NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

NEW YORK SPINE & PAIN PHYSICIANS
NEW PATIENT QUESTIONNAIRE

***Office use* Provider __________
Appt time ________ Entered _____
Ht _________ Wt_____________
BP_________________________

DEMOGRAPHICS- *To be completed by all patients*

Patient Name: ____ Today's Date: ___/____/___

Patient Address: ___________________________________ City: ________ State: ____ Zip: _________

Home Phone #: (____) ____-______ ☐Preferred Work #: (____) ____-______ ☐Preferred Cell #: (____) ____-______ ☐Preferred

Date of Birth: ___/____/____ SSN: _________________________ Marital Status: ________________

Gender: ☐Male ☐Female Preferred Language: __________________

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Refuse to Report

Race: ☐American Indian, Alaska Native ☐Asian ☐Native Hawaiian ☐African American ☐White ☐Other Pacific Islander ☐Other Race ☐Refuse to Report

*Email Address: ____

HEALTH INSURANCE COVERAGE- *To be completed by all patients. (In the case of Workers' Compensation or No Fault, this information will only be used if coverage is denied).*

Health Insurance Company Name: ____

Address: _________________________________ City: _______ State: _______ Zip Code: _________

Phone #: (____) ____-____

Insured's Name: _______________________________ Relationship to Patient: ___________________

Insured's Date of Birth: __/__/____ Insured's Social Security #: _________________

Insured's Employer: _______________________ Group #: _____________________

ID #: ____________________ Medicare ID #: _____________________

Do you have secondary insurance? ☐Yes ☐No Carrier Name: _______________ID#: ____________

My Visit is NOT related to an accident (*Please Initial*): _____________

NO FAULT/LIABILITY- *Please complete this section is your illness/injury is the result of an accident (auto or otherwise- but NOT related).*

Insurance Company Name: _______________________________ Date of Accident: _______________

Address: _____________________________________City: _______State: ______ Zip Code: ________

Policy #: ______________ Claim #: _________________ Claims Adjuster: _______________________

Phone #: (____) ____-____ Location of Accident (State): ___________________________________

WORKERS' COMPENSATION- *Please complete this section if your illness/injury is work related.*

Insurance Company Name: __________________________________ Date of Accident: _____________

Address: _____________________________________City: _______State: ______ Zip Code: ________

Claim #: ________________Claims Adjuster: _________________________Phone #: (____) ____-____

WCB Case #: ________________ Employer at the time of the accident: __________________________

Address: ________________________________City: ________ State: ________Zip Code: __________

Contact Person: ____ Phone #: (____) ____-____

Patient's usual work activities on date of illness/injury?

____

DISABILITY- *To be completed by all patients*

Are you, or have you been disabled? ☐YES ☐NO Date: ________________________

Are you out of work? ☐YES ☐NO

Are you partially or totally disabled? ____

Name of physician who placed you on disability: ____

Are you receiving disability payments? ☐YES ☐ NO If yes, for how long? ___________________

Are you currently involved in a lawsuit? ☐YES ☐ NO If yes, please explain below:

____

Attorney Name: ____ Phone #: (____) ____-____

Address: _____________________________________City: ________State: ______ Zip Code: ________

EMPLOYMENT- *To be completed by all patients.*

Are You Currently Employed: ☐YES- FULL TIME ☐YES- PART-TIME ☐NO ☐RETIRED

Patient's Employer: ___________________________________ Employer Phone #: (____) ____-_____

Patient's Employer's Address: ______________________________ Occupation: ___________________

PHYSICIANS- *Please list all of your providers. If you do not have a particular physician, enter N/A.*

Primary Care Provider: _______________________________________ Phone #: (____) _____-_____

Referring Provider: ____ Phone #: (____) _____-_____

Cardiologist: ____ Phone #: (____) _____-_____

Neurologist: ____ Phone #: (____) _____-_____

Pulmonologist: ____ Phone #: (____) _____-_____

Endocrinologist: ____ Phone #: (____) _____-_____

Other: ____ Phone #: (____) _____-_____

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

➢ AUTHORIZATION TO DISCUSS INFORMATION WITH DESIGNATED PERSON

It is often difficult to reach a patient to discuss appointments, medications, and other information that is pertinent to our patients' care. In this event, we would discuss such information with the person whom you sign authorization and designate below. Please complete the following section:

I hereby authorize New York Spine & Pain Physician to discuss any information required in the course of my examination or treatment when I cannot be reached by phone to the following designated person(s):

Name of Designee: ________________________ Phone Number: ________________________

Relationship to Patient: ____________________

Name of Designee: ________________________ Phone Number: ________________________

Relationship to Patient: ____________________

This individual will be considered your emergency contact.

