Interventional Pain Management
Anne Marie Stilwell, M.D.
45 McClean Avenue
Staten Island, NY 10305
718-448-6373
718-448-6648 Fax

Patient Information

Name: _____

Address city state zip code: _____

SS# _____ Date of Birth: _____ M or F ____

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Email Address: _____

Employer Information

Name of Employer: _____

Address city state zip code: _____

Phone # _____

Emergency Contact Information

Contact Name: _____

Address city state zip code: _____

Relationship_____ Phone # _____

Pharmacy Information

Pharmacy: _____ Pharmacy Phone # _____

Address city state zip code: _____

Mail Away Pharmacy Information

Pharmacy: _____Pharmacy Phone # _____

Address city state zip code: _____

Physician Information

Primary Care Physician: _____

Address city & state zip code: _____

Office Phone #:_____

Referring Physician: _____

Address city & state zip code: _____

Office Phone # _____

Insurance Information

Primary Insurance: _____Policy ID #: _____

Policy Holder: _____ Date of Birth_____

SS# _____ Relation: _____

Secondary Insurance: _____ Policy ID #: _____

Policy Holder: _____ Date of Birth _____

SS# _____Relation:_____

Please select appropriate lab: _____Quest _____ Lab Corp ____SIUH _____Other

Agreement of Compliance

I agree to follow my physician's treatment recommendations as specified. I will not adjust medication(s) or application(s) without first consulting with and obtaining the permission of my physician. I hereby certify that, to the best of my knowledge, the above information is accurate. If reasonable payment of the services rendered is not made to the provider by my insurance carrier(s), I agree to accept full financial responsibility for the payment of my physician's services.

Signature: _____Date: _____

Interventional Pain Management
Anne Marie Stilwell, M.D.
45 McClean Avenue
Staten Island, NY 10305
718-448-6373
718-448-6648 Fax

Patient Information

Name: _____ Date: __/__/___

Date of Birth: __/__/__ Age: ___ Male: ___ Female: ___

Martial Status:

SINGLE MARRIED DIVORCED SEPARATED WIDOW

* PLEASE ANSWER THESE QUESTIONS AS BEST YOU CAN. A THOROUGH RECORD IS IMPORTANT FOR THE BEST CARE.

General Information About Your Pain

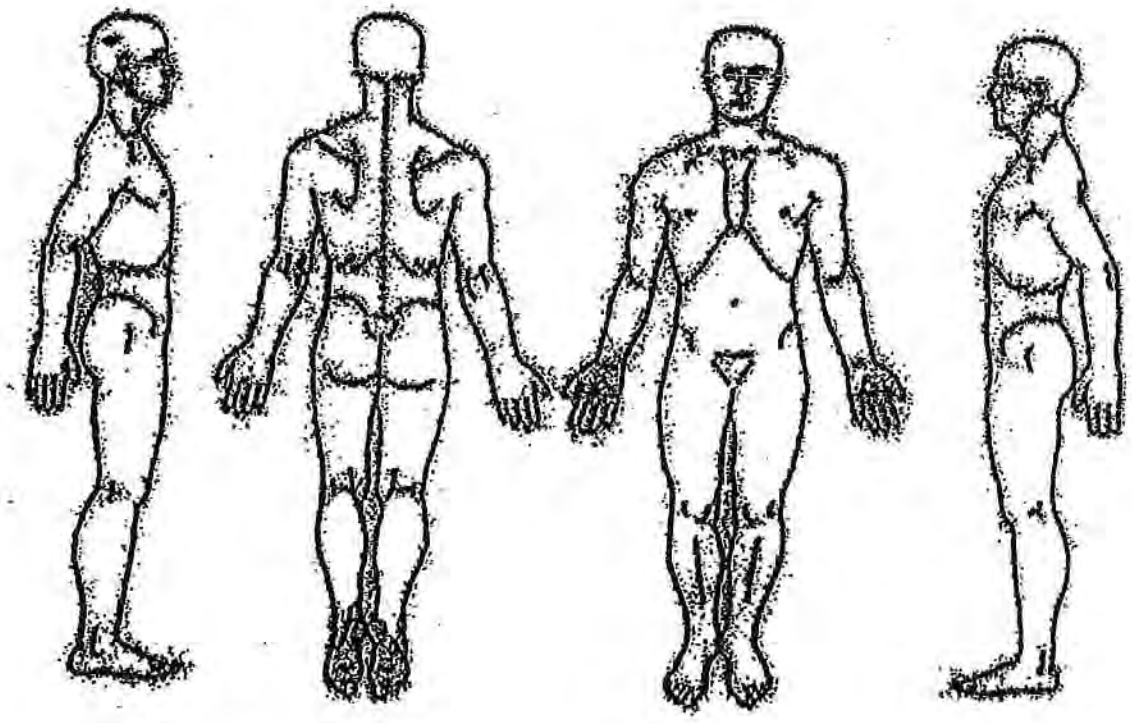
What is the location of you pain?

