North Shore LIJ North Shore Long Island Jewish Health System

NORTH SHORE UNIVERSITY HOSPITAL
DEPARTMENT OF SURGERY

NAME:____________________
DOB:____________________

PAIN SCREENING:

HAVE YOU EXPERIENCED PAIN WITHIN THE PAST WEEK? ☐ NO ☐ YES
(If no, stop here. If yes, please continue)

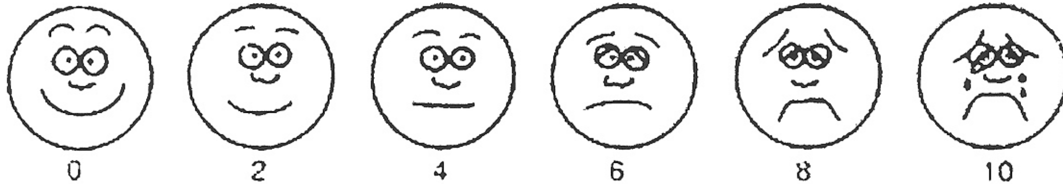
WHERE IS THE PAIN LOCATED?____

ARE YOU BEING TREATED FOR YOUR PAIN? ☐ NO ☐ YES

CIRCLE A NUMBER FROM 0-10 THAT BEST DESCRIBES HOW MUCH PAIN YOU ARE HAVING NOW

NO PAIN	0	1	2	3	4	5	6	7	8	9	10	MOST SEVERE PAIN

PLEASE CIRCLE THE FACE THAT BEST DESCRIBES HOW YOU FEEL



PAIN ASSESSMENT – TO BE COMPLETED BY HCP

WHAT DOES YOUR PAIN FEEL LIKE?

☐SHARP	☐THROBBING	☐GNAWING	☐MISERABLE
☐DULL	☐TENDER	☐SHOOTING	☐UNBEARABLE
☐BURNING	☐NUMB	☐EXHAUSTING	☐CONTINUOUS
☐ACHING	☐STABBING	☐PENETRATING	☐OCCASSIONAL

WHAT MAKES THE PAIN BETTER?____________________________________

WHAT MAKES THE PAIN WORSE?____________________________________

______________________________ ______________
PHYSICIAN/RN SIGNATURE DATE

5/24/2006

I agree to allow disclosure of my PHI (including date/time of appointments) to:

___ My Spouse ____
(Printed name and phone number)

___ Member(s) of my Family ____

____

____
(Printed name and phone number)

___ Other ____
(Printed name and phone number)

___ Myself only

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

I have been provided and have reviewed the *Notice of Privacy Practices.*

____
Print Name of Patient or Legal Representative Date

____
Signature of Patient or Legal Representative Date

____
Relationship to patient

Authorization to release information via e-mail

By proving your e-mail address, you agree to receive e-mail information about your healthcare, including protected health information.

____ ____________________
Signature Date

This does not serve as an Authorization to Release Medical Records

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ an emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Witness: ____________________ **Date:** ____________________