Pain Clinic of Michigan

5456 15 Mile Road * Suite #101 * Sterling Heights, MI 48310-5111
2820 Crooks Road * Suite #200 * Rochester Hills, MI 48309
Phone: 586.977.PAIN (7246) * Fax: 586.977.1492 * www.painclinicmi.com
Dr. Rakesh Vakhariya, D.O. * Dr. Jason Peter, D.O. * Dr. Mark Mounayer, M.D.

You have been scheduled on: _____
You have been scheduled with: Dr.Jason Peter Dr. Rakesh Vakhariya Dr. Mark Mounayer

PATIENT INFORMATION

First Name:_____ **Last Name:**_____

Date of Birth:_____ **Social Security #:**___ - ___ - ____

Sex: Male Female **Marital Status:** Married Single Divorced Widowed Separated

Address:_____

City:_____ **State:**_____ **Zip Code:** _____

Home Phone :(___)_____ **Cell Phone :(___)**_____

Work Phone :(___)_____ **E-Mail Address:**_____

Alternate Contact:_____ **Phone :(___)**_____**Relationship:** _____

Primary Care Physician:_____ **Phone :(___)**_____

Referring Physician:_____ **Phone :(___)**_____

Work Status Employed Unemployed Not Employed Retired Student Disabled
Name of Employer:_____**Occupation:**_____

Employer Address:_____ **Years Worked:**_____

If Retired, Date Retired:_____

If disabled or unemployed, exact date last worked:_____

INSURANCE INFORMATION

Do you have Medicare Part A?___**Part B?**_____ **Medicare Policy #:**_____

Is this a Worker's Compensation, Auto/Other Accident/ Injury Claim? ☐Yes ☐No
Primary Insurance Name:_____**Phone :(___)**_____

Policy Holder Name:_____**Relationship:**_____

Date of Birth:_____**Policy Holder S.S. #:**___ - ___ - ____

Policy Holders Phone :(___)_____ **Policy/ID Number:**_____

Group Name:_____ **Group Number:**_____

Secondary Insurance Name:_____**Phone :(___)**_____

Policy Holder Name:_____**Relationship:**_____

Date of Birth:_____**Policy Holder S.S. #:**___ - ___ - ____

Policy Holders Phone :(___)_____ **Policy/ID Number:**_____

Group Name:_____ **Group Number:**_____

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MEDICATION HISTORY

Patient Name:_____ **Patient DOB:**_____

Do you have any Drug/Medication Allergies? **YES** **NO**

If so, please list all Medications you are allergic to & the reaction:

Medication	**Allergic Reaction**

Drug Name Brand & Generic	Dosage	Frequency & Directions	Prescribing M.D.

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SOCIAL HISTORY

Patient Name:_____ **Patient DOB:**_____

Sex: Male Female **Marital Status:** Married Single Divorced Widowed Separated
Children: _____**Sons** _____**Daughters**
Living Status Independently Assisted Living Facility Nursing Home
Lives with: Alone Spouse/Partner One/Both Parents Sibling(s)
Children Other Relative(s) Friend Roommate
Language English Other_____
Race White Hispanic European African American
Asian Hawaiian Latin American Other_____
Ethnic Group Hispanic/Latino African American Asian
Not Hispanic/Latino Other_____
Work Status Employed Unemployed Not Employed Retired Student Disabled
Work Duration _____Weeks _____Months _____Years
Are you presently involved in a lawsuit? Yes No
If yes, please explain_____

_____

SUBSTANCE ABUSE

Have you used any of the following substance's in the past? If yes, please specify how often below:
Alcohol: never, weekly, 1-2x week, rarely, daily, occasionally, history of abuse, history of use
Cocaine: never, weekly, 1-2x week, rarely, daily, occasionally, history of abuse, history of use
Amphetamines: never, weekly, 1-2x week, rarely, daily, occasionally, history of abuse, history of use
Heroin: never, weekly, 1-2x week, rarely, daily, occasionally, history of abuse, history of use
Marijuana: never, weekly, 1-2x week, rarely, daily, occasionally, history of abuse, history of use
Barbiturates: never, weekly, 1-2x week, rarely, daily, occasionally, history of abuse, history of use

