INTAKE

DATE_____ **NAME** _____

1. BRIEFLY, WHICH IS THE **MAIN PROBLEM** THAT BRINGS YOU TO THE DOCTOR TODAY?

_____

_____

_____

2. When did this problem start? _____ . Is this the first time you have this problem? □Yes □No

3. If this problem happened before; WHEN was the first time it happened? _____

4. ARE YOUR **SYMPTOMS RELIEVED BY**: o HEAT o ICE o MOVEMENT o PAIN MEDS o REST

5. WHAT MAKES YOUR **SYMPTOMS GET WORSE**? o ACTIVITY o STAIRS o BEND o COUGH

o DRIVING o LIFTING o RAISE ARMS OVER HEAD o SIT 15min 30min 1hr o STAND 15min 30min 1hr o WALK 5min 15min 30min 1hr o WORK

6. Have you seen **OTHER DOCTORS FOR THIS PROBLEM?** □No

Dr's name: _____ Date _____ Treatment _____
Dr's name: _____ Date _____ Treatment _____

7. HAVE YOU HAD **TESTS DONE FOR THIS PROBLEM?** □No

MRI of: _____ Date _____ Findings_____
X-ray of: _____ Date _____ Findings_____
Other _____ Date _____ Findings_____

8. Have you had **SURGERY FOR THIS PROBLEM?** □No
OTHER SURGERIES not related to this problem:
1._____ Date _____
2._____ Date _____
3._____ Date _____

Surgery type: _____ Date of surgery: _____
Surgery type: _____ Date of surgery: _____

9. Have you had **PHYSICAL THERAPY FOR THIS PROBLEM?** □No □Yes; From _____ to _____

LIST ALL **MEDICATIONS AND SUPPLEMENTS YOU TAKE DAILY**: □LIST ATTACHED

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

INTAKE (Page 2 of 2) **DATE**_____ **NAME** _____

MEDICATION ALLERGIES ☐ I have **NO** medication allergies

1. _____
2. _____
3. _____
4. _____

YOUR MEDICAL PROBLEMS Circle if you have/had:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

FAMILY HISTORY Circle the following if applys:

1. High Blood Pressure
2. Diabetes
3. Asthma
4. Cancer
5. Ulcers
6. Arthritis
7. Heart Disease
8. Kidney Disease
9. Depression/Anxiety
10. Osteoporosis

SOCIAL HISTORY:

Marital status: ☐Married ☐Single ☐Divorced
Do you Live alone? ☐Yes ☐No
Do you Drive? ☐Yes ☐No

PERSONAL HABITS:

Are you a current smoker? ☐Yes ☐No
Alcohol use? ☐Yes ☐No
Drug use? ☐Yes ☐No

EMPLOYMENT

Your occupation is? _____ ☐ Unemployed

1. ☐Working FT ☐Working PT ☐ Retired
2. ☐ Disabled ☐ On leave

CIRCLE IF YOU ARE **EXPERIENCING**:

- o Difficulty to hold/pass urine
- o Weight Loss without dieting
- o Pain that Wakes You Up
- o Unexplained fever

CIRCLE IF **YOU HAVE**:

1. Difficulty Walking
2. Difficulty with Stairs
3. Difficulty getting in/out the car

(I have reviewed & discussed all above information with the patient)

Doctor's Signature _____

CHRONIC PAIN
Questionnaire

FILL THIS FORM ONLY IF YOU HAVE BEEN IN PAIN FOR 3 MONTHS OR MORE

 NAME: **DATE:**

Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable
Intermittent	Continuous	Tingling

Circle the number that best describes your PAIN AT IT'S **WORST DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

Circle the number that best describes your PAIN AY IT'S **LEAST DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

Circle the number that best describes your PAIN **ON AVERAGE DURING THE LAST MONTH.**