☐ None

I agree to all of the above information.

____ __________________________

Patient Signature or Legal Guardian Signature Date

➢ HIPAA ACKNOWLEDGEMENT/PATIENT RIGHTS AND RESPONSIBILITIES

THE PURPOSE OF THIS DOCUMENT IS TO ACKNOWLEDGE THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO RECEIVE A COPY OF THE "HIPAA PRIVACY ACT" AND THE PATIENTS RIGHTS AND RESPONSIBILITIES DOCUMENTATION FROM THIS OFFICE. I AM AWARE THAT IF I HAVE ANY QUESTIONS REGARDING THIS I CAN CONTACT THE OFFICE MANAGER OR VIEW THIS INFORMATION AT WWW.TREATINGPAIN.COM

____________________________________ ____________________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

➢ MEDICAL INFORMATION RELEASE-

I, __________________________GIVE NEW YORK SPINE & PAIN PHYSICIANS PERMISSION TO OBTAIN MY PAST MEDICAL HISTORY FROM MY REFERRING PHYSICIAN OR PRIMARY CARE PHYSICIAN.

________________________________ ____________________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

➢ I hereby authorize payment directly to New York Spine & Pain Physicians for services rendered to me and paid by my carrier. I understand that if my insurance carrier does not make payment for these charges I am financially responsible for the charges for services rendered.

________________________________ ____________________________________

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

Our goal is to provide and maintain a positive physician-patient relationship. Providing you with our financial policy in advance allows for a good flow of communication and enables us to operate efficiently. To prevent misunderstanding between patients and our practice, New York Spine Physicians (the 'Practice') adheres to the following patient financial policy. Your complete understanding of your financial responsibilities is an essential element of the physician- patient relationship and continued medical management. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

- The Practice must collect copays at the time of service and is required to report to the carrier any enrollees failing to pay the co-pay. For your convenience we accept cash, personal check, credit cards (Visa, MasterCard or Discover), and money orders. The Practice is required to collect these based on your benefit contract and the Practice's contractual agreement with your insurance carrier.

- It is your responsibility to provide the Practice with current, accurate insurance information at the time of check in and to notify the Practice of any changes in this information. A valid insurance card(s) and picture ID must be presented at the time of service

- It is the patient's responsibility to obtain insurance carrier coverage limitations.

- If the Practice does not participate with your insurance, you are expected to pay in full for our services at the time of visit. The Practice may provide assistance in filing the charges to your insurance company; however payment is expected up front.

- If you do not have medical insurance, payment for services is required at the time of the visit.

- It is the patient's responsibility to ensure that an authorization and/or referral is obtained prior to your appointment if required by your insurance.

- Patients are billed for any patient responsibility (co-insurance /deductibles/non-covered services) as determined on the Explanation of Benefits (EOB) from your carrier. Patients will receive two (2) statements for any patient balance due after insurance payment. Patients that have not made payment prior to the second statement being mailed are placed in a collection status. Patients with a delinquent balance may be sent to an outside collection service.

- Patients will receive a separate bill from third party laboratories for processing of any laboratory services. Questions about these bills should be directed to the respective lab.

- The Practice does not accept post-dated checks. Checks written to the Practice that are canceled or returned for non-sufficient funds results are assessed a $35.00 fee. To rectify your account, you will be required to pay with cash, money order, cashier's check, or credit card.

- Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

- We request that **you please give our office 24 hour notice in the event that you are unable to keep your appointment**. This courtesy allows us to be of service to other patients. **Failure to comply with this policy will result in a $25 fee for office visits and $100 fee for procedures.**

- Please be advised **that failure to request medications within four (4) business days before your medication runs out will result in a $15 fee to cover the cost of processing the refill request prior to your next scheduled appointment.**

I agree to provide information regarding health insurance, workers' compensation, automobile, and other health care benefits which the patient may be entitled. Patient assigns payment(s), if any, from insurance carriers(s)/health benefit(s) plan to New York Spine & Pain Physicians for services rendered. The direct payment assigned and authorized includes any medical insurance benefits entitled, including any Major Medical benefits otherwise payable to patient under the terms of the policy, but not to exceed the balance due for services rendered.