Smoking Status: Current Smoker Former Smoker Never

FAMILY HISTORY

Please Mark all appropriate diagnoses as they pertain to your first-degree relatives:

	Relationship
Arthritis	_____
Cancer	_____
Osteoporosis	_____
Stroke	_____
Diabetes	_____
Cardiac Disease	_____
I have no significant family medical history	

Other Medical Problems (If not listed above): _____

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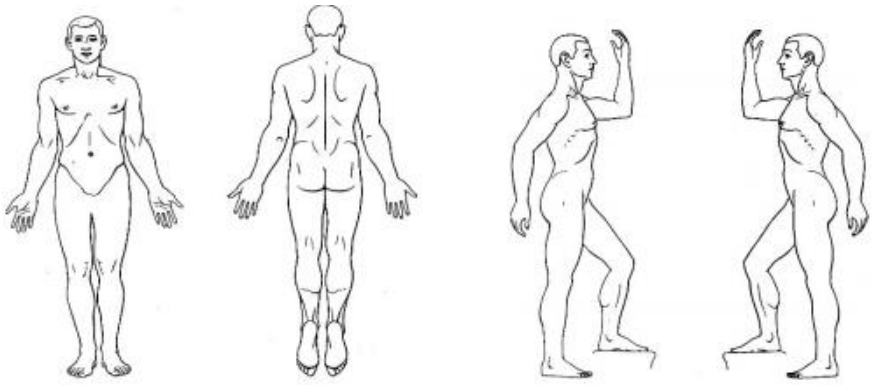
PATIENT PAIN HISTORY

Patient Name:_____ **Patient DOB:**_____

Please Read Carefully. Mark the areas on the diagram below that coincide with your pain.
Include all the affected areas.
Use as many individual symbols as you'd like to describe the pain intensity.
Please use the appropriate symbol(s) listed below.

ACHING	XXX	NUMBNESS	= = = =	PINS &	OOOO
	XXX		= = = =	NEEDLES	OOOO
BURNING	>>>>	THROBBING	+ + + +	STABBING	/ / / / /
	>>>>		+ + + +		/ / / / /



Do you do any form of Exercise to help with your pain? Yes No **If yes, please choose below.**

☐Walking ☐Running ☐Hiking ☐Weight Lifting ☐Swimming ☐Cardio
☐Biking ☐Dancing ☐Home Exercise Program ☐Physical Therapy

Please identify which of the following Nerve Blocks, Injections, or Procedures have been performed on you in the past. If you've had a procedure, but you don't remember what it was called, please choose "Other"

Treatment	How Many	Date(s) Performed
☐ Epidural Steroid Injection Cervical Thoracic Lumbar	_____	_____
☐ Facet Joint Block Cervical Thoracic Lumbar	_____	_____
☐ Facet Joint Rhizotomy	_____	_____
☐ Trigger Point Injection	_____	_____
☐ Occipital Nerve Block	_____	_____
☐ Intercostal Nerve Block	_____	_____
☐ Spinal Cord Stimulator	_____	_____
☐ Intrathecal Pump	_____	_____
☐ Other		
❖ Physical Therapy	_____	_____
❖ Chiropractic	_____	_____
❖ Ice Heat Rest	_____	_____

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PATIENT PAIN HISTORY

Patient Name:_____ Patient DOB:_____

Please identify which of the following medications you have tried in the past by checking the appropriate box.
(Please do not check any drug you have never taken.)

OPIOID (Narcotic)	HELPFUL?		MUSCLE RELAXANT	HELPFUL?		ANTIDEPRESSANT	HELPFUL?	
	YES	NO		YES	NO		YES	NO
Oxycodone			Skelaxin			Elavil		
Percocet			Soma			Pamelor		
Lortab/Vicodin			Robaxin			Wellbutrin		
Norco			Flexeril			Zoloft		
Duragesic/Fentanyl			Zanaflex			Effexor		
Dilaudid			Valium			Cymbalta		
Oxycontin			NSAID	YES	NO	OTHER(S)	YES	NO
MS Contin			Motrin			Talwin		
MS IR			Naprosyn			Fioricet		
Suboxone			Relafen			Ultram		
Methadone			Celebrex			Lidoderm		
Actiq			Mobic			Imitrex		
ANTICONVULSANT	YES	NO						
Neurontin								
Lyrica								