0 1 2 3 4 5 6 7 8 9 10

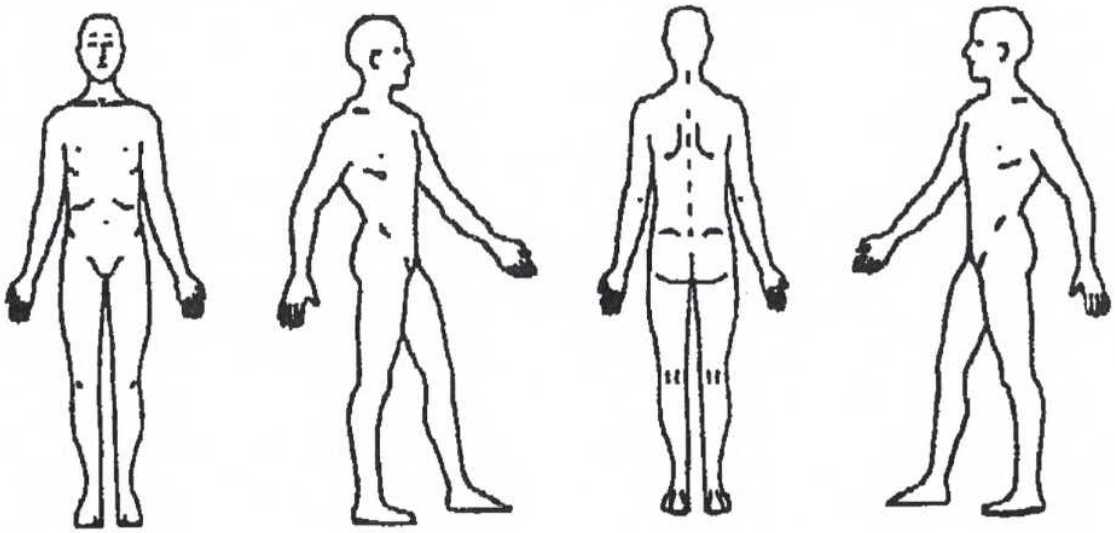
No Pain — Worse Pain

Circle the number that best describes your PAIN AS IT IS **RIGHT NOW.**

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worse Pain

On the diagram below,
SHADE THE AREA(s) WHERE YOU FEEL PAIN. **"X" THE AREAS THAT HURT THE MOST.**



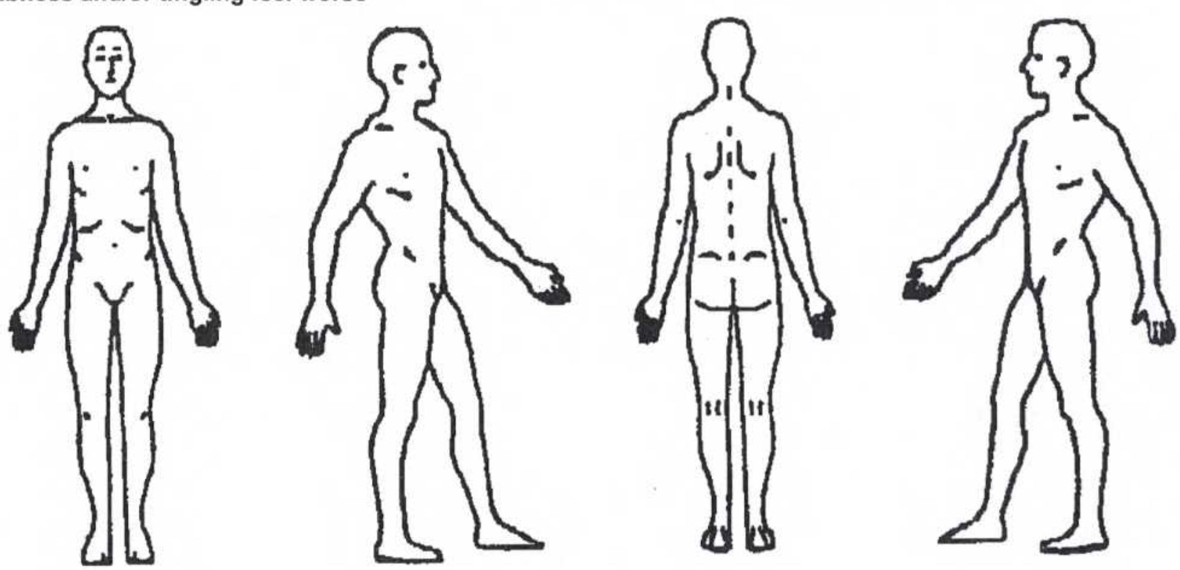
CHRONIC PAIN
Questionnaire

 NAME: **DATE:**

WHAT PAIN TREATMENTS OR MEDICATIONS ARE YOU RECEIVING NOW OR HAVE RECEIVED IN THE PAST? (For example, pain medications, physical therapy, acupuncture, TENS, etc.) Circle the number that best describes the amount of pain relief that the medication or treatment is providing or has provided.