I understand that if my insurance company or health maintenance organization does not consider the services received as covered or has not authorized the services, then I will be fully responsible for the service provided

Our practice believes that a good provider-patient relationship is based upon effective communications. If you have any questions, please feel welcome to call 914-873-8313.

By signing below I certify that I have read and understand the Patient Billing Policy, have had the opportunity to ask questions and have them answered and accept the above conditions and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.

____ ___________________________
Patient Name (please print) Date

____ ___________________________
Signature of Patient or Responsible Party Date

____ ___________________________
Witnessed by Practice Representative Date

NEW YORK
Spine & Pain
PHYSICIANS
An affiliate of National Spine & Pain Centers

In addition to the enclosed paperwork, please bring the following with you to your appointment:

Babylon
500 West Main Street Suite 116
Babylon, NY 11702

Babylon Village
100 West Main Street Suite C
Babylon Village, NY 11702

Bay Shore
8 Saxon Avenue
Suite E
Bay Shore, NY 11706

Westchester
550 Mamaroneck Ave Suite
503 Harrison, NY 10528

- ✓ A picture ID
- ✓ Insurance cards
- ✓ Your co-pay (if required by your insurance)
- ✓ Your referral (if required by your insurance)
- ✓ Any report, film, or disc of radiology relating to your pain and treatment
- ✓ Any medical records relating to your pain and treatment
- ✓ A list of medications you are currently taking or their medication bottles

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

*Office use * Provider ___________

Appt time ________ Entered _____

Vitals _________________________

____

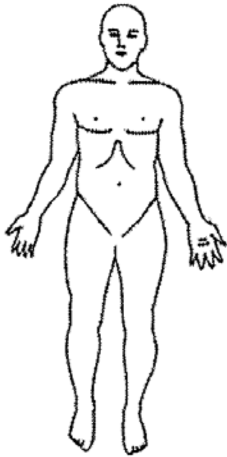
PAIN COMPREHENSIVE QUESTIONNAIRE

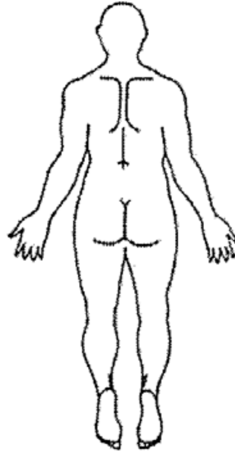
Patient Name _______________________________ **DOB** ________________ **Date** ____________________

Referring Physician _____________________________ **Primary Care Physicians** _______________________________

Chief Complaint (main problem seeking treatment) _______________________________________ **Side** ☐ right ☐ left

On the Diagram, shade in or circle the area where you feel pain:





R L   L R

Preferred Pharmacy Name/Address:

____

Preferred Pharmacy Phone:

____

Are you pregnant or possibly pregnant?

☐Yes ☐No ☐N/A

---- (0 = no pain 10 = unbearable pain) ----

Pain level today

0 1 2 3 4 5 6 7 8 9 10

Over the last 4 weeks, please identify your pain levels below:

Severe pain level (on a bad day)

0 1 2 3 4 5 6 7 8 9 10

Average pain level (on an average day)

0 1 2 3 4 5 6 7 8 9 10

Allergies _______________________________

Email _________________________________

The onset of your pain was:

☐Motor vehicle accident

Date of Accident __________

Were you wearing a seatbelt: ☐Yes ☐No

Position during the accident:

☐Driver ☐Passenger in front seat ☐Passenger in back seat

☐Falling from a height

☐Injury at work

Date of injury __________

What injury occurred? _________

☐Insidious onset ☐Lifting an object ☐Playing a sport ☐Slipping and falling ☐Trauma ☐Tripping/uneven surface

Your pain occurs: ☐Constantly ☐Intermittent ☐Worse after activity ☐Worse at the end of the day ☐Worse during activity ☐Worse during cold seasons ☐Worse during the day ☐Worse during the night ☐Worse in the morning

