

Dear Patient,

Welcome to Southern Michigan Pain Consultants. Please arrive 30 minutes early to your appointment to complete the registration process.

You will receive a reminder call prior to your appointment. If you have any questions or concerns, please call us between 8:30AM-5:00PM at (877) 377-6227 and select option 1.

In order for us to address your needs at the time of your appointment we ask that you please;

1. Bring your License/ID and Insurance card to each appointment. *A digital picture will also be taken at this initial appointment* for your electronic medical chart.
2. Plan to update or verify your personal information at each appointment.
3. Complete the enclosed Patient Information Forms and bring them to your appointment. This information will be used by the provider during your evaluation. Failure to have the forms completed prior to your arrival may result in your appointment being delayed or rescheduled.
4. Please arrange for a driver to arrive with you for your appointment. Some procedures may require the use of light sedation. Please be aware that you must have a driver present in the waiting room in order to receive sedation.
5. Anticipate being at our office for your initial appointment for approximately two (2) hours.
6. Please remember that your appointment time is set aside specifically for you. If you are unable to keep an appointment, you are required to provide us with a 24-hour notice. Failure to do so will result in a \$25 reinstatement fee being applied to your account. This fee is not covered by your insurance. You will be responsible for paying this fee before you are able to schedule another appointment.

FINANCIAL POLICY

Our office participates with a variety of insurance plans including but not limited to:

Medicare Priority Health Blue Cross HAP Aetna Cofinity United Healthcare

If you have questions regarding your insurance, we will try to help. However, questions relating to specific coverage issues must be directed to your insurance company's member services department. Their telephone number should be listed on the back of your insurance card.

Referrals: Many insurance plans require a referral from your primary care physician to be seen by a specialist. We will contact your insurance carrier to arrange for a referral but ask that you follow up with them too. If a referral is required but not secured, your visit may be rescheduled or you may be financially responsible.

All applicable co-payments, deductibles, co-insurance and personal balances, both current and prior, are due at the time of service unless other payment arrangements have been made. In some cases, you may be asked to pay the balance of your account or make payment arrangements prior to making your next appointment.

For your convenience, we accept cash, checks, VISA, MasterCard, Discover, American Express and money orders. You may also pay your bill online through our website (shown below).

Please note that there is a \$25.00 service charge for all returned checks.

We understand that there may be times and circumstances that come up where you are unable to pay your entire bill. In these situations it is very important that you contact our Billing Office (877-377-6227) so a financial representative can assist you in setting up a reasonable payment plan and to keep your account from being sent to a collection agency.

If you fail to meet the financial obligations agreed upon in this financial policy or have other payment arrangements made, your outstanding balance will be sent to a collection agency. You will be required to pay your entire balance and any collection agency fees, up to 25% of your account balance, before being scheduled for any further appointments.

If you have billing related questions, please contact our billing office at (877) 377-6227 and select option 2.

