



**SUBJECT: WELCOME TO MICHIGAN PAIN MANAGEMENT CONSULTANTS, P.C.**

Dear New Patient

We are delighted to welcome you to the Michigan Pain Management offices. Our mission is to diminish pain and enhance the quality of life for our patients. We understand that managing pain is crucial for your well-being, and we are committed to providing compassionate care.

Here are some important details for your upcoming visit:

**Appointment Details**

- Date and Time:
- Please arrive 15-30 minutes prior to appointment
- 26750 Providence Parkway Suite 120 Novi, MI 48374

**Pre-Registration**

- Photo ID, insurance cards, referral and open claim letter (if applicable)

**What to Bring**

- Completed Pain Questionnaire
- A current list of all medications and vitamins you are currently taking.
- A copy of MRI, CT Scan, X-Ray or relevant reports
- Any additional information that you believe would assist our physicians in understanding your condition.

**Your Initial Consultation**

- During the first visit, our pain management physician and nurse will:
  - Review your pain assessment forms
  - Discuss your pain history and medical background
  - Review any relevant MRI or x-ray results
  - Conduct an initial physical examination

**Cancellation or Rescheduling**

- If you need to cancel or reschedule your appointment, kindly provide 48 hours notice by calling the clinic at 248-679-8000

We appreciate the opportunity to participate in your care and look forward to meeting you soon.

Sincerely,

# Michigan Pain Management Consultants

26750 Providence Parkway, Suite 120

Novi, MI 48374

P - (248) 679-8000

F - (248) 596-0800

## Patient Information

Your Name: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

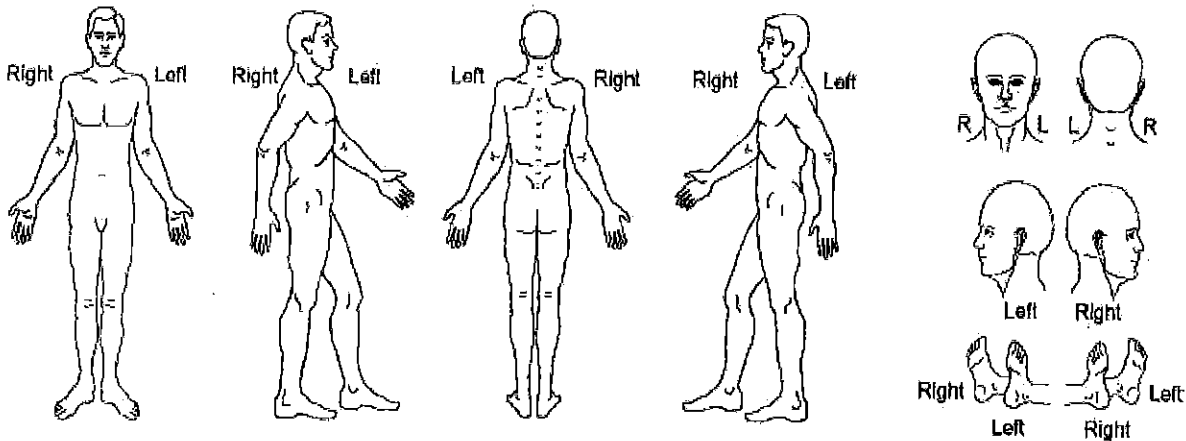
## Pain History

Chief Complaint (Reason for your visit today)? \_\_\_\_\_

Does this pain radiate? If so where? \_\_\_\_\_

Please list any additional areas of pain: \_\_\_\_\_

Use this diagram to indicate the area of your pain. Mark the location with an "X"



## Onset of Symptoms

Approximately when did this pain begin? \_\_\_\_\_

What caused your current pain episode? \_\_\_\_\_

How did your current pain episode begin?  Gradually  Suddenly

Since your pain began how has it changed?  Improved  Worsened  Stayed the same

## EMERGENCY CONTACT

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

May we leave information with your emergency contact?  Yes  No

## Pain Description

Check all of the following that describe your pain:

- Dull/Aching       Hot/Burning       Shooting       Stabbing/Sharp  
 Cramping       Numbness       Spasming       Throbbing  
 Squeezing       Tingling/Pins and Needles       Tightness

When is your pain at its worst?

- Mornings       Daytime       Evenings       Middle of the night  
 Always the same

How often does the pain occur?

- Constant       Changes in severity but always present  
 Intermittent (comes and goes)

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain?

