BUFFALO
PAIN & HEALING

Bernard Hsu, M.D.
1416 Sweet Home Road, Suite 12
Amherst, NY 14228
716-688-5088 (main)
716-650-5744 (fax)
www.buffpain.com

Dear New Patient,

We welcome your upcoming visit to our practice. Please kindly fill out our initial intake forms prior and bring them with you to your appointment. **Be sure to fill out both sides of these forms.** Please also do not forget to bring the following:

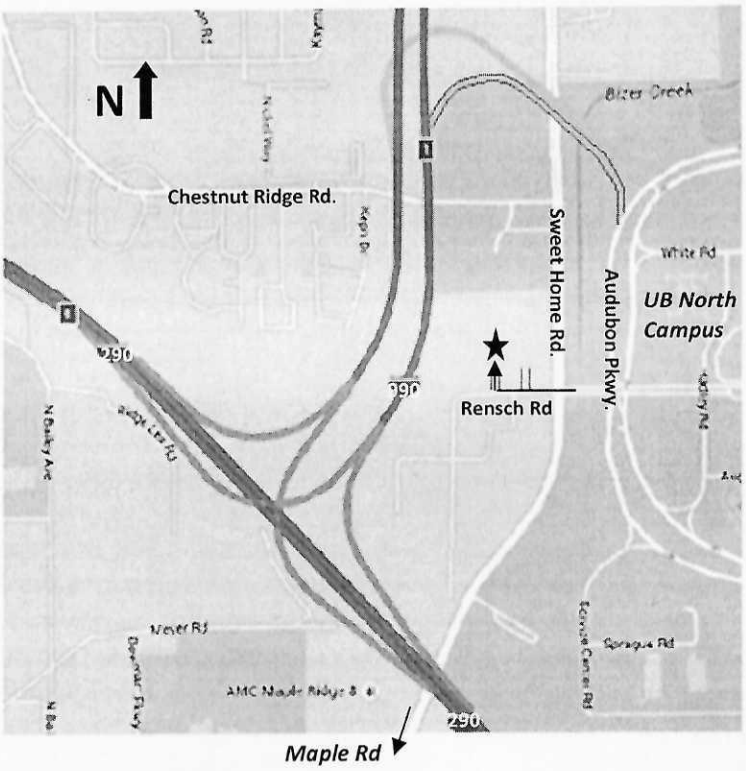
- Insurance card
- Photo ID
- Referral (if required)
- Co-payment
- Any medical records or imaging studies that you may have available.

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.

We have included a map on the reverse of this page to assist you in locating our office.

Sincerely,

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



Please note: although our address is listed on Sweet Home Rd, you ***must* turn onto Rensch Rd. to access our driveway!!

Directions from I-290:

Exit I-290 at 990.

Take Exit 1 ("University at Buffalo")
Stay to the right, you are on Audubon Parkway.

Turn right at first signal (Rensch Rd.); proceed across intersection of Rensch and Sweet Home Rd.

Turn right into **2nd** driveway after crossing Sweet Home Rd.
We are the last suite in the building to the left. 1416 Suite #12

First Name _____ Last Name _____ Date _____

PAIN AND OTHER HEALTH HISTORY WORKSHEET

1. Where is your pain? _____

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			

2. What is your pain score right now on a scale of 0-10 (0=no pain, 10=extreme pain) _____
3. When did your pain symptoms initially begin: _____
4. The onset of your pain symptoms were: ☐ Gradual ☐ Sudden

What happened?:

5. 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?

6. 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			

7. Course:

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

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

8. What makes the pain worse?
9. What makes the pain better?

10. Check if appropriate:

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

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

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

13. Surgical History (operations):

Date	Operation

14. 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

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

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

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

18. List all current doctors:

Full Name	Specialty	Phone Number

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?

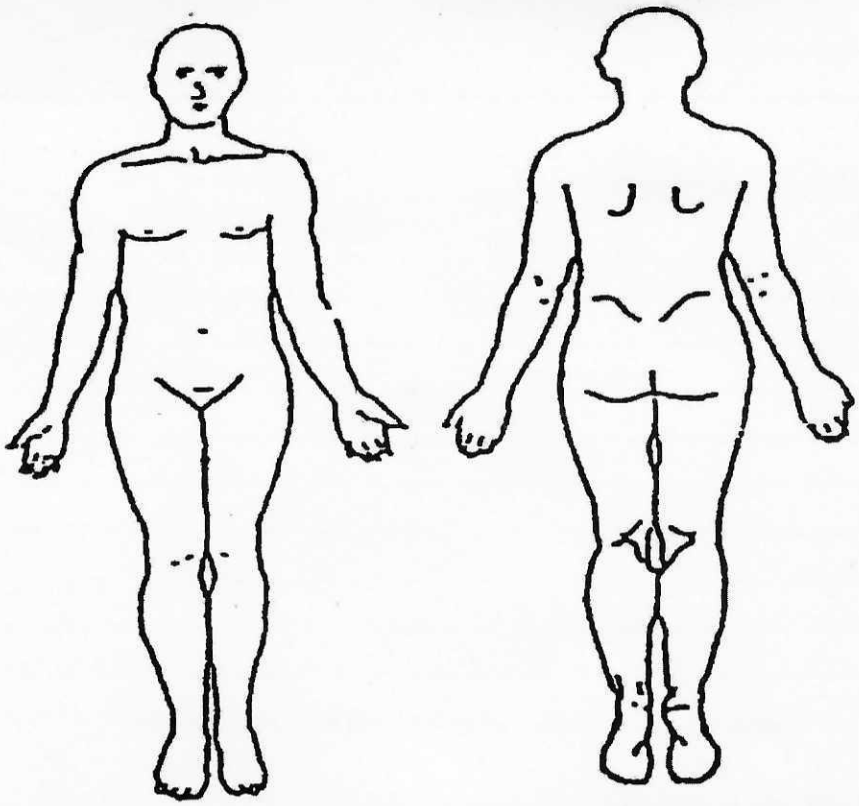
- ☐ Flickering
- ☐ Quivering
- ☐ Pulsing
- ☐ Throbbing
- ☐ Pounding
- ☐ Jumping
- ☐ Flashing
- ☐ Shooting
- ☐ Pricking
- ☐ Boring
- ☐ Drilling
- ☐ Stabbing
- ☐ Lancinating
- ☐ Sharp
- ☐ Cutting
- ☐ Lacerating
- ☐ Pinching
- ☐ Pressing
- ☐ Gnawing
- ☐ Cramping
- ☐ Crushing