MEDICAL HISTORY

Have you been diagnosed with any of the following conditions? If yes, please circle them below*:*

Seizures
Heart burn/Acid reflux (GERD)
Depression
HIV/AIDS
Anxiety
Diabetes
Cancer
Stroke
Asthma
Kidney Disease
Insomnia
Stomach Ulcer/GI Bleed
Hypothyroid/Hyperthyroid
Hypertension
Migraines
Psychiatric conditions
Abnormal Heart beat
Bleeding Disorder
Hepatitis
Vascular Disease
Osteoarthritis
Heart attack/Cardiac Disease
Fibromyalgia
Alcoholism
Sleep Apnea
Rheumatoid arthritis
Emphysema/COPD
Peripheral Neuropathy
Multiple Sclerosis (MS)
Irritable bowel syndrome

Surgical History

SURGERY	SURGEON	DATE OF SURGERY

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ROS

Patient Name:_____ **Patient DOB:**_____

****For Office Use**

Where is your pain located?_____

Does the pain radiate? Yes No **Where?**_____

Describe the pain. ☐Aching ☐Cramping ☐Dull ☐Hot/Burning ☐Sharp ☐Numbing ☐Pins/Needles ☐Pressure ☐Shooting ☐Stabbing ☐Stiffness ☐Throbbing ☐Tightness ☐Muscle Cramp ☐Muscle Spasm

How long have you had this pain?_____

When did this pain start? ☐Suddenly ☐Gradually over time ☐While Bending ☐While Climbing ☐After a fall ☐While Sitting ☐While Lifting ☐Upon ☐Standing ☐While Walking ☐After a Car Accident ☐After an Injury ☐work

How often do you feel the pain? ☐Constantly ☐Intermittently ☐Infrequently ☐Rarely

What makes the pain worse? ☐Bending ☐Walking ☐Lifting ☐Lying Flat ☐Going Up Stairs ☐Going Down Stairs ☐Twisting ☐Prolonged Sitting ☐Prolonged Standing ☐Turning ☐Reaching Above Shoulders ☐All Activity

What makes the pain better? ☐Nothing ☐Assistive Devices ☐Exercise ☐Changing ☐Position ☐Cold ☐Heat ☐Injections ☐Inactivity ☐Lying Flat ☐Massage ☐Manipulation ☐Medications ☐Physical Therapy ☐Rest ☐Sitting ☐Standing ☐Walking

Do you use any of the following? ☐None ☐Cane ☐Crutches ☐Walker ☐Scooter ☐Manual Wheelchair ☐Electric Wheelchair

What is the level of your pain **@ ITS BEST**? Circle the number below.

0 1 2 3 4 5 6 7 8 9 10

What is the level of your pain **@ ITS WORST**? Circle the number below.

0 1 2 3 4 5 6 7 8 9 10

Did you bring any test results with you today? Yes No **If yes, what?**

_____

_____

Does the pain cause any of the following? ☐Nervousness ☐Feel Miserable ☐Loss of Sleep ☐Loss of Energy ☐Anxiousness ☐Lack of Interest ☐None of the above ☐Other_____

What doctors have you seen for this pain in the past? ☐**None** ☐Pain Management ☐Primary Care ☐Orthopedic Spine Surgeon ☐Physical Therapist ☐Neurologist ☐Chiropractor ☐Cardiologist ☐PM & R ☐Neurosurgeon ☐Psychiatrist ☐ER Doctor ☐Urgent Care

What Medications have you tried in the past that didn't work?_____

_____

What treatments have you tried in the past? ☐None ☐Acupuncture ☐Rest ☐Chiropractic ☐Ice ☐Heat ☐Exercises ☐Tens ☐Home Exercise Programs ☐Physical Therapy ☐Psychiatric ☐Surgery ☐Injection Therapy

Did any of those treatments help? Yes No

Are you currently involved in any legal matters?
Yes No

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OSWESTRY PAIN QUESTIONNAIRE

Patient Name:_____ **Patient DOB:**_____

This questionnaire has been designed to give the doctor the information as to how your pain has affected your ability to manage in everyday life. Please answer every section by marking in only the box that applies to you. We realize you may consider that 2 statements in a section may relate to you, but please choose only the box which most closely describes your problem.