Right Now \_\_\_\_\_ The Best It Gets \_\_\_\_\_ The Worst It Gets \_\_\_\_\_

Mark the effect each of the following have on your pain level -

	Increases	Decreases	No Change
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking upward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking downward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from seated position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other factors worsen or affect your pain which is not mentioned above?

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### Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Where? _____
Weakness in the arm/leg	<input type="checkbox"/>	<input type="checkbox"/>	_____
Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bladder Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bowel Incontinence	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Swelling/Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fevers/chills	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please mark all of the following treatments you have used for pain relief:

	No Change	Worsened Pain	Helped Pain
Spine Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other \_\_\_\_\_

### Interventional Pain Treatment History

- Epidural Steroid Injection - (circle all levels that apply) Cervical/Thoracic/Lumbar
- Joint Injection - Joint(s) \_\_\_\_\_
- Medial Branch Blocks/Facet Injections - (circle levels) Cervical/Thoracic/Lumbar
- MILD (Minimally Invasive Lumbar Decompression) - \_\_\_\_\_
- Nerve Blocks - Area/Nerve(s) - \_\_\_\_\_
- Radiofrequency Nerve Ablation - (circle levels) - Cervical/Thoracic/Lumbar
- Spinal Cord Stimulator - Trial Only/Permanent Implant \_\_\_\_\_
- Trigger Point Injections - Where? \_\_\_\_\_
- Vertebroplasty/Kyphoplasty - Level(s) \_\_\_\_\_
- Other - \_\_\_\_\_

Which of these procedures listed above have helped with your pain? \_\_\_\_\_

## Diagnostic Tests and Imaging

Mark all of the following tests that you have related to your current pain complaints:

- MRI of the: \_\_\_\_\_ Date: \_\_\_\_\_
- X-Ray of the: \_\_\_\_\_ Date: \_\_\_\_\_
- CT Scan of the: \_\_\_\_\_ Date: \_\_\_\_\_
- EMG/NCV study of the: \_\_\_\_\_ Date: \_\_\_\_\_
- Other Diagnostic Testing: \_\_\_\_\_ Date: \_\_\_\_\_
- I have not had ANY diagnostic tests for my current pain complaint

Mark the following physicians or specialists you have consulted for your current pain problem(s):

- Acupuncturist                       Neurosurgeon                       Psychiatrist/Psychologist
- Chiropractor                           Orthopedic Surgeon                       Rheumatologist
- Internist                                   Physical Therapist                       Neurologist
- Other \_\_\_\_\_

If you have had physical therapy for your current pain problem, where was your physical therapy performed?

Name of Facility \_\_\_\_\_  Home Exercise Regimen

Please check the location of the problem for which you received physical therapy. (Check all that apply)

- Neck                                       Hip
- Lower Back                               Foot
- Shoulder                                   Hand
- Knee                                         Elbow
- Other, please indicate \_\_\_\_\_

Frequency of physical therapy: Weeks? \_\_\_\_\_ How many times a week? \_\_\_\_\_

Did the physical therapy help with your current pain problem?

- Yes     No     Temporarily: How long? \_\_\_\_\_



## Past Surgical History

Please list any surgical procedures you have had done in the past including date:

1) \_\_\_\_\_ Date? \_\_\_\_\_

2) \_\_\_\_\_ Date? \_\_\_\_\_

3) \_\_\_\_\_ Date? \_\_\_\_\_

4) \_\_\_\_\_ Date? \_\_\_\_\_

5) \_\_\_\_\_ Date? \_\_\_\_\_

I have NEVER had any surgical procedures performed.

## Current Medications

Are you currently taking any blood thinners or anti-coagulants?  YES  No

If YES, which ones?  Aspirin  Plavix  Coumadin  Lovenox  Other \_\_\_\_\_

Please list all medications you are currently taking including vitamins. Attach additional sheet if required:

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____
6)	_____	_____	_____
7)	_____	_____	_____
8)	_____	_____	_____
9)	_____	_____	_____
10)	_____	_____	_____

Please list all past pain medications that you have been on at any point for your current pain complaints?

	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

## Previous Medications Tried

Mark all the following medications you have previously tried.

