Stony Brook Medicine

Dear New Patient,

Welcome to the Stony Brook Center for Pain Management. Please take the time to fill out the enclosed packet in entirety, as the provider requires the information from these forms to provide you with the best care possible. Please return all forms to the front desk the day of your visit.

On the day of your visit, it is required that you bring the following to our office:

- The CD and/or films from any relevant X-ray, MRI or CT scan.
- Your completed new patient history forms.
- Your insurance card and photo ID.

If you have not had the chance to fill out the paperwork prior to your appointment, please arrive 30 minutes before your scheduled appointment.

If you have completed your paperwork, please arrive 15 minutes before your scheduled time to allow for registration and check in. If you arrive after your scheduled appointment time, we may reschedule your visit to the next available date.

Call your insurance company to verify our doctor participates in your health plan and ask them if you need an insurance referral to see a specialist. When your health plan requires a referral you need to contact your primary care doctor at least 5 days in advance to allow sufficient time for processing your request. If you do not bring the insurance referral to the visit, your appointment will be rescheduled to the next available date.

For detailed directions and to learn more about our practice, please visit our website
https://medicine.stonybrookmedicine.edu/anesthesiology/division/chronic

Thank you for your cooperation. We look forward to meeting with you. If you have any questions, please do not hesitate to contact us. 631-638-0800

Lake Grove
4 Smith Haven Mall
Suite 102
Lake Grove N.Y 11755

Pain Center Resident Clinic
24 Research Way
Suite 500
Setauket N.Y 11733

THE CENTER FOR PAIN MANAGEMENT AT STONY BROOK
Patient Demographics

Name _____Date_____

Address _____

_____

Home Phone # _____Alternate Phone # _____

Date of Birth _____ SS# _____

**Emergency Contact name and phone_____

Primary Insurance _____ ID# _____

Insurance phone number_____

Policy Holder _____Relationship _____ DOB _____

Secondary Insurance_____

ID#_____

Insurance phone number_____

Policy Holder _____Relationship _____ DOB _____

Workers Compensation

Employer at the time of injury: _____ Date of Injury_____

Employer Address: _____Phone #_____

WC Insurance Carrier Name: _____

Address: _____

Adjustor Name and Phone #: _____

Social Security #: _____WCB#: _____ Carrier Claim #_____

No Fault

Policy Holder: _____ Policy Number: _____

Date of Accident: _____ Claim #: _____

No Fault Insurance Carrier Name & Address: _____

Adjustor Name and Phone #: _____

Stony Brook Medicine

Name: _____ DOB: _____

COMMUNICATION CONSENT

It is the policy of Stony Brook Anesthesiology not to release confidential information other than face to face without authorization to do so by alternative methods. Any information that will be provided will be released only to the authorized person(s) listed below.

I authorize Stony Brook Anesthesiology and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Telephone: ☐ Yes ☐ No _____-_____-_____

Voicemail: ☐ Yes ☐ No

E-mail: ☐ Yes ☐ No _____

*An invitation to join the Stony Brook patient portal will be sent to your e-mail.

If you would like to have information released to someone other than yourself, please complete the following list of authorized people:

1. Name: _____ Rel: _____ Tel: _____-_____-_____
2. Name: _____ Rel: _____ Tel: _____-_____-_____
3. Name: _____ Rel: _____ Tel: _____-_____-_____

*Patient Signature: _____ Date: _____

Stony Brook Medicine

Center for Pain Management
New Patient Intake Form

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best possible care. Please inquire at our front desk or call (631) 638-0800 if you have any question on how to complete any section on this form.

