SMPC
SOUTHERN MICHIGAN
PAIN CONSULTANTS

Dear New Patient,

Welcome to our practice. You will meet with one of our physicians at SMPC located at _____. **Your appointment is scheduled for _____Date ____Time with _____. Please arrive 30 minutes early to complete necessary practice paperwork.**

We will contact you prior to your appointment to confirm the date and time. If you are not at home during regular business hours, please call us at **(877) 377-6227 and press 1**. If you have any questions or concerns, please feel free to address them at the time of the confirmation phone call.

In order for us to address your needs at the time of your appointment, we ask that you follow these instructions:

1. Please bring your insurance card with you to your appointment.

1. Please complete the Patient Information Intake forms and bring them with you to your appointment. This will be used by the doctor during your examination.

2. To better serve your medical needs, our physicians will need the following information at the time of your scheduled appointment:

    - 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.

3. Please arrange for a driver to arrive with you for your visit. 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.

4. Please anticipate being at our office for your initial visit for approximately two (2) hours.

Thank you for your cooperation in giving us all the necessary information in advance. By doing this, we hope to ensure your experience with our practice is a pleasant one. If you need to change your appointment, please call us at **(877) 377-6227 and press 1.** We look forward to assisting you with the management of your pain.

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Welcome to Southern Michigan Pain Consultants

Our staff is committed to providing you with the best medical care possible and to assisting you with the administrative process. We have a central billing office that you can contact anytime you have a question about your bill; the phone number is 1-800-281-3237. 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 is probably on the back of your card.

Our office participates in a variety of insurance plans including, but not limited to the ones listed below:

- Medicare
- Blue Cross Blue Shield of Michigan and related plans
- PHP/IBA
- United Healthcare
- Cofinity
- Aetna

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.

We accept cash, credit card and money order only, no personal checks for self-pay services
The following apply to every visit.

- Bring your insurance card.
- Bring a picture ID
- Be prepared to provide us with updated personal information as needed
- For medical care not covered by your insurance, payment in full is due at the time of the visit.

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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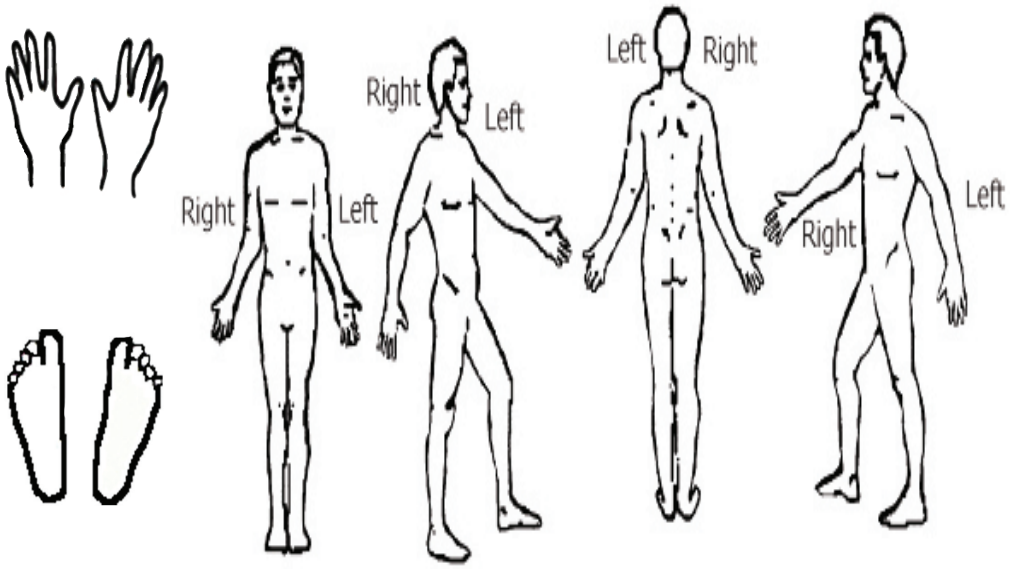
Patient Intake Information

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 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 Ice	O Walking	O Avoiding activity	O Exercise/PT	O Lying down
O Heat	O Massage	O Lose weight	O Medication	O Resting more often
O Using a walker or a shopping cart		O Other, _____	O Sitting more	

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

Eyes
_____ Change in vision

Ears/Nose/Throat/Mouth
_____ Difficulty hearing/ringing in ears
_____ Hay fever/allergies/congestion
_____ Trouble swallowing

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

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

Respiratory
_____ Cough/wheeze
_____ Coughing up blood
_____ Asthma

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

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

Endo
_____ Cold/heat intolerance
_____ Increase thirst/appetite

Skin
_____ Rash
_____ Sores

Neurological
_____ Headaches
_____ Numbness
_____ Tremors
_____ Poor balance

Psychiatric
_____ Anxiety/stress
_____ Sleep problem
_____ Depression

Blood/Lymphatic
_____ Unexplained lumps
_____ Easy bruising/bleeding

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: _____