_____

_____

_____

On the drawing below, please shade in the areas in which you are having pain.



Does you pain travel? If so, check and circle where.

To buttock___R, L	Down leg to the ankle___R, L
To groin___R, L	Down side of leg to knee___R, L
Up spine___R, L	Down leg to toes___R, L
To head___R, L	Down back of leg to knee___R, L
Around eye___R, L	Down Back of leg to sole of foot___R, L
To calf___R,L	To shoulder blade___R, L
To shoulder___R, L	To hip___R, L

How would you describe your pain? Please circle all that apply. Next to each put where you feel this.

Aching_____	Dull_____	Pins & Needles_____
Burning_____	Electrical_____	Sharp_____
Cramping_____	Gripping_____	Shooting_____
Cutting_____	Numbness_____	Stabbing_____
Other_____		

On average, 0 being no pain and 10 being the worst pain, rate the severity of your pain and circle that number.

At its worst: 0 1 2 3 4 5 6 7 8 9 10

At its least: 0 1 2 3 4 5 6 7 8 9 10

Right now: 0 1 2 3 4 5 6 7 8 9 10

How long has the pain been present in this (these) area(s)?

How many: Day(s) _____
Week(s) _____
Month(s) _____
Year(s) _____

Did this pain begin following an event such as: Date of Event: _____

Motor Vehicle Accident Injury at Work Fall Lifting Surgery Illness

Are you currently in litigation? Yes___ No___

Are you currently working? Yes___ No___

If no, when did you stop? _____ Why? _____

If yes, were and what position? _____

Medical History

Surgical History:

Date	Procedure
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalization(s):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please circle the tests you have undergone. Put approximate date and name of facility where performed.

X-ray _____ CT scan _____
MRI scans _____ Bone scan _____
EMG _____ others (please List) _____

Do you have any medical or psychiatric problems that you see a doctor for? _____
_____
_____
_____

Do you have any allergies to food or medication? If yes, please list your reaction to that food/ medication. _____
_____
_____

Social History:

Do you smoke? If yes, how many per day? _____
Do you drink alcohol? If yes, how much per day? _____
Do you have any children? _____
Current height_____ Current weight _____

How frequently do you have your pain? (Please circle)

Constantly	(about 80-100% of the time)
Often	(about 50-80% of the time)
Intermittently	(about 25-50% of the time)

Worse in the AM	With walking
Worse in the PM	With sitting
Wakes at night	With standing
Changing positions	With lying down

In your experience check those factors that HELP your pain.

__Lying down	__Bending	__Looking up
__Rest	__Position change	__Looking down
__Standing	__Movement	__Looking around
__Sitting	__Heat	__OTC medications
__Walking	__Cold	__Opioids
__Lifting	__Nothing in particular	

In your experience check those factors that make your pain WORSE.

__Lying down	__Bending	__Looking up
__Rest	__Position change	__Looking down
__Standing	__Movement	__Looking around
__Sitting	__Heat	__Stress
__Walking	__Cold	__Lifting

Please circle any treatment you have had for pain and give details.

