30 E. 40th Street, Ste 1100 * New York, NY 10016
Ph: 212-532-7999 * Fax: 212-532-5957
Email: support@nmpi.com * www.nmpi.com

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____

S.S.#:_____ DATE OF BIRTH:_____ AGE:_____ SEX: M ( ) F ( )

ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE:_____

HOME PHONE:_____ CELL PHONE:_____

WORK PHONE: _____ EMAIL: _____

( ) SINGLE ( ) MARRIED ( ) DOMESTIC PARTNERSHIP ( ) DIVORCED ( ) WIDOWED

OCCUPATION/EMPLOYER:_____

REFERRED BY:_____

IN CASE OF EMERGENCY, CONTACT:_____

RELATION:_____ PHONE:_____

PRIMARY CARE PHYSICIAN:_____

ADDRESS:_____ PHONE: _____

PREFERRED PHARMACY – NAME: _____

ADDRESS: _____

PHONE: _____

INSURANCE:_____ NAME OF INSURED:_____

INSURED DATE OF BIRTH: _____ RELATION:_____

I.D.#:_____ GROUP #:_____

FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that the prompt payment of your bill is essential in order for us to continue to serve patients. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

All patients must complete our Information and Insurance forms before seeing the doctor.

Full payment is due at the time of service.

We accept cash, checks and all major credit cards. Any checks that have been returned for any reason will incur a charge of $15. We ask that you immediate rectify your balance by paying the balance and the fee.

Please be advised that Dr. Marcus has opted out of participation in the Medicare program under §1128 of the Social Security Act, which means the following:

- Medicare will not reimburse for any visits in our office.
- Medigap and other supplemental insurance plans will not reimburse for any visits in office.
- Neither our office nor you can submit a claim to Medicare for reimbursement.

By signing below, you acknowledge the above statements and choose to continue with Dr. Marcus as a treating physician.

Our practice is committed to providing the best treatment for our patients and we charge fees that are usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

CANCELLATION POLICY: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at 50% of the rate of your scheduled visit fee. Please cooperate by keeping scheduled appointments. Payment for the missed appointment must be made before another appointment is scheduled.

I have read and understand my financial responsibilities to the Norman Marcus Pain Institute.

_____ _____

Signature Date

_____

Print Name

NORMAN MARCUS
PAIN INSTITUTE
"Dedicated to the Elimination of Pain"

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I, the undersigned, have insurance coverage with _____
Name of Insurance Co.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I permit a copy of this authorization to be used in place of the original.

X_____ _____
Signature of Patient/Guardian Date

****

PRESCRIPTION MEDICATIONS:

Should Dr. Marcus choose to prescribe medications, please acknowledge that you must see Dr. Marcus every:

_____(initial here) 3 months for non-controlled substances

_____ (initial here) every month for controlled substances

Any change in prescriptions (including changes in dosages, lost or stolen medications, or changes in the drug) must be done in person and cannot be done over the phone.

Anyone receiving opioid medication prescriptions will be required to sign an opioid agreement and be subject to randomized drug testing.

Please note that anyone will Medicaid will NOT have coverage for the medications (at the pharmacy) and will end up paying cash for the medication(s).

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PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name _____

Signature _____

Relationship to Patient _____

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Dear Patient:

Norman Marcus, MD, and his practice, Norman Marcus Pain Institute, participates in ongoing research on chronic pain and various treatments, including medications, injections, and other therapies. Any patient data used in this research is de-identified and HIPAA Compliant. We request your permission to use the data we collect during the course of your evaluation and treatment in this research. While you will not directly benefit from this, nor will it change your current treatment, we hope that through participation of patients such as yourself, we can continue to clarify our understanding of the pathophysiology of chronic pain and further refine effective treatments.

Your signature below indicates your permission to use your de-identified data (or of that of your child) in building our research database.