Medication or Treatment	Not Good — Very Good	Check if taking now
________________	0 1 2 3 4 5 6 7 8 9 10	◯
________________	0 1 2 3 4 5 6 7 8 9 10	◯
________________	0 1 2 3 4 5 6 7 8 9 10	◯
________________	0 1 2 3 4 5 6 7 8 9 10	◯
________________	0 1 2 3 4 5 6 7 8 9 10	◯
________________	0 1 2 3 4 5 6 7 8 9 10	◯

On the diagram below, shade the area(s) where you feel **numbness and/or tingling**. Mark with an **"X"** where **numbness and/or tingling feel worse**



CHRONIC PAIN
Questionnaire

 NAME: **DATE:**

Circle the numbers below that best describe how pain has interfered with your daily functioning.

	"0" DOES NOT INTERFERE									TOTALLY INTERFERES "10"
Self Care Activities	0	1	2	3	4	5	6	7	8	9	10
House Chores	0	1	2	3	4	5	6	7	8	9	10
Normal Work Routine	0	1	2	3	4	5	6	7	8	9	10
Walking Ability	0	1	2	3	4	5	6	7	8	9	10
Sleep	0	1	2	3	4	5	6	7	8	9	10
Sexual activity	0	1	2	3	4	5	6	7	8	9	10
Appetite	0	1	2	3	4	5	6	7	8	9	10
Ability to Concentrate	0	1	2	3	4	5	6	7	8	9	10
Mood	0	1	2	3	4	5	6	7	8	9	10
Relations With Other People	0	1	2	3	4	5	6	7	8	9	10
Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

WHAT LEVEL OF PAIN, DO YOU THINK, WOULD ALLOW YOU TO FUNCTION ON A DAILY BASIS?

0 1 2 3 4 5 6 7 8 9 10

No Pain **Worse Pain**

SUBSTANCE USE:

Which of the following drugs or substances, if any, have you **USED IN THE PAST?** (Circle all that apply)

Next to each drug or substance that you've circled, indicate if you used it:
Occasionally ("O"), Frequently ("F"), or Continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin_____	Amphetamines_____	Marijuana_____
Other _____	Other _____	Other _____

Are you **PRESENTLY USING** any of the drugs or substances below? (Circle all that apply)
Next to each drug or substance that you've circled, indicate if you use it :

Occasionally ("O"), Frequently ("F"), or Continuously ("C").

Alcohol _____	Barbiturates _____	Cocaine _____
Heroin_____	Amphetamines_____	Marijuana_____
Other _____	Other _____	Other _____

I have reviewed & discussed all above information with the patient, Doctor's Signature _____

Date _____

Patient Name _____

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, ~~Schizophrenia~~	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.

PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE
BENEFITS ASSIGNMENT

I here by authorize and direct my (Insurance Company):_____
To pay directly to:

1207 Route 9
Wappingers Falls, Ny 12590

If in the event my current policy prohibits direct payment to the doctor, then I hereby also authorize and direct you to pay directly to:

Your Name):_____

1207 Route 9
Wappingers Falls, Ny 12590

This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner any balance of the said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize Dr. Gladys Cardenas of the release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date_____

_____
Signature of Policyholder

_____
Witness

_____
Signature of Claimant, if other than Policyholder

1207 Route 9
Wappingers Falls, NY
(845) 297-3200
FAX (845) 297-9466

PREGNANCY RELEASE

This is to certify that to the best of my knowledge, I am not pregnant and that the has my permission to take x-rays.

Last day of menstrual period:_____

Signed:_____ Date:_____

Witness:_____ Date:_____

CONSENT TO TREAT / EXAMINE MINOR CHILD

I hereby give my permission to the to examine and treat my child of ward.

Child's Name:_____

Signature:_____ Date:_____

Witness:_____

CONSENT TO X-RAY A MINOR CHILD

I hereby give my consent to the to x-ray my child.

