Bernard Hsu, M.D.
1412 Sweet Home Road, Suite 6
Amherst, NY 14228
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www.buffpain.com

Dear New Patient,

We welcome your upcoming visit to our practice. Please kindly fill out our initial intake forms prior to your visit and bring them in with you on the day of your appointment. Please also do not forget to bring the following:

- Insurance card
- Photo ID
- Referral (if required)
- Co-payment
- Any medical records or imaging studies that you may have available.

We also must remind new patients that our practice is primarily *interventional* pain management. Your consultation will be to evaluate you for any type of procedure to help treat pain or for recommendations on medical management. Although we do occasionally write prescriptions for certain medications, we typically do not provide opiates/narcotics at this practice. We are trying to create a different atmosphere within our group in an effort to promote healthy wellbeing and long-term pain relief. We will send all consultation reports back to your primary and referring doctors. Thank you.

Just a reminder, our driveway is on Rensch Road, second driveway on the right. After turning into the driveway, drive straight back to Suite #6.

Sincerely,

Bernard Hsu, M.D.
Assistant Clinical Professor – University at Buffalo
Board Certified Pain Medicine and Anesthesiology
Licensed Medical Acupuncturist

Buffalo Pain and Healing
Dr. Bernard Hsu

REGISTRATION FORM

(Please Print)

Today's date: | Primary Doctor:

PATIENT INFORMATION

Patient's last name: | First: | Middle: | ☐ Mr. ☐ Mrs. | ☐ Miss ☐ Ms. | Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ☐ Yes ☐ No | If not, what is your legal name? | (Former name): | Birth date: / / | Age: | Sex: ☐ M ☐ F

Street address: | Social Security no.: | Home phone no.: ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Cell phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Insurance Plan ☐ Hospital

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Email address:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: | Birth date: / / | Address (if different): | Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation: | Employer: | Employer address: | Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance | ☐ BC/BS | ☐ Univera | ☐ Independent Health | ☐ Medicare | ☐ United Health

☐ Other: | ☐ Workers' Comp | ☐ No-Fault | No-Fault or Workers' Comp claim number: | Date of Injury:

Subscriber's name: | Subscriber's S.S. no.: | Birth date: / / | Group no.: | Policy no.: | Co-payment: $

Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other

Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.:

Patient's relationship to subscriber: | ☐ Self | ☐ Spouse | ☐ Child | ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dr. Bernard Hsu or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

First Name _____ Last Name _____ Date _____

PAIN AND OTHER HEALTH HISTORY WORKSHEET

1. Height:_____ Weight:_____ Left or right handed?:_____

2. Where is your pain located? _____

Check appropriate descriptive words below, if accurate.

☐ Left ☐ Right ☐ Outer ☐ Front ☐ Back ☐ Upper ☐ Lower

☐ Aching	☐ Burning	☐ Deep	☐ Disabling	☐ Dull
☐ Excruciating	☐ Hot	☐ Lancinating	☐ Red	☐ Sharp
☐ Spasm	☐ Stabbing	☐ Stiff	☐ Swollen	☐ Tender
☐ Tight	☐ Weak			

3. What is your pain score right now on a scale of 0-10 (0=no pain, 10=extreme pain) _____

4. When did your pain symptoms initially begin: _____

5. The onset of your pain symptoms were: ☐ Gradual ☐ Sudden

☐ After an injury on the job

Job Title:

Hours per week prior to the injury:

Employer Name and Address:

What happened?:

☐ After a motor vehicle accident. What happened?:

☐ Other incident. What happened?:

6. Are you working? ☐ Yes ☐ No

If no, date of last day of work:

If yes, same job as before you were injured? ☐ Yes ☐ No (specify current job) _____

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

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

7. The pain is:

☐ Constant						
☐ Intermittent, lasting:	☐ Seconds	☐ Minutes	☐ Days	☐ Hours	☐ Weeks	
☐ Frequent, lasting:	☐ Seconds	☐ Minutes	☐ Days	☐ Hours	☐ Weeks	
☐ Worse during:	☐ Morning	☐ Afternoon	☐ Evening	☐ Night	☐ With Activity	
☐ Worse with:	☐ Exposure to cold		☐ Exposure to heat			
☐ Better with:	☐ Exposure to cold		☐ Exposure to heat			