	Dates	Was the treatment helpful
Surgery	_____	_____
Injections	_____	_____
Tens	_____	_____
Physical therapy	_____	_____
Psychotherapy	_____	_____
Biofeedback/hypnosis	_____	_____
Chiropractor	_____	_____
Acupuncture	_____	_____
Other	_____	_____
	_____	_____

Current Medication: Please List

Name	Strength (mg/mcg)	How many	How often (ex. Twice a day)

Musculoskeletal: check all that apply
Leg cramps___ Joint pain___ Muscle cramps___
Joint swelling___ Joint stiffness___

Neurology: check all that apply
Headache___ Tingling/numbness___ Seizures___
Insomnia___ Memory loss___ Tremors___
Vertigo___ Weakness in arms___ Weakness in legs___

Opioid Management: check all that apply
Nausea/vomiting___ itching, rash___ Constipation___
Sedation___ Sweating___ Swelling___ Dry mouth___
Blurred vision___ headaches___ Hallucination, weird dreams___

General: check all that apply
Easily fatigues___ trouble sleeping___ coldness (feel cold when others are comfortable)
___ cold limbs (feet, hands) ___ easy bruising___

Cardiology: check all that apply
Dizziness___ Chest pain___ Irregular heartbeats___ shortness of breath___

Hematology: check all that apply
Abnormal bruising___ Abnormal bleeding___

Respiratory: check all that apply
Wheezing___ Cough___

Signature_____ Date_____

Interventional Pain Management
Anne Marie Stilwell, M.D.
45 McClean Avenue
Staten Island, NY 10305
718 448-6373
718 448-6648 Fax

Chronic Opioid Pain Medication Agreement

Purpose

This chronic Opioid Medication Agreement is entered into by the physician of Interventional Pain Management, Anne Marie Stilwell, M.D. located at 45 McClean Avenue Staten Island, NY 10305 and _____ for the purpose of protecting the Patient's access to Opioid Pain Medication (OPM) and the Physicians ability to prescribe such medications for the patient. OPM are considered controlled substances as per New York State and Federal regulations and carry risks related to health and addiction. The Physicians have determined that the Patient's chronic pain requires the use of OPM. In order for the Patient to receive the recommended treatment the Patient shall adhere to all the terms and conditions contained in this Agreement.

Health Risks

The Patient understands that there are potential health risks that accompany the use of OPM. Such risks include fatal overdoes from respiratory depression, drowsiness, increased pain sensitivity, sexual dysfunction, constipation, nausea or vomiting, chronic dry mouth.

Risk of Addiction

As states above, tolerance, physical dependence and opioid dependence are potential risks associated with taking OPM. Tolerance is defined as a reduction in sensitivity to effects of opioids repeated administration requiring increased doses to produce the same magnitude of effects. Physical dependence is defined as the occurrence of withdrawal symptoms when the opioid is abruptly discontinued or reduced. Symptoms of withdrawal include agitation, insomnia, diarrhea, sweating, rapid heartbeat and runny nose. Opioid dependence is defined as a maladaptive pattern of use leading to significant impairment or distress. Three or more of the following symptoms signify opioid dependence: tolerance, withdrawal, inability to control use, unsuccessful attempts to decrease or discontinue use, time lost in obtaining substance, using substance or recovering from substance use despite physical or psychological problems.

Interventional Pain Management
Anne Marie Stilwell, M.D.
45 McClean Avenue
Staten Island, NY 10305
718 448-6373
718 448-6648 Fax

Pain and Mental Health

The presence of pain can coexist with depression and anxiety symptoms. In turn, such psychological conditions may increase the risk of opioid use and misuse. The level of depression and anxiety could be influenced by the level of pain experienced by the Patient.

Patient Responsibilities

In light of the aforementioned information, the Patient agrees to the following:

1. OPM medication shall **only** be prescribed by the Physician, specifically Anne Marie Stilwell, M.D. Accordingly, requesting or receiving opioids from any physician other than Anne Marie Stilwell, M.D. is not permissible;
2. Medication must be taken as prescribed. Any changes to the patient's prescription, including dose and frequency of use, shall only be determined by Anne Marie Stilwell, M.D.;
3. Driving or operating heavy machinery shall be avoided;
4. The Patient shall inform Anne Marie Stilwell, M.D. of any side effects of the medication;
5. The Patient's prescription can only be written and filled on a monthly basis, as per New York State and Federal regulations. **Early refills of prescriptions will not be given;**
6. Renewal of medication is contingent upon adherence to scheduled appointments. Prescriptions will not be given over the phone or in the absence of an appointment. Accordingly, the patient is advised to allow five (5) business days to schedule an appointment for prescription refill. In addition, prescription refills do not constitute an emergency;
7. All prescriptions shall be filled at one (1) pharmacy. The Patient shall advise the office if he/she must change to a different pharmacy.
8. The Patient's medication **will not be replaced** if they are lost, stolen, get wet, etc. Therefore, it is the Patient's responsibility to keep all medication safe and in a place where other people do not have access to the medication;
9. OPM may be hazardous or lethal to children or anyone not tolerant to the effects of the medication. Therefore, it is the Patient's responsibility to keep all medication safe and in a place where other people do not have access to medication;

