200 South Broadway-Ste #205
Tarrytown, NY 10591

83 Montgomery Avenue
Scarsdale, NY 10583

Office: (914) 681-9089 **Fax: (914) 831-3922**

Date: ________ **Last Name:** ______________________________ **First Name:** ____________________

Social Security #: ________________ Birthdate: ______________ Gender: M / F Marital Status: S/ M/ D/ W

Address: ____ Apt #: _________

City: ________________________________ State: __________ Zip Code: ____________________

Email Address: ____

Would you like to receive e-mails for updates and promotions? Please check one ( ) **YES or** ( ) **NO**

Home #: _______________________ **Work #:** __________________ **Cell #:** ____________________

Current Occupation: __________________ **Employer:** ______________________________________

Emergency contact: ____

Relation to patient: ______________________ Phone: __________________ Alt #: ___________________

Please provide complete detailed information

Insurance: ______________________ ID#: ________________________ Group # ________________

Effective Date: ___________ Policy Holder's Name: ______________________ D.O.B ______________

2nd Insurance: ____________________ ID #: ______________________ Group # ________________

Effective Date: ___________ Policy Holder's Name : ______________________ D.O.B ______________

If this is Worker's Compensation or No Fault Claim. Please provide complete detailed information

Carrier: __________________________ WCB# __________________ Case File: ___________________

Carrier Address: ____ Date of Accident: ____________

Occupation at time of injury: __________________ Employer: ___________________________________

Employer Address ____ Phone # ______________________

Adjuster: ______________________ Phone # ___________________ Fax # ______________________

Attorney: ______________________ Phone # __________________ Fax # ______________________

Attorney Address: ____

PLEASE FILL OUT COMPLETELY BOTH SIDES - FRONT and BACK PAGES

PATIENT QUESTIONNAIRE

These forms are to be completed one time by each patient. Although the questionnaire contains personal information, **it is vital you answer all questions completely and thoroughly**, so the Pain Management Team, can tailor a plan of care for you. Our records are strictly **confidential** and **no unauthorized person is permitted to see your case record without your written permission or consent**.

Please provide us with the names and addresses of any other physicians you are currently seeing:

Referring Physician: ______________________________
Address: ______________________________
Phone: ____________________ Fax: ____________________

Ortho/Neurology Physician: ______________________________
Address: ______________________________
Phone: ____________________ Fax: ____________________

Primary Care Physician: ______________________________
Address: ______________________________
Phone: ____________________ Fax: ____________________

What is the problem you would like us to help you with?

____

When, where and how did your pain start?

____

____

Do you have any of the following? ___Numbness ___Tingling ___Weakness ___Bowel/Bladder Dysfunction

What makes the pain worse? ______________________________

What make your pain feel better ? ______________________________

Does this pain interrupt your sleep? ________Yes ________NO

Circle the number that best describes your pain

At its WORST	0	1	2	3	4	5	6	7	8	9	10
At its BEST	0	1	2	3	4	5	6	7	8	9	10
On AVERAGE	0	1	2	3	4	5	6	7	8	9	10

0 = NONE 1 – 3 = MILD 4 – 6 = MODERATE 7 – 10 = SEVERE

Does this pain interfere with you daily activities? ______________________________