- ☐ 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.
3 I feel I am being punished

First Name _____ Last Name _____ Date _____

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.

Buffalo Pain and Healing
Dr. Bernard Hsu, MD

REGISTRATION FORM

(Please Print)

Today's date:	Primary Physician (FULL NAME):

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:	Cell phone: ( )	Home phone: ( )

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

Occupation:	Employer:	Social Security Number: last 4 digits 000-00-

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.: ( )

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

Please indicate primary insurance ❑ BCBS ❑ IHA ❑ Medicare ❑ United Health ❑ Univera

❑ No Fault (claim #) ❑ Workman's Comp (claim #) ❑ Other

Subscriber's name:	Last 4 digits Subscriber's S.S. no.: 000-00-	Birth date: / /	ID #.:	Group # .:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	ID #.:	Group #.:

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:	Home phone:	Work phone:

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 my insurance company to release any information required to process my claims.

➡ _____ _____

Patient signature *Date*

Office Policy Agreement—Dr. Bernard Hsu, M.D.

Dr. Hsu primarily practices interventional pain management. New patients will be seen either for evaluation for a procedure or for medical consultation. **Absolutely no opiates/narcotics will be prescribed on the initial visit**. While we do prescribe certain pain medication (nerve blockers, anti-inflammatories, topical creams, etc.) we typically do not prescribe opiate/narcotic pain medications at this practice. Since this is only a part-time practice, we are not equipped to handle monthly medical monitoring of opiates/narcotics. The following policies regarding medications must be observed while under the care of our physician:

1. If another physician has already prescribed opiate medications for you (ex: Lortab, Norco, Oxycontin, Percocet, Morphine, Opana, etc.), you must continue receiving prescriptions from the physician who ordered them. **This office does not take over the writing of prescriptions started by other prescribers.**
2. Our practice may occasionally prescribe pain medication during transitions. If new pain medications are prescribed by our office, patients may ONLY obtain those medications from our office. The patient may be asked to sign an "opiate agreement" to acknowledge that they understand the policies regarding the use of opiate medications. Any breach of this agreement may result in dismissal of the patient from this office.
3. Refills of medications will only be made during regular office hours. The current office hours are: Tuesday through Friday, 9:00 AM until 3:00 PM. These hours are subject to change. Refills will not be made during nights, weekends, off-hours or holidays.
4. **You must contact our office for all refills on medications. We do not take requests for refills from pharmacies**.
5. No opiate medication prescriptions will be called in to the pharmacy. For emergencies, please go to the nearest emergency room.

In signing this document, you indicate your agreement with the above policies. If you do not feel comfortable with the policies described herein, do not sign below. We are able to cancel your appointment at the initial visit without penalty if you do not wish to be seen by the doctor. Thank you.

Signature:_____ Date:_____

Printed name:_____

Buffalo Pain and Healing

Bernard H. Hsu, M.D.

HIPAA CONSENT & ACKNOWLEDGMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a patient rights section describing your patient rights under the law. You have a right to review this Notice before signing this Consent. The terms of the Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction but if we do, we shall honor the agreement. By signing this form, you consent to our use and disclosure of protected health information about you for:

1) Treatment (including direct and indirect treatment by other health care providers involved in your medical care);
2) Payment from your insurance company or other third party payers;
3) The day to day health care operations of our Practice.

You have the right to revoke this Consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1) Protected health information may be disclosed or used for treatment, payment or health care operation
2) The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice
3) The Practice reserves the right to change the Notice of Privacy Practices.
4) The patient may revoke this Consent in writing at any time.
5) The Practice may condition receipt of treatment upon the execution of this Consent.

Please provide us the name(s) of family members or other persons, if any, to whom we may release information regarding your general medical condition, financial account or who have permission to pick up information you have requested.

Name_____ Relationship_____

Name_____ Relationship_____

Patient name (please print)_____

Signature:_____self ( ) Parent ( ) Legal Guardian ( ) Representative ( )

Date:_____