www.southernmichiganpain.com

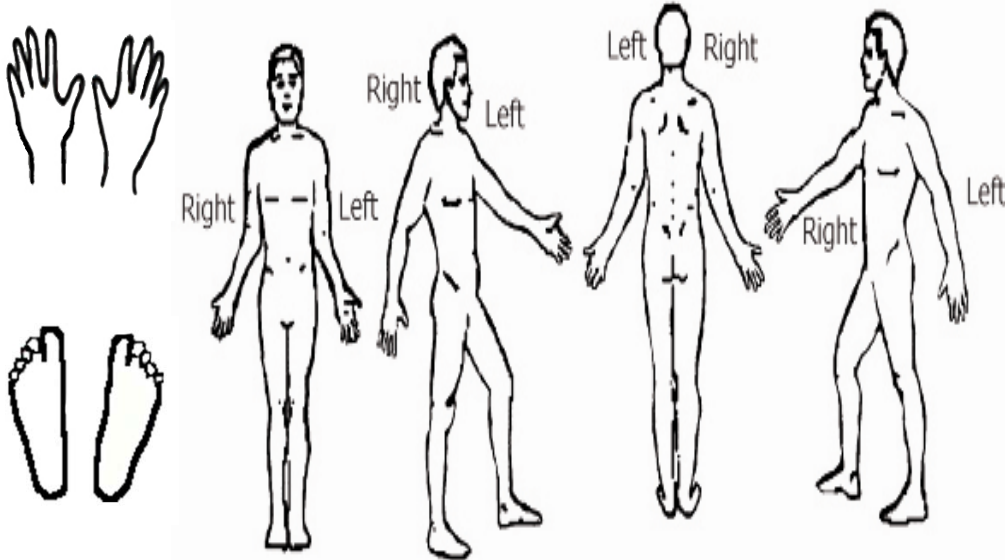
Patient Intake Information

Patient Data

A. Name: _____ Age: _____ Spouse Name: _____

Family Physician: _____

B. Mark your pain on the diagrams.



Nurse Use Only	
BP _____	P _____
R _____	SPO2 _____
Temp _____	
Ht: _____	
Wt: _____	

Pain Rating

Scale used 0-10 (10=worst pain)

Worst Pain: _____

Best Pain: _____

Description of Pain and Influencing Factors

How long have you had this problem?

Please describe how your pain first began (e.g. accident, illness, etc.):

Please circle any of the following symptoms that you are experiencing.

Is your problem: constant, intermittent, frequent, occasional, infrequent

Is the pain: sharp, dull, aching, throbbing, burning, tingling, shooting, stabbing, electrical

Is your problem: mild, moderate, severe, excruciating

What makes your pain worse?

- | | | |
|--|---|---|
| <input type="checkbox"/> Time of Day | <input type="checkbox"/> Weather | <input type="checkbox"/> Moving affected limb |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lifting floor to waist | <input type="checkbox"/> Sexual Activity |
| <input type="checkbox"/> Twisting | <input type="checkbox"/> Lifting waist to over head | <input type="checkbox"/> Lying Down |
| <input type="checkbox"/> Running | <input type="checkbox"/> Other, _____ | |
| <input type="checkbox"/> Standing | | |
| <input type="checkbox"/> Bending | | |
| <input type="checkbox"/> Climbing Stairs | | |
| <input type="checkbox"/> Walking | | |
| <input type="checkbox"/> Squatting | | |
| <input type="checkbox"/> Physical activity | | |

What are you doing to reduce your pain?

- | | | | | | |
|--|---------------------------------------|--|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Ice | <input type="checkbox"/> Walking | <input type="checkbox"/> Avoiding activity | <input type="checkbox"/> Exercise/PT | <input type="checkbox"/> Medication | <input type="checkbox"/> Lying down |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Massage | <input type="checkbox"/> Lose weight | <input type="checkbox"/> Sitting more | <input type="checkbox"/> Resting more often | |
| <input type="checkbox"/> Using a walker or a shopping cart | <input type="checkbox"/> Other, _____ | | | | |

Do you have:

- | | | | | | |
|--------------------------------|------------------------------|-----------------------------|--------------------------|------------------------------|-----------------------------|
| Numbness or tingling? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Muscle weakness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Swelling in the affected area? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Muscle spasms or cramps? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does your pain affect your:

- | | | | | | |
|-------------------|--|-----------------------------|--|------------------|--|
| Sleep | <input type="radio"/> Yes <input type="radio"/> No | Appetite | <input type="radio"/> Yes <input type="radio"/> No | Eating | <input type="radio"/> Yes <input type="radio"/> No |
| Physical activity | <input type="radio"/> Yes <input type="radio"/> No | Emotions | <input type="radio"/> Yes <input type="radio"/> No | Bathing | <input type="radio"/> Yes <input type="radio"/> No |
| Relationships | <input type="radio"/> Yes <input type="radio"/> No | Concentration | <input type="radio"/> Yes <input type="radio"/> No | Using the toilet | <input type="radio"/> Yes <input type="radio"/> No |
| Dressing | <input type="radio"/> Yes <input type="radio"/> No | Getting out of bed or chair | <input type="radio"/> Yes <input type="radio"/> No | | |
- Other, _____

Previous Treatments:

Treatment	Yes/No	How Helpful Was This?
Nerve Blocks		
Surgery		
TENS Unit		
Physical Therapy/OT		
Chiropractic		
Biofeedback/Hypnosis		
Psychological Therapy		
Other Pain Physician		

Patient's Goals for Treatment:

What pain medications have you previously

used? _____

Review of Symptoms: Please check any that you currently have or had in the past.

