

Name: _____
 Chart #: _____
 Date: _____



I N T E R N E T

Neil B. Kirschen, M.D.
 Steven M. Shoum, M.D.
 Michael Luvin, M.D.
 Robert Iadevaio, M.D.
 Jacob J. Rauchwerger, M.D.

PATIENT DEMOGRAPHIC

Patricia Kirschen, L.Ac.
 Candra Snyder, ANP
 Nichole Lopez, FNP

Do you have an Advance Directive
 YES NO
 If yes, is it on file with us.
 YES NO

Is this related to: **Motor Vehicle Accident?** YES NO
Work Related Accident? YES NO
If YES, Please ask for additional required form

Patient Last Name		First Name		MI	Date of Birth	Age	Sex M F
Patient Address			City	State	Zip Code	Social Security #	
Marital Status	Race	Religion	Ethnicity		Country of Birth		
Mother's Maiden Name	Father's First Name		Patient Telephone #		Cell Phone#		
Emergency Contact	Relationship	Telephone #	Primary Language Spoken				
Policy Holder Employer Name		Employer Telephone #		Employer Address			
Patient's Retirement Date	Disabled? <input type="checkbox"/> YES <input type="checkbox"/> NO		Retired? <input type="checkbox"/> YES <input type="checkbox"/> NO		Referred to us by:		
Primary Reason(s) for Visit			Family Doctor		Telephone #		
1st Insurance	Policy #	Group #	Policy Holder Date of Birth				
Policy Holder Name	Relationship to Pt.	Insurance Billing Address					
2nd Insurance	Policy #	Group #	Policy Holder Date of Birth				
Policy Holder Name	Relationship to Pt.	Insurance Billing Address					
3rd Insurance	Policy #	Group #	Policy Holder Date of Birth				
Policy Holder Name	Relationship to Pt.	Insurance Billing Address					
PLEASE HAVE PHOTO I.D. AND ALL INSURANCE CARDS AVAILABLE							

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Comprehensive Pain Evaluation and History

Date (Fecha): _____

Height (Altura) _____ Weight (Peso) _____ lbs Age (Edad) _____ Right handed or left handed? _____

- ☉ What is the complaint which you are seeking help for? (Cual es su dolor?)

 - ☉ Is the pain related to an injury, accident, cancer, surgery, or other disease? (Es relacionado a un tipo de accidente, cancer, cirugia o enfermedad?)

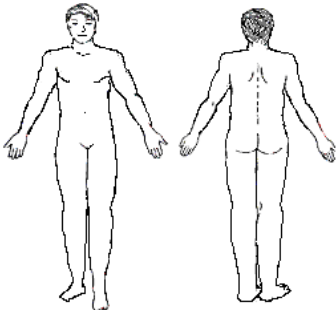
 - ☉ When did the pain begin? How long has it been present? (Cuando empezo su dolor y cuanto tiempo lo tiene?)

 - ☉ Since it began how has the quality changed? e.g. Increased, decreased, unchanged. (Como ha cambiado su dolor? Tiene mas, menos, sin cambios desde el inicio del dolor)

 - ☉ How often does the pain occur? **Circle ONE** (Con que frecuencia le ocurre su dolor? Marque Uno
Nonstop-continuous, Several times a day, Once a day several times a week (Seguido y constante,
Several times a month, Other _____ Varias veces por mes o por semana)

 - ☉ **For the following please use 0-10** (Del # 0 al 10, con diez siendo el dolor mas grave anote como le afecta su dolor?)
0 = no pain disruption, 10 worst pain imaginable extremely disruptive
- | | |
|--|---|
| Pain at its worse ever? Maximo Dolor _____ | Effect on work/school? Efecto en el trabajo/escolar _____ |
| Pain at its best ever? Minimo Dolor _____ | Effect on household chores? Efecto en obras de domicilio _____ |
| Pain currently worst? Dolor Ahorra _____ | Effect on social/family interactions? Efecto en familia _____ |
| Pain currently best? _____ | Effect on leisure activity? Efecto en actividades de recreo _____ |
| Pain currently most of the time? _____ | Effect on sexual activity? Efecto en actividad sexual _____ |

☉ Please shade in the affected areas (Marque las areas de su dolor)



☉ Which characteristics describe your pain? **Circle all that apply.** (Marque las descripciones de su dolor)

Denote how often? (Always, Often, Rarely for each circled)

Throbbing (Palpitante)	Gnawing	Tight (Apretado)	Punishing/cruel (Castigado/Cruel)
Shooting	Hot-burning (Arde)	Squeezing	Pins/needles (Sentir como agujas)
Stabbing (Apuñalado)	Aching (Agotado)	Splitting	Numb (Entumecido)
Sharp (Agudo)	Heavy (Pesado)	Tiring/Exhausting (Cansado)	Fearful (Miedoso)
Cramping (Calambres)	Tender (Tierno)	Sickening (Enfermiso)	

☉ What makes the pain better? (Que le alivia su dolor?)