Interventional Pain Management
Anne Marie Stilwell, M.D.
45 McClean Avenue
Staten Island, NY 10305
718 448-6373
718 448-6648 Fax

10. Any medication that is not used because of side effects or dose adjustments shall be returned to the office. **The Patient will not dispose of or throw away unused medication;**
11. Any travel or vacation plans must be discussed with the Physician in advance to ensure that the Patient has all required medications.
12. The Physician cannot prescribe and the pharmacy cannot dispense more than 30 days of medication. The patient shall take this into account when planning travel or vacation;
13. The Patient shall pick up his/her own medication from the pharmacy. Spouses, children, friends or family members shall not pick up the Patient's medication;
14. The Patient shall not share medication with anyone;
15. The Patient shall not sell or trade medication;
16. The Patient shall not use illegal substances, such as marijuana, cocaine, etc;
17. The Patient shall not imbibe alcohol while on pain medication;
18. The Physician has the right to conduct random urine drug screening and serum toxicity screening to ensure compliance with medication instructions. In addition, by signing this Agreement, the Patient give the Physician permission to speak to family or other physicians and pharmacy involved in your care;
19. The Patient takes responsibility for informing other physicians involved in his/her care of the prescriptions received by the Physician to avoid interaction with other drugs;
20. If legal authorities have questions regarding the Patient's treatment, all confidentiality is sustained and such authorities may be given full access to the records of the Interventional Pain Management regarding controlled substance administration only with a signed privacy form by you;
21. The Patient shall comply with other recommendations by the Physician in connection with treatment of pain, including psychological counseling, physical therapy, diagnostic evaluations and other conservative treatments that may be deemed necessary;
22. If the Patient is female, she agrees that she is not pregnant at the commencement of therapy. If she becomes pregnant or is planning to become pregnant, the Patient shall inform the Physician;
23. Any medical treatment is initially on a trial basis and continued prescription of OPM is contingent on evidence benefit;
24. Treatment will be ceased immediately if the Patient is involved in an illegal activity involving the drug or any drug other than that prescribed;
25. The Patient understands the terms addiction, tolerance, dependence and withdrawal;

Interventional Pain Management
Anne Marie Stilwell, M.D.
45 McClean Avenue
Staten Island, NY 10305
718 448-6373
718 448-6648 Fax

26. The Patient acknowledges that he/she understands the risks and benefits of opioid (narcotic) therapy.

Discharge of Patient from Interventional Pain Management

By signing this Agreement, the Patient understands that failure to meet any of the conditions set forth in Patient Responsibilities may result in discharge from the Interventional Pain Management practice. In the event that the Patient is discharged, the Physician will give the Patient four (4) weeks notice to find a new physician. The Interventional Pain Management practice will forward the Patient's medical records to his/her new physician.

By signing this Agreement the Patient acknowledges and certifies that he/she understands all the risks involved in taking the prescribed medication and his/her responsibilities required in order to receive OPM treatment.

Patient name: _____

Signature: _____

Date: _____

Anne Marie Stilwell, M.D. _____

I had access to the HIPAA policy (policy is in a binder at the front desk of this office) and I hereby authorize the use and disclosure of my health information as described in this form.

I make the following special request for confidential communications: (List all doctors and family members you want, otherwise we cannot communicate with them at all).

_____

_____

_____

_____

_____

_____

_____

Signature Date

Anne Marie Stilwell, M.D.
Board Certified
Interventional Pain Management & Anesthesiology

Financial Agreement effective January 1, 2020

This is to inform you that your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for the visit, you will be responsible for the bill. You are responsible for all deductibles, co-insurances and copays. If you do not provide us with the correct information to process your claim, such as your insurance cards or other information related to an accident in a car or at work, and the claim is denied, you will be responsible for the charges.

