

**Nitin Bansal, MD**  
**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 MEDICATIONS MAY NOT BE WRITTEN ON THE FIRST VISIT, IF THE**  
**NECESSARY MEDICAL RECORDS HAVE NOT BEEN RECEIVED.**

*YOUR MEDICAL RECORDS MUST BE PROVIDED IN ORDER TO CREATE A SUCCESSFUL TREATMENT PLAN.*

**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, XRAY'S, OR EMG REPORTS NEED TO BE FAXED TO **716-242-0225** . **NO DISC OR FILMS. REPORTS ONLY!!!**
- YOU MUST BRING INSURANCE CARDS AND PHOTO ID. PLEASE BE PREPARED TO PAY YOUR COPAY (IF APPLICABLE) OR IF YOU HAVE A DEDUCTIBLE 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

**Nitin Bansal, MD**  
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 \_\_\_\_\_

Birthdate \_\_\_\_\_ Last First MI (Preferred)  
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	HIV
Y N	Arthritis	Y N	Hypertension
Y N	Bipolar	Y N	Kidney Disease
Y N	Cancer	Y N	Liver Disease
Y N	Cardiac Arrhythmia	Y N	Myocardial infarction
Y N	Congestive Heart Failure	Y N	Psychiatric Therapy
Y N	Deep Vein Thrombosis	Y N	Pulmonary Embolism
Y N	Depression	Y N	Stroke
Y N	Diabetes	Y N	Suicidal Ideation

### Past Surgical History

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

### 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**

		<b>Female</b>	<b>Male</b>
1. Family history of substance abuse	<ul style="list-style-type: none"><li>• Alcohol</li><li>• Illegal drugs</li><li>• Prescription drugs</li></ul>	<input type="checkbox"/>	<input type="checkbox"/>
2. Personal history of substance abuse	<ul style="list-style-type: none"><li>• Alcohol</li><li>• Illegal drugs</li><li>• Prescription drugs</li></ul>	<input type="checkbox"/>	<input type="checkbox"/>
3. Age (mark box if 16-45 years)		<input type="checkbox"/>	<input type="checkbox"/>
4. History of preadolescent sexual abuse		<input type="checkbox"/>	<input type="checkbox"/>
5. Psychological disease	<ul style="list-style-type: none"><li>• Attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia</li><li>• Depression</li></ul>	<input type="checkbox"/>	<input type="checkbox"/>

## 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 fidgety 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, TOTAL:   
please refer to accompanying scoring card).

<b>10.</b> If you checked off <i>any problems</i> , how <i>difficult</i> 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	_____