Constitutional

- _____ Recent fevers/sweats
- _____ Unexplained weight loss/gain
- _____ Unexplained fatigue/weakness

Respiratory

- _____ Cough/wheeze
- _____ Coughing up blood
- _____ Asthma

Skin

- _____ Rash
- _____ Sores

Eyes

- _____ Change in vision

Gastrointestinal

- _____ Blood or change in bowel movement
- _____ Nausea/vomiting/diarrhea

Neurological

- _____ Headaches
- _____ Numbness
- _____ Tremors
- _____ Poor balance

Ears/Nose/Throat/Mouth

- _____ Difficulty hearing/ringing in ears
- _____ Hay fever/allergies/congestion
- _____ Trouble swallowing

Genitourinary

- _____ Painful/bloody urination
- _____ Leaking urine
- _____ Nighttime urination
- _____ Discharge: penis or vagina
- _____ Unusual vaginal bleeding
- _____ Concern with sexual functions

Psychiatric

- _____ Anxiety/stress
- _____ Sleep problem
- _____ Depression

Musculoskeletal

- _____ Muscle/joint pain
- _____ Recent back pain
- _____ Weakness

Endo

- _____ Cold/heat intolerance
- _____ Increase thirst/appetite

Blood/Lymphatic

- _____ Unexplained lumps
- _____ Easy bruising/bleeding

Cardiovascular

- _____ Chest pains/discomfort
- _____ Palpitations/irregular heartbeat
- _____ Short of breath

Medical History

Have you ever, or do you now have, any of the following conditions?

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Attack/Heart Disease | <input type="checkbox"/> Bleeding/Bruise Easily | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Irregular Heart Rate | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cigarette Use |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression/Psych | <input type="checkbox"/> Alcohol Use (per week) |
| <input type="checkbox"/> Substance Abuse/Addiction | <input type="checkbox"/> Other, _____ | |

List any Surgeries you have had:

Type of Surgery	Date	Type of Surgery	Date

Recent Hospitalizations:

(If you have been hospitalized in the past year, when was it and for what reason.) _____

Family History:

(Please list any illnesses that are present in your family or the cause of their death.) _____

List all Medication you are currently using and how often you use them. Please indicate below:

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Allergies: _____

List any TESTS you have had:

Tests	Date & Place Done	Results	Tests	Date & Place Done	Results
X-rays			X-rays		
MRI			MRI		

Social History:

Tobacco Use

Cigarettes: Never Quit: date _____ Current smoker: packs/day _____ # of years _____
Other Tobacco: Pipe Cigar Snuff Chew
Are you interested in quitting? No Yes

Alcohol Use

Do you drink alcohol? No Yes, # of drinks/week _____
Is your alcohol use a concern for you or others? No Yes

Drug Use

Do you use any recreational drugs? No Yes
Have you ever used needles to inject drugs? No Yes

Other Concerns:

Caffeine Intake: None Coffee/tea/soda _____ cups/day

Weight: Are you satisfied with your weight? No Yes

Diet: How do you rate your diet? Good Fair Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements? No Yes

Exercise: Do you exercise regularly? No Yes

What kind of exercise? _____

How long (minutes)? _____ How often? _____

If you do not exercise, why? _____

Marital Status/Support

Single Married Widowed Separated Divorced

Is there any person or organization that you rely on to help you cope with your pain? _____

Occupational History:

Working full-time Working part-time On medical leave Disabled Unemployed

What is your current occupation? _____

Where do you work and how long have you been there? _____

What duties do you perform? _____

When did you last work? _____

Litigation

Is Workers' Comp, disability, legal suit or an insurance settlement pending? No Yes, if yes, describe the current status of the litigation or settlement: _____

DEMOGRAPHICS

Spoken Language:

English Spanish Vietnamese Non-English Other _____ Declined

Ethnicity:

Are you Hispanic/Latino?

- Yes
- No
- Declined

Race:

- American Indian / Alaskan Native
- Asian
- Black/African American
- White
- Native Hawaiian / Other Pacific Islander
- Multiracial
- Other _____
- Declined

Patient Signature: _____

Date: _____

Nurse's Signature: _____

Date: _____