8. Course:

How has the pain changed since onset? ☐ Better ☐ Worse ☐ Same

☐ Progressive – over ☐ Days ____ ☐ Weeks _____ ☐ Months _____

9. What makes the pain worse?

10. What makes the pain better?

11. Check if appropriate:

☐ Numbness ☐ Tingling ☐ Weakness ☐ Urinary urgency ☐ Urine – loss of control ☐ Bowel – loss of control

12. Previous procedures for pain: ☐ Acupuncture ☐ Injections ☐ Discogram ☐ MRI/CT scans ☐ Surgery ☐ Chiropractor ☐ Physical Therapy

Describe:_____

13. List any other medical history of yourself (e.g.: high blood pressure, heart attack, stroke, etc.)

14. Surgical History (operations):

Date	Operation

15. Check the following systems if you have had difficulty with any of the following:

☐ Fever, weight loss
☐ Ears, Nose, Mouth, Throat
☐ Cough, shortness of breath
☐ Urinary frequency, urgency
☐ Skin disease
☐ Psychiatric
☐ Anemia or clotting problems
☐ Eyes
☐ High blood pressure, chest pain, vascular problems
☐ Heartburn, hiatal hernia, stomach ulcers
☐ Muscle strength, joint pain
☐ Neurological
☐ Diabetes, thyroid, glandular
☐ Allergy

16. Family Medical History: Please list below any major health problems of your family (father, mother or siblings)

17. Do you smoke? ☐ No ☐ Yes Packs per day _____ times _____ years

18. Do you drink alcohol ☐No ☐ Yes Drinks per day _____

First Name _____ Last Name _____ Date _____

19. List your current medications:

Medicine	Dose (# mg)	How often per day

20. List any pain medications you have tried in the past and the outcomes:

21. List your allergies to medicine:

22. List any other allergies:

23. Which of the words below describe your **usual** pain?

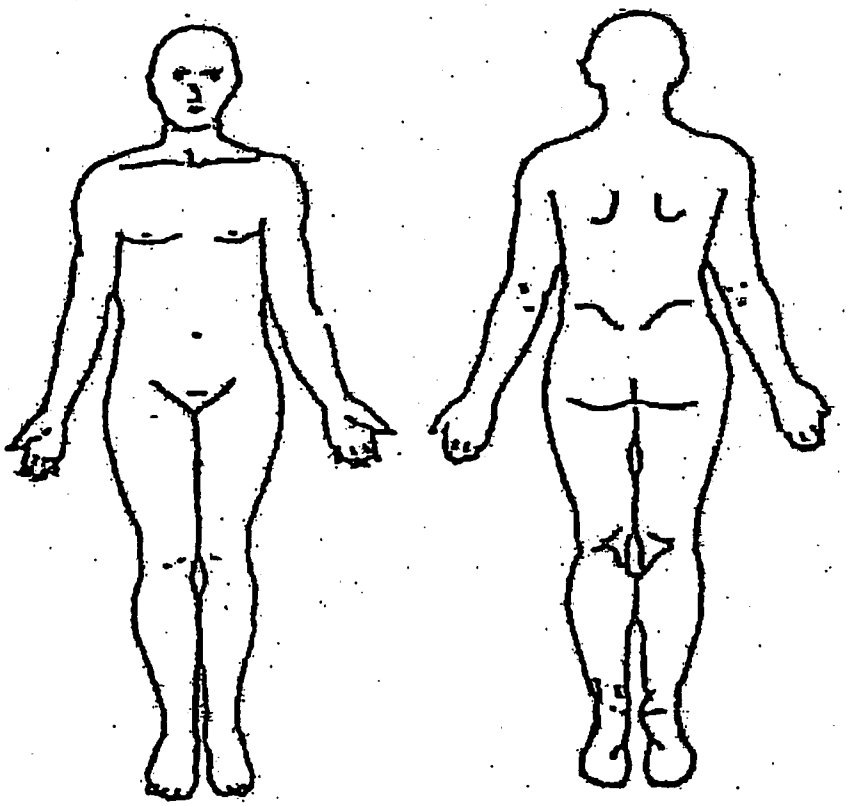
- ☐ Flickering
- ☐ Quivering
- ☐ Pulsing
- ☐ Throbbing
- ☐ Pounding
- ☐ Jumping
- ☐ Flashing
- ☐ Shooting
- ☐ Pricking
- ☐ Boring
- ☐ Drilling
- ☐ Stabbing
- ☐ Lancinating
- ☐ Sharp
- ☐ Cutting
- ☐ Lacerating
- ☐ Pinching
- ☐ Pressing
- ☐ Gnawing
- ☐ Cramping
- ☐ Crushing