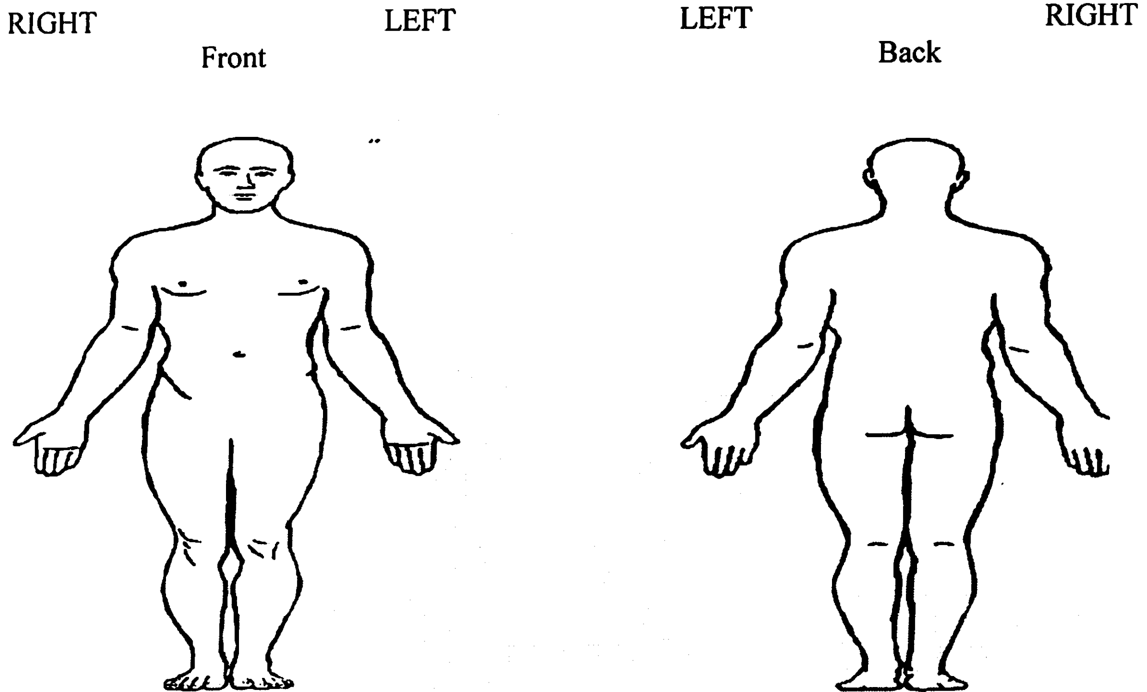
How often? ______________________________

Studies & Past Pain Treatments

Please check all that apply also list dates and/or results

____ Nerve Block/Injections –When________ ____
____ Back Surgery – When/Where____
____ EMG –When/Whom____
____ MRI/CT Scan – Dates ____
____ Physical Therapy- Dates/Where____
____ Chiropractor –Dates/Whom____
____ Acupuncture –When/Where____
____ Other ____

In the figure provided, please indicate the location and description of your pain by circling the areas and placing a check in the box below which corresponds for the areas indicated.



☐ Throbbing ☐ Pounding ☐ Tight ☐ Unbearable	☐ Jumping ☐ Flashing ☐ Shooting ☐ Numb	☐ Pricking ☐ Drilling ☐ Stabbing ☐ Intense	☐ Sharp ☐ Lacerating ☐ Crushing ☐ Annoying	☐ Pinching ☐ Gnawing ☐ Cramping
☐ Tugging ☐ Wrenching ☐ Dull	☐ Hot ☐ Burning ☐ Searing	☐ Tingling ☐ Itchy ☐ Stinging	☐ Sore ☐ Aching ☐ Heavy	☐ Tender ☐ Taut ☐ Splitting
☐ Cold ☐ Cool ☐ Freezing	☐ Suffocating ☐ Tearing ☐ Squeezing	☐ Radiating ☐ Penetrating ☐ Piercing	☐ Punishing ☐ Grueling ☐ Tolerable	☐ Wretched ☐ Blinding ☐ Torturous

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List all medications you are currently taking including, <u>non – pain medications.</u>

1.____________________________________How often___________________________

2.____________________________________How often___________________________

3.____________________________________How often___________________________

4.____________________________________How often___________________________

5.____________________________________How often___________________________

6.____________________________________ How often ___________________________

7.____________________________________How often___________________________

ALLERGIES

Do you have allergies to the following:
___ Insulin ___ Non-Insulin ___ Lavender ___ Shellfish ___ Eggs _____Contrast/CAT scan dye

Do you have any medicinal allergies? Yes or No
If Yes, List ____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS

Check all that apply

Endocrine: ____ Diabetes ____ Thyroid

Medications for diabetes ____

Eyes: ____Glaucoma ____Narrow Angle ____Wide Angle _____

Cardio: ____High Pressure ____Heart Attack ____Valve Problem _____Angina

Circulation: ____Peripheral vascular disease ____Chronic Edema

Neurological: _____ CVA/Stroke _______Seizures

Respiratory: _____Emphysema ____Asthma ____COPD

Gastrointestinal: _____Ulcers _____Heartburn _____Acid Reflux _____Liver Issues

Genitourinary: ____Urinary Issues ____ Kidney Stones _____ Erectile dysfunction

Musculoskeletal: ____Arthritis ____Joint Replacement

Psychiatric Difficulties: ____Depression ____Anxiety ____Claustrophobia

Hematologic Difficulties: ____Low platelets ____Excessive Bleeding ____Poor Clotting _____Anemia

