SMPC
SOUTHERN MICHIGAN
PAIN CONSULTANTS

WEBSITE NEW PATIENT PACKET

You will receive a reminder call two days prior to your appointment. If you have any questions or concerns, please call us between 8:30am-5:00pm at **(877) 377-6227 and press 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 Patient Information forms and bring to your appointment. This information will be used by the doctor during your examination.
4. Bring or request the following information for your scheduled appointment as our physicians will need it to help assess you:
    a. All written reports and films from X-Rays, MRI's, EMG's, CT's, and bone scans that you have had in the last 6 months. Contact your referring doctor to see if this information has been sent.
5. 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.
6. Anticipate being at our office for your initial appointment for approximately two (2) hours.

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

Medicare	PHP/IBA	Blue Cross Blue Shield	Aetna	Cofinity	United Healthcare

If you do not have insurance, we do offer self pay options for you initial appointment and we will be happy to provide you with an estimate regarding the cost for subsequent treatment. However, if you do not have insurance, payment if full is expected at the time of service. If you have billing questions contact our billing office **(877) 377-6227 and press 2.**

We accept cash, credit card and money order only, no personal checks for self-pay services.

- For medical care not covered by your insurance, payment in full is due at the time of the visit.

Continued on back

Co-payments and deductibles: Since we are a specialty office sometimes your co-pay may not be due. Please be prepared to pay your co-payment amount at each visit if asked. We will not waive or discount co-payments or deductible payments that are required by your health insurance carrier. Personal checks will be accepted for co-pays and deductibles.

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 you do not have a required referral, your visit may be rescheduled or you may be financially responsible.

Financial assistance: If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us of any such concerns before your visit.

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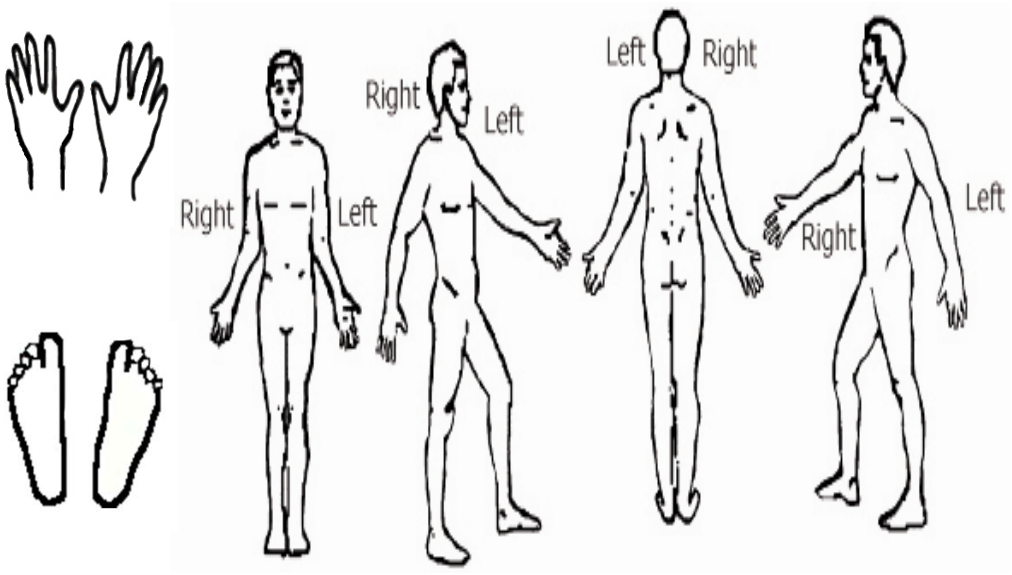
Patient Intake Information

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? O Time of Day O Weather O Moving affected limb
O Sitting O Twisting O Running O Lifting floor to waist O Sexual Activity
O Standing O Bending O Climbing Stairs O Lifting waist to over head O Lying Down
O Walking O Squatting O Physical activity O Other, _____

What are you doing to reduce your pain? O Exercise/PT O Lying down
O Ice O Walking O Avoiding activity O Medication O Resting more often
O Heat O Massage O Lose weight O Sitting more
O Using a walker or a shopping cart O Other, _____

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 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

Patient Signature: _____ Date: _____

Nurse's Signature: _____ Date: _____