Describe your pain: ☐aching ☐burning ☐cramp-like ☐dull ☐in a glove distribution ☐in a stocking distribution ☐pins & needles-like ☐sharp ☐shooting ☐stabbing

Your pain has been occurring for: ________________ ☐days ☐weeks ☐months ☐years

Symptoms	Associated with your pain	**Symptoms**	Associated with your pain
Arm numbness		Insomnia	
Awakens you from sleep		Leg numbness	
Changes in bladder function		Perineal numbness	
Changes in bowel function		Sexual Dysfunction	
Changes in temperature in the affected area		Shoulder numbness	
Depression		Suicidal ideation	
Finger numbness		Sweating in affected area	
Flushing in affected area		Toe numbness	
Hand numbness		Hand numbness	

PAIN COMPREHESIVE QUESTIONNAIRE

What activities aggravate/relieve your symptoms?

ACTIVITIES	AGGRAVATES YOUR PAIN	RELIEVES YOUR PAIN
All Movements		
Bending Forward		
Exercise		
Lifting Objects		
Lying Flat		
Rest		
Rotating the neck		
Sitting		
Standing for long periods		
Walking long distances		

What treatments have you used to treat the symptoms?

TREATMENTS	NO RELIEF	MODERATE RELIEF	EXCELLENT RELIEF
ACTIVITY MODIFICATION			
ACUPUNCTURE			
BRACE			
What type of Brace?	☐Back Brace ☐Neck Brace ☐Cervical traction ☐TENS unit ☐Ankle Brace (R or L) ☐Wrist Brace (R or L) ☐Knee Brace (R or L)		
How long have you had the product?			
Are you obtaining relief?			
Are your products in good condition?			
CHIROPRACTIC MANIPULATION			
HEAT TREATMENT			
ICE TREATMENT			
PHYSICAL THERAPY			
PILATES			
WEIGHT REDUCTION			
YOGA			
MEDICATIONS	**Check mark all medication that apply below**		

Opioids
- ☐ Tramadol
- ☐ Demerol
- ☐ Codeine
- ☐ Fentanyl (Duragesic)
- ☐ Hydromorphone (Dilaudid,)
- ☐ Hydrocodone (Vicodin)
- ☐ Oxycodone (Percocet, Oxycontin)
- ☐ Oxymorphone (Opana)
- ☐ Methadone
- ☐ Morphine
- ☐ Nucynta
- ☐ Butrans
- ☐ Suboxone

NSAIDs/Tylenol
- ☐ Tylenol
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Daypro
- ☐ Indocin
- ☐ Feldene
- ☐ Voltaren
- ☐ Lodine
- ☐ Orudis
- ☐ Relafen
- ☐ Celebrex
- ☐ Toradol

Muscle Relaxants
- ☐ Soma
- ☐ Lorzone
- ☐ Flexeril
- ☐ Baclofen
- ☐ Zanaflex
- ☐ Robaxin
- ☐ Skelaxin
- ☐ Valium (Diazepam)

Antidepressants
- ☐ Elavil (Amitriptyline)
- ☐ Pamelor (Nortriptyline)
- ☐ Desipramine
- ☐ Impramine (Tofranil)
- ☐ Zoloft
- ☐ Paxil
- ☐ Prozac
- ☐ Serzone
- ☐ Cymbalta
- ☐ Savella

Other
- ☐ Neurontin (Gabapentin)
- ☐ Tegretol
- ☐ Dilantin
- ☐ Topamax
- ☐ Depakote
- ☐ Klonopin
- ☐ Lyrica
- ☐ Ativan
- ☐ Xanax
- ☐ Imitrex
- ☐ Ergotamine
- ☐ Mexillitine

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

PAIN COMPREHESIVE QUESTIONNAIRE

Do you have any adverse effects since starting any treatment?

☐Constipation ☐Drowsiness ☐Mental slowness ☐Other

What procedures have you had to treat the pain?

PROCEDURE	Mark if applicable
No Procedure	
Epidural Steroid Injection	
Facet Joint Injection	
Medial Branch Block Trial	
Peripheral Nerve Injection	
Rhizotomy	
Fusion, anterior	
Fusion, posterior	
Fusion, combined anterior and posterior	
Laminectomy	
Microdiscectomy	
Other	

What imaging studies have you had for the pain?