_____ _____

Name of Patient Date

_____ _____

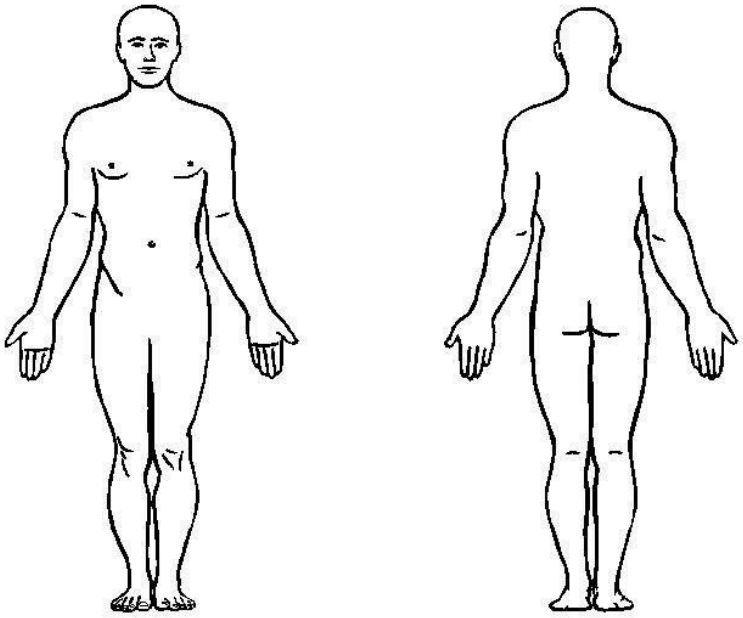
Legal Representative/Guardian Date

PAIN HISTORY

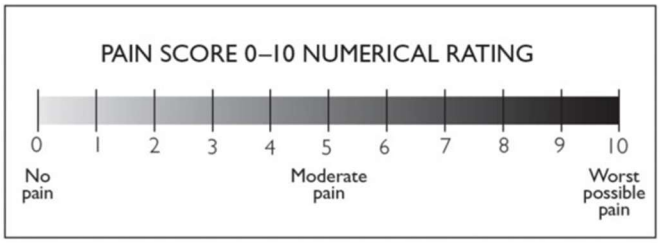
Pain can be difficult to describe. Circle the words that best describe your symptoms:

Burning	Throbbing	Aching	Stabbing	Tingling	Dull
Twisting	Cramping	Cutting	Shooting	Numbing	Vague
Stinging	Squeezing	Pulling	Smarting	Pressure	Hot/Cold
Tender	Indescribable	Other: _____			

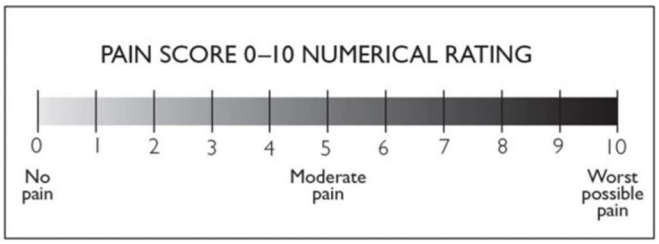
Please mark the areas on the diagram where you feel pain.



Please select a number that describes your pain **today**.



Please select a number that describes your pain **on average**.



Please check any history of pain treatments:

- ❑ Physical therapy (including massage, heat, ultrasound, electrical stimulation)
- ❑ Exercises: _____
- ❑ Surgeries: _____
- ❑ Other: _____

GENERAL HEALTH & HEALTH HISTORY

Please list any *current* medications or supplements that you are taking, the reason for taking them, and how long you have been taking them.

Name of Medication	Dosage	Reason for Taking It	How long have you been taking it?

Please list any allergies:

_____

_____

_____

Please list any prior injuries and when they occurred:

Any past illnesses and when they occurred:

Any past surgeries and when they occurred:

Any past hospitalizations and when they occurred:

Please list any *past* medications or supplements that you have taken for pain, the date range of when they were taken, and why they were discontinued.

Name of Medication	Date Range of Use	Reason for Taking It	Why did you discontinue?

Do any of your family members have history of the following conditions? If so, please list the relation: (e.g. parent, grandparent):

Arthritis

_____

Autoimmune disease

_____

Cancer

_____

Heart disease

_____

Hereditary conditions

_____

High blood pressure

_____

Exaggerated flexibility of the body (Hypermobility)

_____

Joint pain

_____

How would you describe your use of alcohol?

- ❑ Daily
- ❑ Weekly
- ❑ Socially
- ❑ Rarely
- ❑ Never

How would you describe your use of recreational drugs?

- ❑ Daily
- ❑ Weekly
- ❑ Socially
- ❑ Rarely
- ❑ Never

How would you describe your use of tobacco?

- ❑ Daily
- ❑ Weekly
- ❑ Socially
- ❑ Rarely
- ❑ Never

Do you have any history of the following conditions?

- ❑ Depression
- ❑ Anxiety
- ❑ PTSD
- ❑ Other mental health concerns:

_____

PATIENT HEALTH QUESTIONNAIRE-2 (PHQ-2)

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Check all symptoms below that you are currently experiencing or have experienced in the past.

