SMPC
SOUTHERN MICHIGAN
PAIN CONSULTANTS

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 3.

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. You DO NOT need to bring a driver to your appointment

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 Blue Shield	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 <u>very</u> 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

SMPC
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PAIN CONSULTANTS

Welcome to SMPC. The purpose of this letter is to let you know what to
expect from me and our team and to answer some questions that we
commonly respond to from patients.

My practice is not built on a single course of treatment, but on the best use
of multiple team members and tre atment options. Your treatment with us will be individualized and may involve
Osteopathic manipulative medicine (OMM), injections, medications, behavioral health and/or physical therapy.

As a musculoskeletal specialist, I utilize Osteopathic manipulative treatments (OMT) to examine, diagnose and treat
the musculoskeletal system. OMT is a hands-on treatment modality used to treat musculoskeletal or somatic
dysfunctions in a large group of patients including athletes, workers with on-the-job injuries, or patients with
various illnesses and, of course, those with head, neck and back pain. These patients range from infants to seniors.
Musculoskeletal or somatic dysfunctions can be a primary cause of pain, impair function and reduce range of
motion in essentially any part of the body.

I use injections for two main reasons. First, it is to help diagnose the source of pain, the second is that it can be
therapeutic in reducing pain. Back pain provides an examp le. Some sources of back pain may be very obvious, such
hernia tion. In other cases the exact source of the back pain may be less certain. Not every patient is a good
candidate for injections but frequently they can be used to help a person feel better. Injections can initially be used to
break the cycle of constant debilitating pain. As a continued treatment, longer lasting injections can be used to
encourage activity and reduce the need for medications. Injections coupled with OMT, physical therapy, behavioral
health, and/or medications can be a winning combination for helping you to get back to daily activities and to
have reduced pain.

Again, I welcome you to my practice and hope this letter addresses a few of your questions. I realize that you may
have additional questions and I welcome the opportunity to addre ss them when we mee t at your first appointment.
I appreciate the confidence that you have by trusting your care to me and my entire team. We are all eager to meet
you and to help manage your pain.

Healthy regards

Patient Intake Information

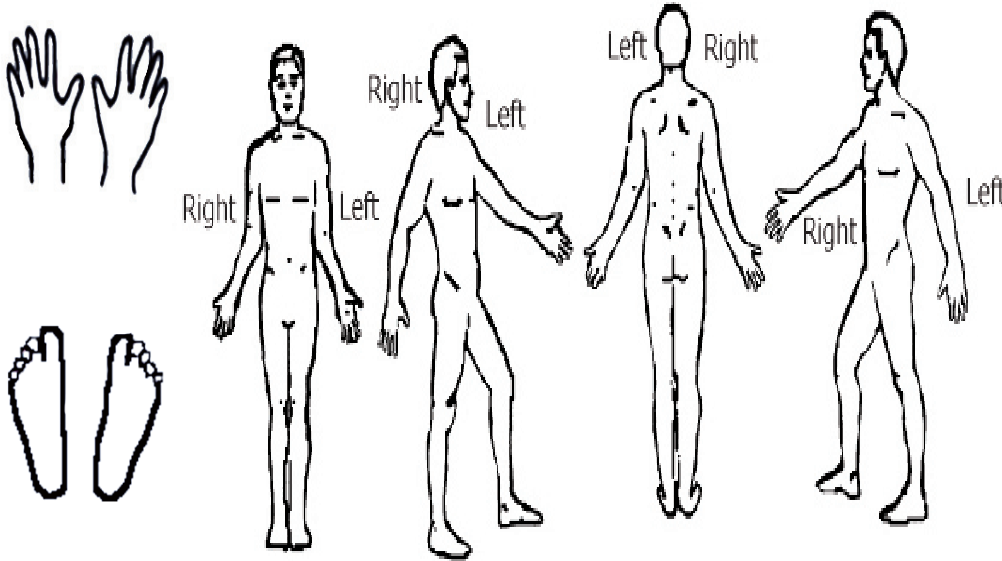
S M P C
SOUTHERN MICHIGAN
PAIN CONSULTANTS

Patient Data

A. Name: DOB:

Family Physician: ____ Spouse Name: ___________________________

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: dull, aching, throbbing, cramping, sharp, burning, shooting, stabbing, tingling

Is your problem: mild, moderate, severe, excruciating

What makes your pain worse?

				Weather
Heat	Sitting	Bending	Climbing Stairs	Lifting
Cold	Standing	Twisting	Touch	Moving affected limb
Physical Activity	Walking	Lying Down	Running	Sexual Activity

What are you doing to reduce your pain?

Rest	Heat	Massage	Using a walker or shopping cart
Sitting Down	Cold	Stretching	Walking
Lying Down	Changing Positions	Medications	Exercise/PT

Do you have:

Numbness or tingling? O Yes O No   Muscle weakness? O Yes O No

Swelling in the affected area? O Yes O No   Muscle spasms or cramps? O Yes O No

Does your pain affect your:

Sleep O Yes O No | Appetite O Yes O No | Eating O Yes O No
Physical activity O Yes O No | Emotions O Yes O No | Bathing O Yes O No
Relationships O Yes O No | Concentration O Yes O No | Using the toilet O Yes O No
Dressing O Yes O No | Getting out of bed or chair O Yes O 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?

O Heart Attack/Heart Disease
O Irregular Heart Rate
O Chest Pain
O High Blood Pressure
O Stomach/Intestinal Problems
O Arthritis
O Substance Abuse/Addiction
O Bleeding/Bruise Easily
O Emphysema
O Asthma
O Thyroid Problems
O Diabetes O Type 1 O Type 2
O Depression/Psych
O Other, ____
O Cancer
O Stroke
O Kidney Problems
O Epilepsy/Seizures
O Cigarette Use
O Alcohol Use (per week)

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. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
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: O Never O Quit: date ___________ Current smoker: packs/day ______ # of years ______
Other Tobacco: O Pipe O Cigar O Snuff O Chew
Are you interested in quitting? O No O Yes

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

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

Other Concerns:

Caffeine Intake: O None O Coffee/tea/soda _______________ cups/day

Weight: Are you satisfied with your weight? O No O Yes

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

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

Exercise: Do you exercise regularly? O No O Yes

What kind of exercise? ____

How long (minutes)? _______________ How often? ____

If you do not exercise, why? ____

Marital Status/Support
O Single O Married O Widowed O Separated O Divorced
Is there any person or organization that you rely on to help you cope with your pain? ___________________________

____

Occupational History:
O Working full-time O Working part-time O On medical leave O Disabled O 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? O No O 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

Gender Identity Values

- Identifies as Male
- Identifies as Female
- Female-to-Male (FTM/Transgender Male/Trans Man)
- Male-to-Female (MTF/Transgender Female/Trans Woman)
- Genderqueer, neither exclusively male nor female
- Choose not to disclose

Sexual Orientation Values

- Lesbian, gay, or homosexual
- Straight or heterosexual
- Bisexual
- Don't know
- Choose not to disclose

Patient Signature: ____Date:_____________

Nurse's Signature: ____Date:_____________