Section 1-Pain Intensity
- ☐ I can tolerate the pain I have without having to use pain killers.
- ☐ The pain is bad but I manage without taking pain killers.
- ☐ Pain killers give complete relief from pain.
- ☐ Pain killers give moderate relief from pain.
- ☐ Pain killers give very little relief from pain.
- ☐ Pain killers have no effect on the pain & I do not use them.

Section 2-Personal Care (Washing, dressing, etc)
- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself & I am slow & careful
- ☐ I need some help but manage most of my personal care.
- ☐ I need help everyday in most aspects of self care.
- ☐ I do not get dressed, wash with difficulty & stay in bed.

Section 3-Lifting
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, eg-on a table.
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all

Section 4-Walking
- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than 1 mile.
- ☐ Pain prevents me from walking more than ½ mile.
- ☐ Pain prevents me from walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I'm in bed most of the time & have to crawl to the toilet.

Section 5-Sitting
- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than 1 hour
- ☐ Pain prevents me from sitting more than ½ hour.
- ☐ Pain prevents me from sitting at all.

Section 6-Standing
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than ½ hour.
- ☐ Pain prevents me from standing for more than 10 mins.
- ☐ Pain prevents me from standing at all.

Section 7-Sleeping
- ☐ Pain does not prevent me from sleeping well
- ☐ I can sleep well only by using tablets
- ☐ Even when I take tablets I have less than 6 Hrs. of sleep.
- ☐ Even when I take tablets I have less than 4 Hrs. of sleep.
- ☐ Even when I take tablets I have less than 2 Hrs. of sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8-Sex Life
- ☐ My sex life is normal & causes no extra pain.
- ☐ My sex life is normal but causes some extra pain.
- ☐ My sex life is nearly normal but is very painful.
- ☐ My sex life is severely restricted by pain.
- ☐ My sex life is nearly absent because of pain.
- ☐ Pain prevents any sex life at all.

Section 9-Social Life
- ☐ My social life is normal & gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interest. Eg-dancing, etc…
- ☐ Pain has restricted social life & I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social lif3e because of pain.

Section 10-Traveling
- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over two hours.
- ☐ Pain restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys of less than ½ hour.
- ☐ Pain prevents me from travelling except to the doctor or hospital.

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OUR PAYMENT POLICY

Patient Name:_____ **Patient DOB:**_____

We are committed to providing you with the best care & we are leased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please inquire if you have nay questions about our fees, Financial Policy or your responsibility.

All patients must complete our "Patient Information" forms before seeing the Doctor.

I fully understand that:
If my insurance company requires pre-certification or referral in order to pay for services provided, it is my responsibility to bring such pre-certification or referral before or at time of service. If I do not, I understand that I will be financially responsible for payment for such services notwithstanding any statement by my insurance company that I am not liable for payment.

Not all services are covered benefits in all contracts. If in doubt of your coverage, please contact your insurance provider.

Some insurance companies & health plans may determine (based on its won arbitrary guidelines) that a producer is not "medically necessary" & many not pay for the service. In this case, I will be responsible for the payment. Again, if in doubt, please contact your insurance provider.

MEDICARE, PPO, PPOM, CHAMPUS & WORKER'S COMPENSATION insurance companies may have specialized payment situation, co-pays & deductibles. Medicare patients are required to pay an annual $100.00 deductible for medical services & 20% co-pay thereafter.

ADULT PATIENTS are responsible for payment at the times of service. **MINOR ACCOMPANIED BY & ADULT**-The adult accompanying the minor is responsible for payment at time of services.

I hereby authorize you to release any information you deem appropriate concerning my physical condition to any insurance company, attorney or claims adjuster, in order to process any claims for reimbursement of charges incurred by me as a result of professional services rendered by you & I release you of consequences therefore.

I also request that authorized insurance (including Medicare) _ benefits be pain on my behalf to the provider for any services furnished me by this provider & its agents. This includes the Social Security Administration, Healthcare Financing Administration or any other agency processing Medicare, Medicaid/HMO or commercial insurance claims. I hereby authorize The Pain Clinic of Michigan Group & whomever they may designate as his assistant to administer care as deemed necessary to me or my relative.

Patient Signature:_____

Parent/Guardian of Minor: _____

Date: _____ Witness: _____