This is also to inform you that it is a medical requirement that any patient who may be prescribed a controlled pain medication must be screened with urine toxicology. The federal government procedure code for this office urine test is 80307 and it is being covered by federal insurances such as Medicare. A urine screen will be performed randomly, up to an average of 4 times per year, for those patients on controlled substances as well as a baseline in all patients. Your insurance will be billed and you will only be responsible for payment if you have a copay or deductible or your insurance refuses to pay. If your insurance refuses to pay, you will only be responsible for the rate at which Medicare reimburse ($62.14).

I have read and understand the above.

_____ _____

Signature Date

The H.H. Richardson House 45 McClean Avenue Staten Island, New York 10305
718.448.6373 718.448.6648 Fax www.statenislandpain.com

DATE: _____

NAME: _____

FLU SHOT _____**YES** _____**NO**

PNEUMONA _____**YES** _____**NO**

Anne Marie Stilwell, M.D.

Board Certified

Interventional Pain Management & Anesthesiology

Patient Name: Date:

Please answer all questions to the best of your ability. Circle the appropriate answer.

Did you have a drink containing alcohol in the past year?	YES	NO
Does your family have a history of alcohol abuse?	YES	NO
Does your family have a history of abusing Illegal drugs?	YES	NO
Does your family have a history of abusing prescription drugs?	YES	NO
Do you have a personal history of alcohol abuse?	YES	NO
Do you have a personal history of Illegal drug use?	YES	NO
Do you have a personal history of prescription drug abuse?	YES	NO
Are you between the ages of 16-45 years old?	YES	NO
Do you have a history of pre-adolescent sexual abuse?	YES	NO
Are you a smoker?	YES	NO

Do you suffer from any of these? (Please check all that apply)

___ADD ___ OCD ___Bipolar ___ Schizophrenia?

Are you currently experiencing depression? YES NO

On a scale of 1 – 10, what number best describes your pain on average in the past week? _____

On a scale of 1-10, what number best describes how, during the past week, pain has interfered with your enjoyment of life? _____

On a scale of 1-10, what number best describes how your pain has interfered with your general activity in the past week? _____

How often do you experience little interest or pleasure in doing things?

☐ Not at all ☐ Several days ☐More than half the days ☐ Nearly every day

☐Declined to Specify

Do you generally feel down, depressed, or hopeless?

☐ Not at all ☐ Several days ☐More than half the days ☐Nearly every day

☐Declined to Specify

Turn page fill out back

The H.H. Richardson House 45 McClean Avenue Staten Island, New York 10305

718.448.6373 718.448.6648 Fax www.statenislandpain.com

Over the last 2 weeks, how often have you been bothered by any of the following problems.

Do you have trouble falling or staying asleep, or sleeping too much?

☐ Not at all ☐ Several days ☐More than half the days ☐ Nearly every day

Do you feel tired or have little energy?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Do you experience poor appetite?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Do you feel bad about yourself, feel that you are a failure or have let yourself or your family down?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Do you have trouble concentrating on things, such as reading the newspaper or watching television?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Do you move or speak slowly that other people have noticed a change in you?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Do you experience being fidgety or restless that you have been moving around a lot more than usual?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Have you had thoughts of suicide, or hurting yourself or someone else in any way?

☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Are you a : (Check all that apply)

☐ Current smoker
☐ Current every day smoker
☐ Heavy tobacco smoker
☐ Ex-pipe smoker
☐ Former smoker
☐ Ocasional smoker
☐ Ex-cigar smoker
☐ Non smoker
☐ Light tobacco smoker
☐ Ex-cigarette smoker

If "YES" ; when did you start smoking? _____

☐ Chain smoker
☐ Heavy cigarette smoker (20-39 cigs/day)
☐ Moderate cigarette smoker (10-19 cigs/day
☐ Snuff user
☐ Trivial cigarette smoker (less than one cigarette/day)
☐ Chews loose leaf tobacco
☐ Light cigarette smoker (1-9 cigs/days
☐ Very heavy cigarette smoker (40+ cigs/day)
☐ Chews Tobacco
☐ Pipe smoker

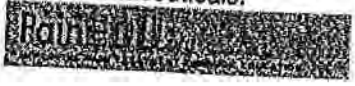
Name: _____

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the past 30 days. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O



Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O