**Over the Counter medications:**     Aspirin     Acetaminophen/Tylenol     Advil/Motrin/Ibuprofen  
 Aleve/Naproxen     Excedrin

**Prescription Anti-Inflammatories:**     Ibuprofen     Naproxen     Diclofenac/Voltaren  
 Meloxicam/Mobic     Celecoxib/Celebrex     Ketorolac/Toradol     Etodolac     Indomethacin  
 Piroxicam

**Muscle Relaxers:**     Flexeril/Cyclobenzaprine     Robaxin/Methocarbamol     Tizanidine/Zanaflex  
 Soma/Carisoprodol     Baclofen     Skelaxin/Metaxalone     Orphenadrine/Norflex  
 Lorzone/Chlorzoxazone

**Nerve Pain Medications:**     Gabapentin/Neurontin     Pregabalin/Lyrica     Duloxetine/Cymbalta  
 Amitriptyline/Elavil     Nortriptyline/Pamelor     Oxcarbazepine/Trileptal  
 Topiramate/Topamax

### Opiates:

**Short Acting:**     Tramadol/Ultram     Tylenol w/ Codeine     Hydrocodone/Vicodin  
 Oxycodone/Percocet     Dilaudid/Hydromorphone     Immediate Release Morphine     Opana IR

**Extended Release:**     Butrans Patch     Fentanyl/Duragesic Patches     MS Contin/Morphabond/Morphine ER  
 OxyContin     Opana ER     Methadone

**Opiate Induced Constipation:**     MiraLAX     Docusate     Senokot     Colace  
 Movantik     Amitiza     Linzess     Relistor

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## Allergies

Do you have any drug/medication allergies?

Yes

No

If so, please list all medications you are allergic to:

<u>Medication Name</u>	<u>Allergic Reaction</u>
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____

Topical Allergies:

Latex

Iodine

Tape

IV Contrast

## Family History

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

Arthritis

Cancer

Diabetes

Headaches/Migraines

High Blood Pressure

Kidney Problems

Liver Problems

Osteoporosis

Rheumatoid arthritis

Seizures

Stroke

Other Medical Problems: \_\_\_\_\_

I have no significant family medical history

## Social History

Occupation: \_\_\_\_\_ When was the last time you worked? \_\_\_\_\_

Temporary Disability

Permanent Disability

Retired

Unemployed

Are you currently under worker's compensation?  No  Yes

Is there an ongoing lawsuit related to your visit today?  No

Yes

### Alcohol Use:

Social Use

History of alcoholism

Current alcoholism

Never

Daily use of alcohol

### Tobacco Use:

Current user

Former user

Never used

Packs per day? \_\_\_\_\_

How many years? \_\_\_\_\_

Quit Date: \_\_\_\_\_

### Illegal Drug Use:

Denies any illegal drug use  Currently uses illegal drugs

Formerly used illegal drugs (not currently using)

Have you ever abused narcotic or prescription medications?

Yes

No

## Review of Systems

Mark the following symptoms that you currently suffer from:

**Constitutional:**     Chills                       Difficulty sleeping                       Easy bruising  
 Night Sweats                       Fatigue                       Fevers  
 Insomnia                       Low sex drive                       Tremors  
 Unexplained Weight Gain                       Weakness  
 Unexplained Weight Loss

**Eyes:**                       Recent Visual changes

**Ears/Nose/Throat/Neck:**     Dental Problems                       Earaches                       Hearing Problems  
 Nosebleeds                       Sinus problems

**Cardiovascular:**     Chest Pain                       Bleeding Disorder                       Blood Clots  
 Fainting                       Palpitations                       Swelling in feet  
 Shortness of breath during sleep

**Respiratory:**                       Cough                       Wheezing                       Shortness of breath

**Gastrointestinal:**     Constipation                       Acid Reflux                       Abdominal Cramps  
 Diarrhea                       Nausea/Vomiting                       Hernia

**Musculoskeletal:**     Back Pain                       Joint Pains                       Joint Stiffness  
 Joint Swelling                       muscle spasms                       Neck Pain

**Genitourinary/Nephrology:**     Flank Pain                       Blood in Urine                       Painful Urination  
 Decreased Urine Flow/Frequency/Volume

**Neurological:**                       Dizziness                       Headaches                       Tremors  
 Numbness/Tingling                       Seizures

**Psychiatric:**                       Depressed Mood                       Feeling Anxious                       Stress Problems  
 Suicidal Thoughts                       Suicidal Planning  
 Thoughts of Harming Others

All other review of systems negative

Reviewer \_\_\_\_\_

## Office Policies and Procedures

PLEASE READ AND INITIAL ALL SECTIONS BELOW:

- \_\_\_\_\_ 1). A cordial and cooperative tone will facilitate communication with our staff and providers. Michigan Pain Management has a very strict **ZERO** tolerance for abusive and aggressive behavior toward its staff; we do not permit patients to swear at our staff, nor be rude, aggressive, belligerent or disruptive. Thank you for remaining calm and friendly.
- \_\_\_\_\_ 2). All patients with pain perceive their symptoms to be special and urgent. We acknowledge that you may be experiencing physical and emotional distress. However, all the patients referred to this clinic feel this same urgency to obtain treatment. Extra-special consideration cannot routinely be granted in scheduling your visits and treatments due to time, space, and staff limitations. Please know that we will do everything possible to serve you in a timely and effective manner within our limitations. Occasionally, a medical emergency arises which may delay the day's schedule – we appreciate your patience in these situations.
- \_\_\_\_\_ 3). Chronic pain is **NOT** considered to be a medical emergency. Therefore, emergency access to our clinic is rarely indicated. You may be referred back to your primary care physician or to an emergency facility if we cannot accommodate your urgent needs. Please do not wait until the last minute to seek care for an escalating problem.
- \_\_\_\_\_ 4). Arriving late for your appointment is very disruptive and makes it nearly impossible to maintain our commitment to serve you in a timely manner. Therefore, our office has a 15-minute late policy. If you arrive 15 minutes after your scheduled appointment, we will usually not be able to see you that day. We will reschedule your appointment for the next available time. Arriving late on a routine basis for your scheduled appointments may be reason for dismissal from our clinic. **THERE ARE NO EXCEPTIONS.** Please keep in mind this rule **DOES NOT** apply for the last appointment before lunch, nor the last appointment of the day, there is **NO** leeway for these appointments. Out of courtesy, if you are running late please call the office to confirm we are still able to see you. **PLEASE REMEMBER THAT ANY LEEWAY IS A COURTESY AND NOT A GUARANTEE.** We make every effort to give reminder calls for upcoming appointments, but it is ultimately the patients' responsibility to keep all scheduled appointments or give appropriate notice for rescheduling or cancelling.
- \_\_\_\_\_ 5). Missed appointments will be rescheduled at the next available time (possibly up to 3-4 weeks). We will not refill medications in the interim, so try not to miss your scheduled appointment. Missing several appointments may be reason for dismissal from our clinic.
- \_\_\_\_\_ 6). When you call our clinic, you may be routed to a voice mailbox. Please leave your message. We listen to our messages daily and will return your call within 24-48 business hours. Multiple phone calls on the same day for the same problem are very disruptive and may cause delay in a call back. If you do this, you will be given a warning to desist. If this behavior continues, you may be dismissed from our clinic.
- \_\_\_\_\_ 7). If narcotics or other potent medications to treat your pain are prescribed, you will be asked to enter into a formal narcotic agreement that outlines rules, risks, and conditions of continued access to these medications. Please remember, it is up to the physician's discretion if opiate medications are prescribed on the first visit.
- \_\_\_\_\_ 8). Pain medication prescriptions are written for a 30-day supply. Medications are refilled once a month during a scheduled office visit. As a rule, we do not call or fax narcotic prescription refills to the pharmacy. Lost or stolen medication will **NOT** be replaced with a new prescription. Pain medication should be taken as directed as we do **NOT** provide early refills. Six months of pharmacy records may be required before a narcotic prescription can be issued. Non-urgent calls regarding medication may be returned within 72 hours. Medication changes are addressed during scheduled office visits, not during/ between procedure series. Before leaving the office, it is recommended that patients schedule their next appointment to avoid any last-minute requests for an appointment which we may not be able to accommodate.
- \_\_\_\_\_ 9). Obtaining pain medications elsewhere without our specific written or verbal approval may be considered a sign of possible narcotic addiction and may be reason for dismissal from our clinic.
- \_\_\_\_\_ 10). It is your responsibility as the patient to inquire if you are due for a urine drug screen (UDS). Please ask the front desk upon arrival if you are due for one **BEFORE** using the restroom. If a UDS is required, you may **NOT** leave the lobby/office once you have checked in. If you do leave the office your urine is considered a fail and you may not receive your prescription and you may be discharged from the practice. Furthermore, if we find reason you may be given a specific time limit to complete your UDS.
- \_\_\_\_\_ 11). **For female patients only:** To the best of my knowledge I am **NOT** pregnant. If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I accept that it is MY responsibility to inform my physician immediately if I become pregnant. If I am pregnant or am uncertain, **I WILL NOTIFY MY PHYSICIAN IMMEDIATELY.** All the above possible effects of medication(s) have been fully explained to me and I understand that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e. opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use and **DO NOT** hold my physician liable for injuries to the embryo/fetus/ baby.

Following these guidelines is important for continued success in managing your pain. If our clinic guidelines are unacceptable to you, you may choose to seek care from another source more suited to your desires. Thank, you for your understanding. We consider it a privilege to serve you. We look forward to a happy and productive working relationship.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_