUE
BUFFALO, NY 14215
Tel: 716-446-5900
Fax: 716-242-0225

APPOINTMENT INFORMATION:		
Appointment Date:	**Time:**	
Location:	X	**1515 KENSINGTON AVENUE, BUFFALO, NY 14215**

Please note that we are an interventional and therapy based pain management practice. Although we provide prescriptions for certain pain medications, we typically do not write for opiates / narcotics.

YOUR NEW PATIENT PACKET MUST BE COMPLETED PRIOR TO YOUR ARRIVAL.

- PLEASE HAVE THE REFERRING MD FAX REPORTS TO OUR OFFICE ***BEFORE YOUR APPOINTMENT*** AT FAX #: **716-242-0225** . WE WILL NEED THE LAST 3 VISIT NOTES, MEDICATION LIST FROM YOUR PRIMARY DOCTOR, AND ANY PREVIOUS PAIN MANAGEMENT VISIT NOTES.

- ANY IMAGING SUCH AS CAT SCANS, MRI'S, XRAYS, OR EMG REPORTS NEED TO BE FAXED TO **716-242-0225** .

- YOU MUST BRING INSURANCE CARDS AND PHOTO ID. PLEASE BE PREPARED TO PAY YOUR COPAY (IF APPLICABLE) OR IF YOU HAVE A DEDUCTILE PLAN A PAYMENT OF $80.00 WILL BE DUE AT THE VISIT. WE ACCEPT CASH OR CREDIT CARDS ONLY (NO CHECKS).

**** IF MEDICAL RECORDS ARE NOT RECEIVED PRIOR TO YOUR FIRST APPOINTMENT, MEDICATIONS WILL NOT BE WRITTEN *****

NEW PATIENTS WILL BE CHARGED A $40 NO SHOW FEE IF APPOINTMENT IS NOT CANCELLED WITHIN 48 HOURS PRIOR TO APPOINTMENT (716-446-5900)

Pain Rehab of Western New York
1515 Kensington Ave. Buffalo, NY 14215
Phone: 716-446-5900 Fax: 716-242-0225

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

Today's Date:_____

PERSONAL

Name_____
Last First MI (Preferred)
Birthdate_____ SS#_____ Gender: [ ] M [ ] F Married: [ ] Y [ ] N

Address_____
City_____State_____Zip Code_____ Home Phone_____
Mobile Phone_____ Work Phone_____
Email_____
Preferred contact method [ ] Home Phone [ ] Work Phone [ ] Mobile Phone [ ] Email

[ ] Employed [ ] Retired [ ] Disabled [ ] Fulltime Student [ ] Part time Student

Employer Name :_____Address:_____

Please Check as it applies to you: Race and Ethnicity
[ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American [ ] Native Hawaiian/ Pacific Islander
[ ] Caucasian [ ] Hispanic [ ] Not Hispanic or Latino [ ] Undetermined (Decline to answer)

Continuity of Care

Primary Care Physician:_____Address:_____
Phone:_____ Fax:_____

Referring Physician:_____Address:_____
Phone:_____ Fax:_____

Pharmacy:_____ Address:-_____
Phone:_____

Emergency Contact: _____Phone:_____Relation:_____

INSURANCE POLICY 1

[ ] Private Insurance [ ] Medicare [ ] Medicaid [ ] Worker's Compensation [ ] No Fault

Your relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber Name_____Subscriber ID # _____
Insurance Company_____Phone_____
Employer_____Group Name_____Group #_____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Subscriber Name_____Subscriber ID # _____
Insurance Company _____Phone_____

Past Medical History

Y N Angina
Y N Arthritis
Y N Bipolar
Y N Cancer
Y N Cardiac Arrhythmia
Y N Congestive Heart Failure
Y N Deep Vein Thrombosis
Y N Depression
Y N Diabetes
Y N HIV
Y N Hypertension
Y N Kidney Disease
Y N Liver Disease
Y N Myocardial infarction
Y N Psychiatric Therapy
Y N Pulmonary Embolism
Y N Stroke
Y N Suicidal Ideation