☐Bone scan

☐CT Scan

☐EMG

☐ MRI

☐ Radiographs

How has the pain limited you? (check mark all that apply)

Activities	Limit Pain	Activities	Limit Pain
No limitations		Inability to attend school	
Attending school on a limited basis		Inability to perform daily activities (ADL's)	
Difficulty getting up from chair		Inability to work	
Difficulty sitting		Requiring constant assistance	
Difficulty standing		Requiring occasional assistance	
Difficulty walking		Working on a limited basis	
Difficulty with daily activities (ADL's)		Working light duty	
Difficulty with recreational sports		Other	
Functional limitations			

Who have you seen for this problem? ☐Chiropractor ☐Emergency Room ☐General Surgeon ☐ Internist

☐Orthopedic Doctor ☐Pediatrician ☐Primary care ☐ Therapist ☐Trainer ☐Urgent Care Center ☐Walk in clinic

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

INTAKE AND HISTORIES

Past Medical History (please check all that apply):

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Venous Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non-Insulin Dependent
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **None**
- ☐ Other___________________

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Bladder Removed
- ☐ Breast: Mastectomy
  ☐Right ☐Left ☐Both
- ☐ Breast: Lumpectomy
  ☐Right ☐Left ☐Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Tonsillectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**
- ☐ Other___________________

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

INTAKE AND HISTORIES

Interventional Pain History (please check all that apply):

- ☐ Epidural Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Facet Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Medial Branch Block- Injection(s)- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Rhizotomy- ☐Lumbar ☐Thoracic ☐Cervical
- ☐ Intrathecal Pump
- ☐ Spinal Cord Stimulator
- ☐ **None**
- ☐ Other______________

Musculoskeletal History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Adhesive Capsulitis
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Low Back Pain
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Polio
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Shoulder Impingement
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **None**
- ☐ Other___________________

Musculoskeletal Surgery (please check all that apply):

- ☐ Achilles Tendon Repair
- ☐ ACL Reconstruction
- ☐ Ankle Fracture ORIF ☐Right ☐Left ☐Both
- ☐ Bunion Correction
- ☐ Carpal Tunnel Decompression ☐Right ☐Left ☐Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ CMC Arthroplasty
- ☐ Distal Radius ORIF ☐Right ☐Left ☐Both
- ☐ Ganglion Cyst Excision
- ☐ Intramedullary Nailing Femur ☐Right ☐Left ☐Both
- ☐ Intramedullary Nailing Tibia ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Hip ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Knee ☐Right ☐Left ☐Both
- ☐ Joint Replacement: Shoulder ☐Right ☐Left ☐Both
- ☐ Knee Arthroscopy ☐Right ☐Left ☐Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
- ☐ Reverse Total Shoulder Replacement
- ☐ Revision of Total Hip Arthroplasty
- ☐ Revision of Total Knee Arthroplasty
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ Rotator Cuff Repair ☐Right ☐Left ☐Both
- ☐ Shoulder Arthroscopy
- ☐ **None**
- ☐ Other__________________

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

INTAKE AND HISTORIES

Medications (please list all current medications or check option, which applies):

- Complete the information below regarding all medications you are currently taking, have discontinued, or modified.
- Be certain to list both prescription and non-prescription medication, including any herbals or supplements you take.

☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option, which applies):

☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

INTAKE AND HISTORIES

Social History (please check all that apply):

Cigarette Smoking
- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - # packs per day_____

Alcohol Use
- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency
- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never
- ☐ Other______________

Drug Use
- ☐ Drug Use
- ☐ IV Drug Use
  - __________________

Family History:
Please check appropriate box "Alive" or "Decease" and list ages for the following Blood Family Members. If Parents or Grandparents are deceased, please write in Age and Cause of Death, if known.