☉ What makes the pain worse? (Que le empeora su dolor?)

☉ What specialist have you seen for the pain? Surgeon, Neurologist, Chiropractor, Physical therapist, psychiatrist?

Que especialistas ha consultado para su dolor? Cirujano, Neurologo, Quiropractico, Terpatia Fisica, Siquiatra?

Date seen Physical therapist (Fechas que tuvo terapia fisica?) _____

Date seen Chiropractor (Fechas que tuvo tratamientos quiropracticos) _____

Date seen Other (Fechas de otros especialistas?) _____

☉ What therapies have you tried for the pain? Circle & write in others. Surgery, nerve blocks, brace, physical therapy, biofeedback, relaxation, TENS, injections, acupuncture, chiropractic, massage, hypnosis, counseling-psychotherapy, heat, ultrasound, etc. (Que terapias le han hecho para su dolor? Marque todas y escriba si no estan listadas: Cirugia, inyecciones, terapia fisica, relajacion, maquina TENS, acupuntura, quiropractico, masajes, ultrasonido)

☉ What medicine do you currently take for your pain? Specify next to each who prescribes them to you and whether: Helps, No-help or Not sure. Include over the counter, herbal and alternative preparations. (Que medicina esta tomando para su dolor? Especifique a lado de cada una si le ayuda. Incluya todas medicinas farmaceuticas y naturales)

☉ What other medication have you taken for pain? Why were they stopped? (Que otras medicinas ha tomado para su dolor? Porque las dejo de tomar?)

☉ Please list **all other medications** you are currently taking. Including over the counter herbal and alternative supplements. (Liste todo tipo de medicamentos que esta tomando incluyendo vitaminas y hierbas naturales)

☉ Please list **all allergies** which you have, including foods. (Anote todo tipo de **ALERGIAS**, incluyendo comidas)

PATIENT NAME: _____

☉ Do you or have you had (check all that apply)

- | | | | |
|--|--|--|-----------------------------------|
| <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart attack (MI) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Bipolar disorder | |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Urinary retention | <input type="checkbox"/> Liver diseases | |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Low energy | <input type="checkbox"/> Thyroid disease | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Nausea/ Vomiting | <input type="checkbox"/> Arrhythmia (irregular heart beat) | |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Constipation | <input type="checkbox"/> Easy bruising/ Bleeding | |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Excessive thirst | |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Difficulty sleeping | |

☯ Please list all other **medical conditions** you have, or other medical conditions you have, or are under treatment for?
(Liste todas sus condiciones medicas)

☯ Have you ever been diagnosed or treated for Cancer? (Tiene cancer o lo han tenido)
What type(s)? (Que tipo de Cancer?)

What therapies? e.g. Radiation, Surgery, Chemo/Hormonal therapy (Radiacion, Cirugia, Quimoterapia)
When? (Cuando)

☯ Do you or have you used **illicit or un-prescribed drugs? If so, which ones.** (Usted usa drogas ilegales? Cuales)

☯ Do you share drugs? (Comparte sus drogas?)

☯ Do you use **tobacco**? What type? How much/often? (Fuma cigarros? Cuantos?)

☯ How much **alcohol** do you consume in a week? (Cuantas bebidas alcolicas toma semanal?)

☯ Please list all previous **surgeries** and dates? (Anote todas las cirugias y fechas)

☯ What is your current employment status? What type of work do/did you do? (Esta trabajando? Que tipo de trabajo hace?)

☯ Does anyone in your family have a history of chronic pain? Who and what Pain? (Tiene familiares que sufren de dolor cronico? Quienes y que tipos de dolores?)

☯ Does anyone in your family have a history of substance abuse? (Tiene historia familiar de abuso de sustancias en su familia? Alcolismo, drogas?)

☯ Are you involved in any lawsuits ? (Tiene un caso legal ahorra contra alguien?)

☯ How much relief do you expect to obtain? _____% Reduction in my pain. (Que porcentaje de alivio espera? ____%)

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Workers Compensation Information

General Information

Patient's Name: _____ Date of Birth: _____ Age: _____
Sex: _____ Marital Status: _____ Social Security # _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Referring MD: _____

Insurance Information

Worker's Compensation Insurance Carrier: _____ Phone #: _____
Address: _____
Claims Adjuster : _____

WCB Case #: _____ Carrier Case # : _____
Employer: _____ Address: _____

Your Job Title at Company?

