MICHIGAN
PAIN MANAGEMENT
CONSULTANTS, P.C.

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
- 21700 Northwestern Hwy. Suite 600 Southfield, MI 48075

Pre-Registation

- 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 248-849-3186

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

Sincerely,

MICHIGAN
PAIN MANAGEMENT
CONSULTANTS, P.C.

21700 Northwestern Hwy., Ste. 600, Southfield, MI 48075
P: (248) 849-3186 F: (248) 849-3461
www.mipain.com

Patient Information

Your Name: _____ Height_____ Weight _____

Todays Date: _____ Date of Birth: _____ Age: _____

Referring Physician: _____ Primary Care Physician: _____

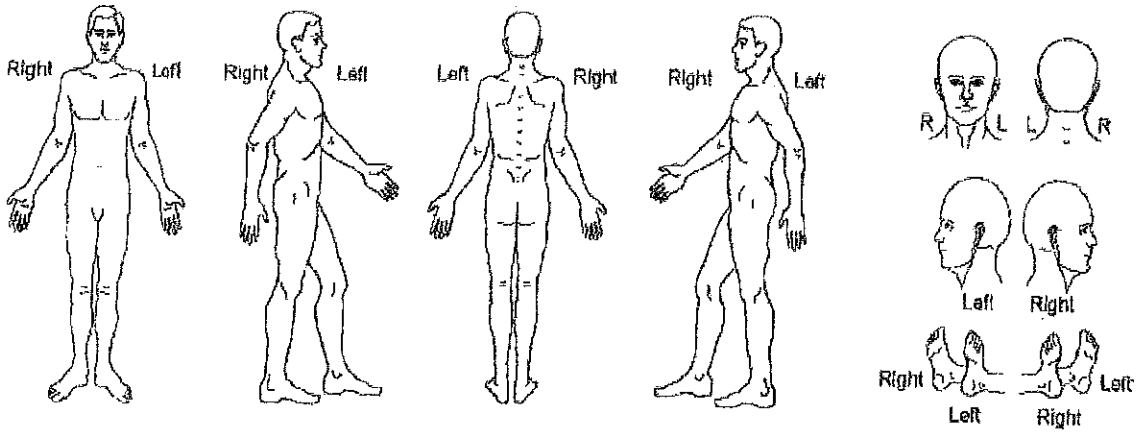
Pain History

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	☐	☐	☐
Bending Forward	☐	☐	☐
Changes in Weather	☐	☐	☐
Climbing Stairs	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Lifting Objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Rising from seated position	☐	☐	☐
Sitting	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐

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

_____

_____

Associated Symptoms

	NO	Yes	Comments
Numbness/Tingling	☐	☐	Where? _____
Weakness in the arm/leg	☐	☐	_____
Balance Problems	☐	☐	_____
Bladder Incontinence	☐	☐	_____
Bowel Incontinence	☐	☐	_____
Joint Swelling/Stiffness	☐	☐	_____
Fevers/chills	☐	☐	_____

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

	No Change	Worsened Pain	Helped Pain
Spine Surgery	☐	☐	☐
Physical Therapy	☐	☐	☐
Chiropractic Care	☐	☐	☐
Psychological Therapy	☐	☐	☐
Brace Support	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Massage Therapy	☐	☐	☐
Medications	☐	☐	☐
TENS Unit	☐	☐	☐

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 Medical History

Please list the names of other Pain Physicians you have seen in the past?_____

_____

Mark the following conditions/diseases that you have been treated for in the past:

General Medical
- ☐ Cancer – Type _____
- ☐ Diabetes – Type_____

Cardiovascular/Hematologic
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stoke/TIA
- ☐ Heart Valve Disorders

Gastrointestinal
- ☐ GERD (Acid Reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers
- ☐ Constipation

Urological
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis

Neuropsychological
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder

Head/Ears/Eyes/Nose/Throat
- ☐ Headaches
- ☐ Migraines
- ☐ Head Injury
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Glaucoma

Respiratory
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Musculoskeletal/Rheumatologic
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Joint Pains

Other Diagnosed Conditions
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

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:

	Medication Name	Dose	Frequency
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?

	Medication Name	Dose	Frequency
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

Allergies

Do you have any drug/medication allergies? ☐ Yes ☐ No

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

Medication Name	Allergic Reaction
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 medicatfon 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: _____