	Alive	Age (if known)	Deceased	Age at Death	If deceased, cause of death	Unknown Status
Father						
Mother						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

	Number Alive	Age (if known)	Number Deceased	Age at Death	If deceased, cause of death	Unknown Status
Brothers						
Sisters						
Sons						
Daughters						

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

INTAKE AND HISTORIES

Family History (continued):
Please mark YES or NO if a Blood Family Member has ever had any of these conditions. If you mark YES, please mark the box under the relationship of the person to you

				Relationship of Person to you				
	YES	NO	DO NOT KNOW	Father	Mother	Grandparent	Brother /Sister	Son/ Daughter
Cancer								
Heart Disease								
Diabetes								
High Blood Pressure								
Stroke/TIA								
Alcohol Abuse								
Drug Abuse								
Psychiatric Illness								
Seizures								
Depression/Suicide								
Osteoarthritis								
Osteoporosis								
Scoliosis								
Other Conditions								

NEW YORK Spine & Pain PHYSICIANS
An affiliate of National Spine & Pain Centers

INTAKE AND HISTORIES

Review of Systems* (check yes or no if you are currently experiencing any of the following):

Symptom	Yes	No	Symptom	Yes	No
Joint pains			Wheezing		
Joint swelling			Pain w/ breathing		
Difficulty Walking			Palpitations		
Muscle Pain			Ankle Swelling		
Pain Radiating down to leg(s)			Labored breathing w/exertion		
Weakness			Nausea/ Vomiting		
Numbness			Diarrhea		
Tingling			Constipation		
Fever			Heartburn		
Weight Gain			Ulcers		
Rash			Blood in Stool		
Chest Pain			Urinary Incontinence		
Incontinence			Urinary hesitancy		
Shortness of Breath			Urinary retention		
Suicidal thoughts			Blood in urine		
Weight loss			Genital pain		
Chills			Excessive bruising		
Fatigue			Excessive bleeding		
Discoloration			Cancer		
Scarring			Excessive thirst		
Environmental Allergies			Heat/Cold intolerance		
Immunosuppression			Diabetes		
HIV/AIDS			Thyroid Disease		
Blurred Vision			Joint Stiffness		
Double Vision			Dizziness		
Glaucoma			Fainting		
Eye pain			Headaches		
Ringing in the Ears			Tremor		
Loss of hearing			Seizure		
Nose bleeds			Memory Loss		
Hoarseness			Depression		
Difficulty Swallowing			Anxiety		
Cough			Hallucinations		

Other Medical Conditions* (check yes or no for the following):

*Please inform the physician, medical assistant or front desk staff of any other medical conditions or concerns.

Symptom	Yes	No	Symptom	Yes	No
Blood Thinners			Rheumatoid Arthritis		
Pacemaker			Hepatitis B or C		
Defibrillator			Pregnancy or planning a pregnancy		
Premedicate Prior to Procedure			HIV/ADS		
Hepatitis B or C			Diabetes		

NATIONAL Spine & Pain CENTERS

Patient Name ____________________________________

DOB ____________________ **Date**_______________

Email ____

NSPC is dedicated to providing comprehensive care to patients and following the federal guidelines regarding important public health issues. Please answer the following questions.

SECTION 1: TOBACCO USE

Please select the option that best describes your current tobacco use.

☐ Current every day smoker	☐Current some day smoker (tobacco)	☐Current some day smoker (cigarette)	☐Former smoker	☐Never smoker

SECTION 2: OPIOID RISK TOOL

Do you have a family history of substance abuse?	☐Alcohol ☐Illegal Drugs ☐Prescription Drugs
Do you have a personal history of substance abuse?	☐Alcohol ☐Illegal Drugs ☐Prescription Drugs
Are you between 16 and 45 years of age?	☐YES ☐NO
Do you have a history of preadolescent sexual abuse?	☐YES ☐NO
Have you been diagnosed with any of the following?	☐Attention Deficit Disorder ☐Obsessive Compulsive Disorder ☐Bipolar ☐Schizophrenia ☐Depression

SECTION 3: BMI

Office Use Only

What is your height? ________feet ________inches

Weight: ________lbs.

SECTION 4: ADVANCE DIRECTIVE

This section is for patients aged 65 years or older.

Do you have a health care proxy in the event you are unable to make your own medical decisions? Provide name, phone number, and relationship. If none assigned, leave blank.

Name: Phone # Relationship

SECTION 5: VACCINATIONS

Have you received a Pneumonia Vaccination? Yes No

Have you received a Covid 19 vaccination? Yes No More than One

Patient Signature: ____ Date__________________