Child's Name:_____

Signature:_____ Date:_____

Witness:_____

PATIENT UNDERSTANDING FOR OPIOID TREATMENT FORM

Patient Name_____

Witness Name _____

I am taking a pain medicine called **OPIOIDS** to help improve my pain.
I agree (*patient must initial each line to show agreement):*

_____I will take my pain medicine exactly the way doctor tells me to. That means I will take the right amount of pain medicine at the right time.
_____I will tell my doctor about any new medical problems.
_____I will tell my doctor about all medicine I take, and will tell my doctor if I am given any new medicines.
_____I will tell my doctor if I see another doctor, or if I go to the Emergency Room.
_____I will only get my pain medicine prescription from this facility.
_____If my doctor is away, I will only get medicine from the doctor who is in charge while my doctor is away.
_____I will only get my pain medicine from one pharmacy (drug store).
_____I will follow my doctor's directions about therapy, exercises and physical things to do so I can learn to live with my pain.
_____I will do what I can to get back to work.
_____I will not drink alcohol or use any other drugs unless I am told to do it by my doctor.
_____When I am asked, I will get lab tests to see if I am taking my medicines the right way.
_____If the lab tests show that I am not taking the medicines the way I should, my doctor may cut down or stop my medicine or send me to a specialist or special program to help care for me.
_____I will store my pain medicine in a safe place where other people cannot take it.
_____I will keep my scheduled appointments. If I must miss an appointment, I will call my doctor to cancel at least 24 hours before the appointment.
_____I am not pregnant and I will call my doctor as soon as possible if I think I may be pregnant.

My doctor may stop giving me pain medicine if:

- I do not follow this agreement.
- The pain medicine is not helping me.
- I'm not meeting my goals in active therapy.
- My pain or my functions do not improve.
- I have bad side effects from the pain medicine.
- I become addicted to the pain medicine.
- I give or sell the pain medicine to someone else.

Patient Signature: _____ Date:_____
I attest that this form was reviewed by me with the patient and all questions were answered.
Doctor Signature:_____ Date:_____

PATIENT INFORMED CONSENT FOR TREATMENT WITH OPIOIDS FORM

Patient Name_____

Witness Name_____

I plan to take a pain medicine called **OPIOIDS.** This pain medicine may help improve my pain but it may also cause some serious problems. The problems may be worse if I mix the pain medicine with alcohol or other drugs.

I understand that the pain medicine I will be taking may cause serious problems including:

⇨ Confusion.
⇨ Poor judgment.
⇨ Nausea (a stomach ache).
⇨ Vomiting.
⇨ Constipation (hard stools that may be painful to push out).
⇨ Sleepy or drowsy feeling.
⇨ Poor coordination and balance (such as feeling unsteady, tripping, and falling).
⇨ Slow reaction time.
⇨ Slow breathing or I can stop breathing - which could cause me to die.
⇨ More depression (such as feeling sad, hopeless, or unable to do anything).
⇨ Dry mouth.
⇨ Increased feeling of pain (hyperalgesia).
⇨ Addiction (it may be very hard to stop taking the pain medicine when I'm ready to quit).
⇨ For men: the pain medicine may lead to less interest in sex and poor sexual performance
⇨ For pregnant women, the pain medicine may hurt my unborn child and may cause my child to be born addicted to the pain medicine.

I will tell my doctor if I have any of the problems listed here.
I understand there may be other problems caused by the pain medicine, in addition to the problems listed here.
I understand that these problems may get better when I stop taking the pain medicine.
My doctor has reviewed the serious problems that this pain medicine may cause. My doctor has answered all questions that I have about this pain medicine and the serious problems it may cause.

Patient Signature:_____ Date:_____
I attest that this form was reviewed by me with the patient and all questions were answered.
Doctor Signature:_____Date:_____

1207 Route 9, Suite 11 Wappingers Falls, NY 12590 Ph: (845) 297-3200 Fx: (845) 297-9466

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

EFFECTIVE DATE: 9/19/2013

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

EFFECTIVE DATE: 9/19/2013

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

PLEASE BE ADVISED THAT OPEN TREATMENT AREAS ARE USED IN THIS OFFICE FOR PART OF YOUR CARE. PRIVATE TREATMENT AREAS ARE AVAILABLE UPON REQUEST.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

I acknowlegde receipt of a copy ofP.C.'S**Notive of Privacy Practices.**

Signature of Patient:_____

Date:_____ **EFFECTIVE DATE: 9/19/2013**