- ☐ Tugging
- ☐ Pulling
- ☐ Wrenching
- ☐ Hot
- ☐ Burning
- ☐ Scalding
- ☐ Searing
- ☐ Tingling
- ☐ Itchy
- ☐ Smarting
- ☐ Stinging
- ☐ Dull
- ☐ Sore
- ☐ Hurting
- ☐ Aching
- ☐ Heavy
- ☐ Tender
- ☐ Taut
- ☐ Rasping
- ☐ Splitting

- ☐ Tiring
- ☐ Exhausting
- ☐ Sickening
- ☐ Suffocating
- ☐ Fearful
- ☐ Frightful
- ☐ Terrifying
- ☐ Punishing
- ☐ Grueling
- ☐ Cruel
- ☐ Vicious
- ☐ Killing
- ☐ Wretched
- ☐ Blinding

- ☐ Annoying
- ☐ Troublesome
- ☐ Miserable
- ☐ Intense
- ☐ Unbearable
- ☐ Spreading
- ☐ Radiating
- ☐ Penetrating
- ☐ Piercing
- ☐ Tight
- ☐ Numb
- ☐ Drawing
- ☐ Squeezing
- ☐ Tearing
- ☐ Cool
- ☐ Cold
- ☐ Freezing
- ☐ Nagging
- ☐ Nauseating
- ☐ Agonizing
- ☐ Dreadful
- ☐ Torturing

24. Shade in the areas of your pain for me:



25. To help us assess how your pain is affecting you, please **circle the number of one statement** within each item that best describes the way you feel today (right now). Be sure to read all the statements in each item before selecting one.

Item 1

0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

Item 2

0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

Item 3

0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see are failures.
3 I feel I am a complete failure as a person.

Item 4

0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

Item 5

0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

Item 6

0 I don't I feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.

First Name | Last Name | Date

3 I feel I am being punished

Item 7

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself worse than anybody else.

Item 8

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses and mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

Item 9

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

Item 10

0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time.
3 I used to be able to cry, but now I can't cry even though I want to.

Item 11

0 I am no more irritated by things that I ever am.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time now.

Item 12

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

Item 13

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

Item 14

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

Item 15

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

Item 16

0 I can sleep as well as usual
1 I don't sleep as well as I used to.
2 I wake up one or two hours earlier than usual and find it hard to get back to sleep
3 I wake up several hours earlier than I used to and cannot get back to sleep.

Item 17

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

Item 18

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be
2 My appetite is much worse now.
3 I have no appetite at all anymore.

Item 19

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

Item 20

0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains or upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

Item 21

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

First Name _____ Last Name _____ Date _____

The following are some questions given to all patients who are on or may be considered for opioids for their pain. Please answer each question as honestly as possible. 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.	How often do you have mood swings?	0	1	2	3	4
2.	How often do you smoke a cigarette within an hour after you wake up?	0	1	2	3	4
3.	How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
4.	How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
5.	How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
6.	How often have you attended an AA or NA meeting?	0	1	2	3	4
7.	How often have you taken medication other than the way that it was prescribed?	0	1	2	3	4
8.	How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
9.	How often have your medications been lost or stolen?	0	1	2	3	4
10.	How often have others expressed concern over your use of medications?	0	1	2	3	4
11.	How often have you felt a craving for medication?	0	1	2	3	4
12.	How often have you been asked to give a urine screen for substance abuse?	0	1	2	3	4
13.	How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
14.	How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4

Please include any additional information you wish about the above answers. Thank you.