Patient Information

Today's date: _____

Your name: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

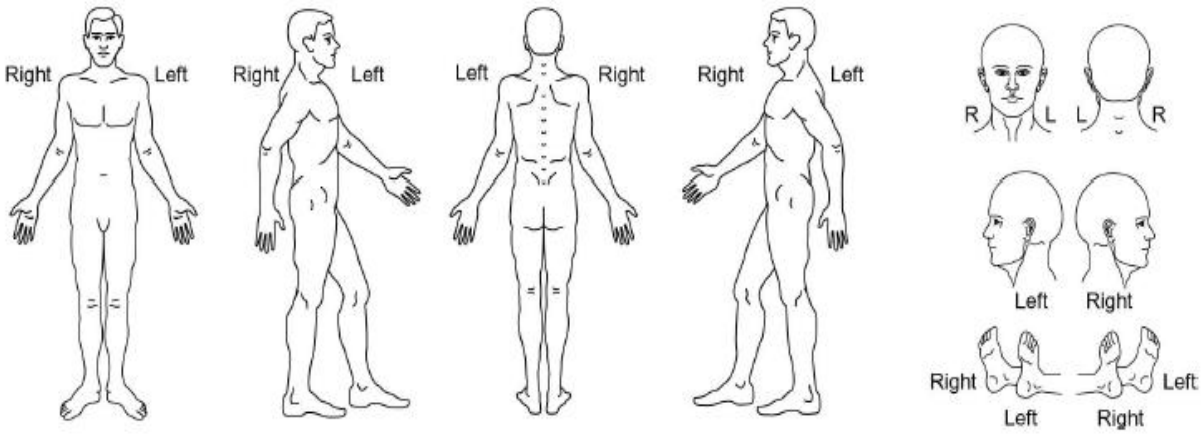
Pain History

Chief Complaint (Reason for your visit today)? _____

Does this pain radiate? If so where? _____

Please list any additional areas of pain: _____

Use this diagram to indicate the area of your pain. Mark the location with an "X"



Onset of Symptoms

Approximately, when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Describe the character of your pain (e.g.: dull, stabbing, throbbing, etc.):

_____

What time of day is your pain at its worst? _____

How often does the pain occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now, _____ The Best It Gets_____ The Worst It Gets_____

What other factors worsen or affect your pain?

_____

What other factors relieve your pain?

_____

Are there any associated symptoms? (e.g.: numbness/tingling/weakness/incontinence, etc.)

_____

What are the goals you wish to achieve with Pain Management? _____

_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐ MRI of the: _____ Date: _____

☐ X-Ray of the: _____ Date: _____

☐ CT Scan of the: _____ Date: _____

☐ EMG/NCV study of the: _____ Date: _____

☐ Other Diagnostic Testing: _____ Date: _____

☐ I have not had ANY diagnostic tests for my current pain complaint

Please mark all of the following treatments you have had for pain relief: ☑

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
TENS Unit	☐	☐	☐

Interventional Pain Treatment History

☐ Epidural Steroid Injection – (circle all levels that apply) Cervical/Thoracic/Lumbar

☐ Joint Injection – Joint(s) _____

☐ Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar

☐ Nerve Blocks – Area/Nerve(s) - _____

☐ Radiofrequency Nerve Ablation – (circle levels) – Cervical/Thoracic/Lumbar

☐ Spinal Cord Stimulator – Trial Only/Permanent Implant _____

☐ Trigger Point Injections – Where? _____

☐ Vertebroplasty/Kyphoplasty – Level(s) _____

☐ Other - _____

Which of these procedures listed above have helped with your pain? _____

_____

Please list the names of other Pain Physicians you have seen in the past?

_____

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist

☐ Chiropractor ☐ Orthopedic Surgeon ☐ Rheumatologist

☐ Internist ☐ Physical Therapist ☐ Neurologist

☐ Other _____

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

Cancer/Oncology

☐ Cancer – Type _____

☐ Cancer –
Type

Cardiovascular/Hematologic

☐ Anemia
☐ Heart Attack
☐ Coronary Artery Disease
☐ High Blood Pressure
☐ Peripheral Vascular Disease
☐ Stoke/TIA
☐ Heart Valve Disorders

☐ Presence of stent/pacemaker/
defibrillator

Gastrointestinal

☐ GERD (Acid Reflux)
☐ Gastrointestinal Bleeding
☐ Stomach Ulcers
☐ IBS/Crohns Disease

Endocrinology

☐ Diabetes – Type_____

☐ Hyperthyroidism
☐ Hypothyroidism

Psychological

☐ Depression
☐ Anxiety
☐ Schizophrenia
☐ Bipolar Disorder

☐ ADD/ADHD

☐ PTSD

Other Diagnosed Conditions

☐
_____
___

Urological

☐ Chronic Kidney Disease
☐ Kidney Stones
☐ Urinary Incontinence
☐ Dialysis

Neurological

☐ Multiple Sclerosis
☐ Peripheral Neuropathy
☐ Seizures

☐ Balance Disorder

☐ Head Injury

☐ Headaches

ENT

☐ Glaucoma

☐ Vertigo

Musculoskeletal/Rheumatologic

☐ Bursitis
☐ Carpal Tunnel Syndrome
☐ Fibromyalgia
☐ Osteoarthritis
☐ Osteoporosis
☐ Rheumatoid Arthritis
☐ Chronic Joint Pains

Respiratory

☐ Asthma
☐ Bronchitis/Pneumonia
☐ Emphysema/COPD

Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) _____ Date? _____

2) _____ Date? _____

3) _____ Date? _____

4) _____ Date? _____

5) _____ Date? _____

☐ I have **NEVER** had any surgical procedures performed.