Cognitive Functions

- ❑ Fatigue
- ❑ Difficulty sleeping
- ❑ Problems with memory
- ❑ Problems with attention or concentration

Musculoskeletal Presentations

- ❑ Clumsiness
- ❑ Dislocations
- ❑ Subluxations
- ❑ TMJ pain
- ❑ Recurrent sprains or muscle strains

Skin Presentations

- ❑ Rashes
- ❑ Varicose veins
- ❑ Dermatographia (light scratches that remain red or raised)
- ❑ Striae (stretchmarks)
- ❑ Environmental sensitivities
- ❑ Blotchy skin after hot showers
- ❑ Bruising easily
- ❑ Slow to heal

Cardiovascular/Dysautonomia

- ❑ Cold hands and/or feet
- ❑ Fevers
- ❑ Excessive sweating
- ❑ Hypotension (low blood pressure)
- ❑ Fast heartbeat
- ❑ Heart palpitations
- ❑ Mitral valve prolapse
- ❑ Arterial aneurysms

Other _____

Gastro-Intestinal Presentations

- ❑ Constipation
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Difficulty swallowing
- ❑ GERD (acid reflux)
- ❑ Problems with chewing
- ❑ Teeth and gum problems
- ❑ Hemorrhoids

Ear-Nose-Throat Issues

- ❑ Ultra-sensitive hearing
- ❑ Poor hearing
- ❑ Ringing in your ears
- ❑ More sensitive to smell than others
- ❑ Dizziness

Eye Manifestations

- ❑ Near-sighted
- ❑ Double vision
- ❑ Visual fatigue
- ❑ Astigmatism
- ❑ Dry eyes
- ❑ Itchy Eyes
- ❑ Contacts/Glasses

Urinary/Genital Issues

- ❑ Problems urinating
- ❑ Recurrent UTIs
- ❑ Painful intercourse
- ❑ Erectile dysfunction
- ❑ Spontaneous abortions (miscarriage)
- ❑ Urinary frequency

Respiratory Manifestations

- ❑ Difficulty taking a deep breath
- ❑ Recurrent bronchitis
- ❑ Problems with your voice
- ❑ Asthma

Physical Function – Short Form 10b

Please respond to each question or statement by marking one box per row.

		Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
PFA11	Are you able to do chores such as vacuuming or yard work?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA56	Are you able to get in and out of a car?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA21	Are you able to go up and down stairs at a normal pace?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA53	Are you able to run errands and shop?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA9	Are you able to bend down and pick up clothing from the floor?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFB28r1	Are you able to lift 10 pounds (5 kg) above your shoulder?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Not at all	**Very little**	**Somewhat**	**Quite a lot**	**Cannot do**
PFA1	Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFA6	Does your health now limit you in bathing or dressing yourself?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFB3	Does your health now limit you in putting a trash bag outside?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
PFB44	Does your health now limit you in doing moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Global Health

Please respond to each question or statement by marking one box per row.

		Excellent	Very good	Good	Fair	Poor
Global01	In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global02	In general, would you say your quality of life is:.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global03	In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global04	In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global05	In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Global09r	In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.).....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		Completely	**Mostly**	**Moderately**	**A little**	**Not at all**
Global06	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
Global10r	How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
		None	**Mild**	**Moderate**	**Severe**	**Very severe**
Global08r	How would you rate your fatigue on average?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Global07r	How would you rate your pain on average?	☐ 0 **No pain**	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10 **Worst pain imaginable**

Brief Fatigue Inventory

STUDY ID# _____ HOSPITAL # _____

Date: _____/_____/_____ Time: _____

Name _____ _____ _____

Last First Middle Initial

Throughout our lives, most of us have times when we feel very tired or fatigued. Have you felt unusually tired or fatigued in the last week? Yes ☐ No ☐

1. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your fatigue right NOW.

0 1 2 3 4 5 6 7 8 9 10

No Fatigue — As bad as you can imagine

2. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your USUAL level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Fatigue — As bad as you can imagine

3. Please rate your fatigue (weariness, tiredness) by circling the one number that best describes your WORST level of fatigue during past 24 hours.

0 1 2 3 4 5 6 7 8 9 10

No Fatigue — As bad as you can imagine

4. Circle the one number that describes how, during the past 24 hours, fatigue has interfered with your:

A. General activity

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

B. Mood

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

C. Walking ability

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

D. Normal work (includes both work outside the home and daily chores)

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

E. Relations with other people

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes

F. Enjoyment of life

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely Interferes