History of sleep apnea? ____ Yes or ____No

OTHER HISTORY

Family history:____

____

____

Social history: ________Cigarettes - How often ______________________________
________Alcohol - How often ______________________________
________Drug Use - What type/How often______________________________

Surgical history:

____

____

____

____

Do you have a Pacemaker?________yes________no
Do you have any metal implants of any kind?________yes________no________
If yes, where?____

Are you suing anyone because of your pain or injury? Yes ______ No _______

Are you receiving compensation or disability? Yes _______ No __________

Do you have an application for compensation or disability payments pending? Yes _____ No ______

The onset of your pain symptoms were after an injury on the job: _____Yes _____No

What happened?____

Job Title: ______________________________Hours worked per week before injury_________

Are you still working? ☐ Yes ☐ No

If No, last day of work:

____

If Yes, is this the same job as before you were injured? ☐ Yes ☐ No (specify, type of work)

____

If Yes, are you now working: ☐ light duty ☐ full duty

____

If Yes, how many hours per week do you now work?

Is there anything causing stress in your life other than your current pain problem?

Yes ___ No ___

If yes, please describe:____

____

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What are you expecting from treatment at the Pain center? Also, please include any additional information which we should know?____

____

Have you ever been treated for Pain Management? ____Yes ____No

If Yes, List where and when____

Was it for your current issue? ____Yes _____No

If no, what where you treated for?____

____

The following questions below are given to all patients who may be taking, or are being considered for opioids for their pain. Please answer each question honestly. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank You.........

Please answer the questions below using the following scale:

0= Never 1= Seldom 2= Sometimes 3= Often 4= Very Often

1. Do you have mood swings?	0 1 2 3 4
2. Have you ever taken medicine other than the way prescribed?	0 1 2 3 4
3. Has your medication ever been lost or stolen?	0 1 2 3 4
4. Have others expressed concerns regarding your use of medications?	0 1 2 3 4
5. Have you ever had cravings for medications?	0 1 2 3 4
6. Have you ever been asked to have a urine screen for drug abuse?	0 1 2 3 4
7. Have you use illegal drugs in the past 5 years?	0 1 2 3 4

Please list any additional information you feel we need to know in relation to the questions above:____

____

____

____

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Notice of Privacy

Available to you is a copy of Jozef M. Debiec, MD, PLLC Notice of Privacy Practices. Please do not hesitate to request to view the Notice of Privacy Practices. Your name and signature on this cover sheet indicate that you have received and read a copy of Jozef M. Debiec, MD, PLLC Notice of Privacy Practices on the date and time indicated. If you have any questions regarding the information set forth in the Notice of Privacy Practices, please do not hesitate to contact the privacy officer:

Jozef M. Debiec, MD, PLLC
Attention: Privacy Officer
Phone: (914) 681-9089
Fax: (914) 831-3922

Name: (Please Print) ______________________________

Signature: ______________________________

Date and Time Notice Received: ______________________________

Other than your Medical Doctors, whom do you allow us to share your information with:

Name: ______________________________

Phone: ______________________________

Relationship: ______________________________

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Office: (914) 681-9089 Fax: (914) 831-3922

Patient Name: ______________________________

Release of Information (all):

I hereby authorize any physician, health care practitioner or other medically related service, to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to my health insurer.

I also authorize my health insurer to disclose to a hospital, provider or health care service plan, self-insurer, or an insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim.
If my coverage is under Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.
This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my health insurer including a reasonable time thereafter, until its final consummation. This authorization shall be binding upon me, my dependents, and our heirs, executors and administrators.
Patients Signature: ______________________________ Date: ______________

Legal Guardian Signature: ______________________________ Date: ______________

Medicare Recipients Only:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that provider to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.
Patient Signature: ______________________________ Date: ______________

Legal Guardian Signature: ______________________________ Date: ______________

Authorization to pay (all):

I request payment of this claim and if the payer accepts assignment, authorize payment direct to the physician or supplier for the services described.
Patient Signature: ______________________________ Date: ______________

Legal Guardian Signature: ______________________________ Date: ______________