Family History

Mark all appropriate diagnoses as they pertain to your parents and siblings:

☐ Arthritis ☐ Cancer ☐ Diabetes

☐ Headaches/Migraines ☐ High Blood Pressure ☐ Kidney Problems

☐ Liver Problems ☐ Osteoporosis ☐ Rheumatoid arthritis

☐ Seizures ☐ Stroke

☐ Other Medical Problems: _____

☐ I have no significant family medical history

Social History

Occupation: _____ When was the last time you worked? _____

Who is in your current household? _____

Are there any stairs in your current home? _____ If so how many? _____

☐ Temporary Disability ☐ Permanent Disability ☐ Retired

☐ Unemployed

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Alcohol Use:

☐ Social Use ☐ Daily use of alcohol ☐Never ☐ History of alcoholism ☐ Current alcoholism

Tobacco Use:

☐ Current user☐ Former user ☐ Never used

☐ Packs per day? _____ ☐ How many years? _____ ☐ Quit Date: _____

Illegal Drug Use:

☐ Denies any illegal drug use ☐ Currently uses illegal drugs ☐ Formerly used illegal drugs (not currently

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Current Medications

Are you currently taking any blood thinners or anti-coagulants? ☐ YES ☐ No

If YES, which ones? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other _____

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	Medication Name	**Dose**	**Frequency**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

Please list all past pain medications that you have been on at any point for your current pain complaints?

	Medication Name	**Dose**	**Frequency**
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

Only if any of your medications cause constipation, please answer these questions. If not, skip this section.

On average, how often do you have a bowel movement? (Please check one)

☐ More than 3 times per day
☐ 2 to 3 times per day
☐ Once per day
☐ 2 to 3 times per week
☐ Less than once per week

Think back to when you started pain medicine. Did your bowel habits change? If so how?

_____

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to

Medication Name	Allergic Reaction
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies: ☐ Latex ☐ Iodine ☐ Tape ☐ IV Contrast

Review of Systems

Mark the following symptoms that you currently suffer from:

Constitutional: ☐ Fevers ☐ Chills ☐ Sweats ☐ Weakness ☐ Fatigue ☐ Decreased Activity ☐ Malaise ☐ Unexplained weight gain ☐ Unexplained weight loss ☐ Low sex drive ☐ Difficulty sleeping

Eyes: ☐ Blurriness ☐ Double vision ☐ Visual disturbance ☐ Pain

Ears/Nose/Throat/Neck: ☐ Hearing problems ☐ Ear pain ☐ Sinus problems ☐ Sore throat ☐ Nosebleeds

Respiratory: ☐Shortness of breath ☐Cough ☐Sputum production ☐Wheezing

Cardiovascular: ☐Chest pain ☐ Palpitations ☐ Swelling in feet ☐ Shortness of breath during sleep ☐ Bleeding disorder ☐ Blood clots ☐ Fainting

Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Heartburn ☐ Abdominal pain

Genitourinary/Nephrology: ☐ Painful urination ☐ Blood in urine ☐ Change in urine stream ☐ Unusual discharge ☐ Flank pain ☐ Urinary incontinence

Musculoskeletal: ☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Muscle pain ☐ Muscle cramp ☐ Muscle spasm ☐ Gait disturbances ☐ Joint stiffness ☐ Joint swelling ☐ Trauma

Integumentary: ☐ Rash ☐ Itching ☐ Lesions ☐ Bruising

Neurological: ☐ Abnormal balance ☐ Confusion ☐ Numbness ☐ Tingling ☐ Dizziness ☐ Headaches ☐ Loss of coordination ☐ Memory loss ☐ Seizures ☐ Tinnitus ☐ Tremors ☐ Vertigo

Psychiatric: ☐ Feeling anxious ☐ Depressed mood ☐ Suicidal thoughts ☐ Hallucinations ☐ Stress problems ☐ Suicidal planning ☐ Thoughts of harming others

Opioid Risk Tool Patient Form

Mark each box that applies

	Female	Male
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 between 16-45)	☐	☐
4. History of Preadolescent Sexual Abuse	☐	☐
5. Psychological Disease		
Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	☐	☐
Depression	☐	☐