Job Activity: _____

Injury Information

Date of Injury: _____ Time: _____
Were X-Rays Taken? Yes or No (Circle one) Where: _____ Date: _____
Have you been treated by anyone else? Including Emergency Room) _____
Where? _____

Briefly Describe the accident and your injury:

Are you out of work? _____ Date Last worked: _____

Authorization

I authorize Island Medical Pain Management Services to release all records pertaining to medical history, services rendered, or treatment to me or my dependent for insurance claims.

I authorize payment of medical benefits to Island Medical Pain Management Services, PC

I promise as guarantor for the above patient or as the patient to pay for all medical services disputed or denied by my insurance.

Patient Signature: _____ Date: _____

Name: _____

Chart #:

I N T E R N E T

Appmnt Date: _____

NOTICE THAT YOU MAY BE RESPONSIBLE FOR MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE, OR IF COMPENSATION CLAIM IS DISALLOWED, OR IF AGREEMENT PURSUANT TO WCL 32 IS APPROVED

WCB CASE NO.	CARRIER CASE NO.	DATE OF INJURY	NATURE OF INJURY/ ILLNESS	INJURED PERSON'S SOC. SEC. NO.
CLAIMANT	Name		Address	Apt No
EMPLOYER				
Insurance Carrier				

You may become responsible for the medical costs of treatment for your illness or condition with the provider listed below if (1) you fail to prosecute the claim for workers' compensation or (2) it is determined by the Workers' Compensation Board that the illness or condition which required treatment was not a result of a compensable workplace accident or occupational disease or (3) if an agreement is executed by you and approved pursuant to Workers' Compensation Law 32 in which you waive your right to medical benefits from the workers' compensation carrier/self-insured employer for treatment/services performed after the date the agreement is approved. If any of the above events occurs, the provider may bill you directly instead of the employer or insurance carrier, and you will be responsible for the providers fees for services rendered.

I hereby acknowledge that I have read the above and understand the circumstances under which I may become responsible for payment.

Claimant's Signature _____ **Date** _____

Provider's Name and Address: **Island Medical Pain Management Services, PC**
77 North Centre Avenue, Suite # 202, Rockville Centre, New York 11570

To the Claimant

Worker's Compensation Board Regulation 325-1.23 permits your doctor or therapist to request that you sign this A-9 notice. By signing this notice, you acknowledge your obligation to pay the provider's fees for the services you receive if it turns out that such fees are not legally required to be paid by your employers or its workers' compensation insurance carrier and if such fees are not covered by other insurance. The employer or carrier may not be required to pay the doctor's fees if, for example, you fail to file a claim for workers' compensation, or fail to notify your employer of your injury or illness, or fail to attend a Board hearing if your employer challenges your right to benefits. Even if you make all required efforts to prosecute your claim, the Workers' Compensation Board may still find that you are not entitled to benefits. In such cases, this notice advises your health provider that you acknowledge your personal liability for payment of his/her bills.

Workers' Compensation Law Section 32

The A-9 notice also covers instances in which a claimant with an existing valid workers' compensation case comes to an agreement with his/her employer or its insurance carrier settling his/her case in accordance with Section 32 of the Workers' Compensation Law. A Section 32 agreement may include a provision which relieves the employers or carrier of the liability to pay future medical bills associated with the case. Your health care provider may ask you to sign this A-9 notice to insure that you acknowledge your personal liability for payment of his/her bills if you have waived your right to future medical benefits under Section 32 agreement.

If you have any questions, contact your attorney or licensed hearing representative, if you have one. You may also contact your local district office of the Workers' Compensation Board.

To the Healthcare Provider

This notice is meant to advise the workers' compensation claimant that he/she may be responsible for payment. Failure of the claimant to sign this form does not relieve the provider of the obligation to treat the claimant, nor does it negate the claimants responsibility for payment.

Keep the original of this form for your records and give a copy to the claimant. **Do not file with the Workers' Compensation Board.** You will receive Notices of Decisions in which the compensability of a claim, authorization of treatment, or payment of medical bills is included. You will also be notified if the claimant submits a Section 32 agreement with the Board for approval. Do not bill the claimant unless and until you receive a Board decision that 1) claimant failed to prosecute the claim, or 2) the claim is denied, or 3) the treatment is not causally related to the work injury, or 4) a Section 32 agreement relieving the carrier of liability for medical treatment is approved