Past Surgical History

Y N Appendectomy
Y N Cervical Spine Surgery
Y N Cesarean section
Y N Cholecystectomy
Y N Coronary artery bypass graft
Y N Heart Valve Replacement
Y N Hernia repair
Y N Intrathecal Pump
Y N Hip Replacement
Y N Knee replacement
Y N Lumbar Spine Surgery
Y N Pacemaker
Y N Rotator cuff repair
Y N Shoulder replacement
Y N Spinal Cord Stimulator

Medications: (Please Bring Bottles / List)

Allergies:

Family History:

Y N Alcoholism
Y N Cancer
Y N Depression
Y N Drug Addiction
Y N Heart Disease
Y N Hypertension
Y N Mental Illness (not retardation)
Y N Suicide

Social History

Living Situation:
Y N Alone
Y N Children
Y N Spouse
Y N Significant Other

Education:
Y N GED
Y N High School
Y N College
Y N Masters
Y N Doctorate

Personal Habits:
Smoking (please check one)
__ current every day
__ current some day
__ former smoker
__ never smoker

Y N Current Alcohol use?
__ per day __ per week

Y N Current Marijuana use?
Y N Current Illegal Drug use?
Y N Former Illegal Drug use?

Review of Systems

Constitutional:
Y N Chills
Y N Fatigue
Y N Fever
Y N Weight Change

Otolaryngology:
Y N Facial Pain
Y N Sinus Pain
Y N Difficulty Chewing
Y N Mouth Pain
Y N Difficulty Swallowing

Cardiovascular:
Y N Chest Pain
Y N Palpitations
Y N Fast Heart Rate

Respiratory:
Y N Breathing Difficulty
Y N Sleep Apnea
Y N Wheezing

Gastrointestinal:
Y N Poor Appetite
Y N Constipation
Y N Diarrhea
Y N Heartburn (GERD)
Y N Nausea
Y N Vomiting

Musculoskeletal:
Y N Muscle Aches
Y N Joint Pain
Y N Joint Stiffness

Skin:
Y N Itchy Skin
Y N Skin Lesions
Y N Rashes

Neurologic:
Y N Concentration Difficulty
Y N Dizziness
Y N Fainting
Y N Sensory Deficits
Y N Vertigo
Y N Weakness

Psychiatric:
Y N Hopelessness
Y N Sleep Disturbance
Y N Suicidal Thoughts

Endocrine:
Y N Excessive Sweating
Y N Excessive Thirst

Hematologic Symptoms:
Y N Easy Bleeding
Y N Easy Bruising

Pain Assessment Tool

Analgesia

If zero indicates “no pain” and ten indicates “pain as bad as it can be,” on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the last week?

   0 1 2 3 4 5 6 7 8 9 10

2. What was your pain level at its worst during the last week?

   0 1 2 3 4 5 6 7 8 9 10

3. What percentage of your pain has been relieved in the last week? (Write in a percentage between 0 and 100%.)

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life? (Please circle.)
   Yes No

Activities of Daily Living

Please indicate whether functioning on your current pain regimen is Better, the Same, or Worse than functioning on prior pain regimens. (Please circle.)

		Better	Same	Worse
1.	Physical Functioning	1	2	3
2.	Family Relationships	1	2	3
3.	Social Relationships	1	2	3
4.	Mood	1	2	3
5.	Sleep Patterns	1	2	3
6.	Overall Functioning	1	2	3

Adverse Events

Are you experiencing any side effects from your current pain regimen? (Please circle.) Yes No

Rate the severity of the following side effects. (Please circle.)

		None	Mild	Moderate	Severe
1.	Nausea	1	2	3	4
2.	Vomiting	1	2	3	4
3.	Constipation	1	2	3	4
4.	Itching	1	2	3	4
5.	Mental Cloudiness	1	2	3	4
6.	Sweating	1	2	3	4
7.	Fatigue	1	2	3	4
8.	Drowsiness	1	2	3	4

Opioid Risk Tool (ORT)
Patient Form

Mark each box that applies

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 16-45 years)		☐
4. History of preadolescent sexual abuse		☐
5. Psychological disease	• Attention-deficit/ hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia	☐
	• Depression	☐

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

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