*Pain Clinic of Michigan*

35634 Dequindre Road* Sterling Heights, MI 48310
2820 Crooks Road * Suite #100 * Rochester Hills, MI 48309
Phone: 586.977.PAIN (7246) * www.painclinicmi.com

# New Patient Information

**PLEASE REVIEW THIS ENTIRE FORM AND COMPLETE THE ATTACHED PACKET**

**Bring with you:**

1) Photo ID
2) Insurance Card(s) –You must have the actual card in order to be consulted with-
3) **COMPLETED** New patient information packet (this packet)
4) All prescribed medication in its original bottle
5) Diagnostic Testing pertaining to your pain (MRI, X-RAY, CT Scan, or EMG)
   **a)** If you do not have any of your diagnostic testing results, please call the facility that you had the test performed at and have the results faxed to our office F#: (586) 977-1492. If a physician's office has your testing results, please have that physician's office fax your results to our office F#: (586) 977-1492. **If you do not provide any diagnostic test, you will be cancelled.**

NOTICE: If you do **NOT** have your **ID** or **insurance card(s)** you will **NOT** be consulted with. A copy of your ID or insurance card(s) is **NOT** acceptable. If you need to reschedule your appointment, please call P#: (586) 977-7246. Please call your insurance company and have a new copy of your insurance card(s) mailed to your home address.

Please **arrive ten minutes prior to your scheduled appointment** to review and sign legal documents such as release of information form, controlled substance agreement, and the HIPPA privacy form. **(These are additional forms that you will have to review and sign in the office due to us having to witness it)**

Your appointment is scheduled at:

2820 Crooks Road Suite 100, **Rochester Hills**, MI 48309

35634 Dequindre Road, **Sterling Heights**, MI 48310

Your scheduled appointment time and date is: ________________________________

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# PATIENT INFORMATION

**First Name:**_______________________________ **Last Name:**_______________________________

**Date of Birth:**____________**E-Mail Address:**_________________________________________

**Social Security #:**_________-_____-__________**(Please provide at least the last 4 of your SSN)**

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

**Address:**_________________________________________________________________________

**City:**________________________________ **State:**____________ **Zip Code:** _______________

**Home Phone** :(____)__________________________ **Cell Phone** :(____)___________________________

**Emergency Contact:**________________ **Phone** :(____)______________**Relationship:** ____________

**Primary Care Physician:**___________________________ **Phone** :(____)________________________

(If your insurance requires approval through your primary care physician **you must** list their name and phone number)

**Referring Physician:**_______________________________ **Phone** :(____)________________________

# INSURANCE INFORMATION

Is this a **Worker's Compensation or Auto Injury** Claim**?** ☐Yes ☐No
If this is related to a **worker's compensation or auto claim**, is it currently in **litigation**? ☐Yes ☐No
If you have an **attorney due to worker's compensation or auto**, please list name and number:
**Attorney Name**: __________________________________________**Phone:** (___)_______________________
**Are you presently involved in a lawsuit**? Yes No
If **yes**, please explain_________________________________________________________________________

_________________________________________________________________________________________

**Primary Insurance Name:**________________________________________________________

Policy/ID Number:____________________________Group Number:____________________

Policy Holder Name:_________________Relationship to Patient:__________________

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

**Secondary Insurance Name:**______________________________________________________

Policy/ID Number:____________________________Group Number:____________________

Policy Holder Name:_________________Relationship to Patient:__________________

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

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# MEDICATION HISTORY

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

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

| **Medication** | **Allergic Reaction** |
|---|---|
| | |
| | |
| | |
| | |
| | |

| Current Medication Name | Dosage | Frequency & Directions | Prescribing M.D. |
|---|---|---|---|
| | | | |
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# SOCIAL HISTORY

**How many children do you have? 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

# SUBSTANCE ABUSE

**Have you used any of the following substances in the past or do you use them currently? 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
**Do You Use Tobacco?** Never, Quit (light history), Quit (heavy history), Second hand Smoke, Current Smoker, Quit Within Last Year, Smoke Off and On, Use Smokeless Tobacco
**Smoking Status**: Current Every Day Smoker, Current Some Day Smoker, Former Smoker, Never Smoker

# FAMILY HISTORY

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

| | **Relationship to Patient:** |
|---|---|
| Arthritis | ______________________________ |
| Cancer | ______________________________ |
| Osteoporosis | ______________________________ |
| Stroke | ______________________________ |
| Diabetes | ______________________________ |
| Cardiac Disease | ______________________________ |
| Other Medical Problems (If not listed above): | ______________________________ |

# Surgical History

| SURGERY | SURGEON | DATE OF SURGERY |
|---|---|---|
| | | |
| | | |
| | | |

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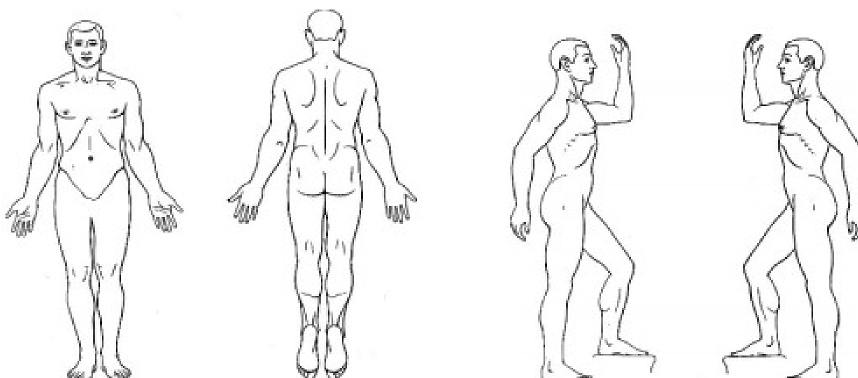
# PATIENT PAIN HISTORY

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 XXX | NUMBNESS | ==== ==== | PINS & NEEDLES | OOOO 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<br>Cervical Thoracic Lumbar | ________ | ________ |
| ☐ Facet Joint Block<br>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 CONTINUED

Please identify which of the following medications you have tried in the past by checking the appropriate box, if you have not tried the medication leave it blank. (Please do not check any drug you have never tried.)

| 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

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# ROS

**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

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**Is the patient 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 every day 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 pleased 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 may questions about our fees, Financial Policy or your responsibility.

All patients must sign this payment policy prior to consulting with the physician.

If you are being treated for a work or auto related injury and the claim becomes settled but the account has an outstanding balance after the settlement, the patient will be responsible for any remaining balance.

**I fully understand that**:
If my insurance company requires pre-certification or a referral in order to pay for services provided, it is my responsibility to bring the pre-certification or the referral before or at time of service. If I do not provide the pre-certification or the referral, I understand that I will be financially responsible for the entire balance.

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 own arbitrary guidelines) that a procedure/injection is not "medically necessary" & may not pay for the service. In this case, I will be responsible for the entire balance. Again, if in doubt, please contact your insurance provider.

All patients are responsible for payment at the time of service.

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

I also request that authorized insurance (including Medicare) benefits may pay on my behalf to the provider for any services furnished to me by this provider & its agents. This includes Auto insurance, Worker's compensation, Social Security Administration, Healthcare Financing Administration or any other agency processing my medical claim.

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:________________________________________________________Date: _______________

Parent/Guardian of Minor: _________________________________________________