

PAIN CARE ASSOCIATES

A DIVISION OF NEURO PAIN CONSULTANTS, P.C.

799 Denison Court, 2nd Floor

Bloomfield Hills, MI 48302

www.paincareassociates.com

WELCOME

This is a reminder that you have an appointment with:

Dr. _____ on _____ at _____.

***** IMPORTANT *****

1. Please arrive 15 minutes before your scheduled appointment
If you are more than 15 minutes late you may not be seen.
2. **WE MUST HAVE YOUR MEDICAL RECORDS AT YOUR FIRST VISIT.** Please request these from your referring physician before your visit and bring them with you. Without these records, our physician may not be able to treat you.
3. **In order for your physician to give you the best care possible, it will be necessary for you to bring the following items with you to your appointment:**
 - * Drivers License
 - * Insurance Cards
 - * Completed forms contained in the packet
 - * Referral, if you have an HMO. **Without your referral we will be unable to see you.**
 - * Written authorization letter, if you have a workman's compensation or motor vehicle accident claim. **Without these payor guarantees, we will be unable to see you.**

Thank you in advance for your cooperation in providing this information. If you have questions, please call 248-751-7246, Monday through Friday 9:00 AM-4:30 PM. YOU CAN ALSO VISIT US [AT OUR WEBSITE AT www.paincareassociates.com.](http://www.paincareassociates.com)

PATIENT INFORMATION

Patient Name _____ Home Phone _____ Work Phone _____

Address _____ City/State _____ Zip _____

Date of Birth _____ Social Security Number _____

Employer _____ Employer Address _____

Spouse's Name _____ Spouse's Employer _____

Nearest relative that we may contact if we are unable to reach you:

Name _____ Relationship _____ Phone _____

Referred by (Physician, Family, Friend, Etc.) _____

PRIMARY INSURANCE _____ CONTRACT # _____

GROUP # _____ SUBSCRIBER'S NAME _____

SECONDARY INSURANCE _____ CONTRACT # _____

GROUP # _____ SUBSCRIBER'S NAME _____

IS INJURY COVERED BY AN AUTOMOBILE ACCIDENT INSURANCE? YES _____ NO _____

DATE OF ACCIDENT _____ STATE _____ CLAIM NUMBER _____

NAME OF INSURANCE COMPANY _____ PHONE # _____

ADDRESS _____ NAME OF ADJUSTER _____

IS INJURY COVERED BY WORKERS COMPENSATION? YES _____ NO _____

DATE OF INJURY _____ CLAIM NUMBER _____

NAME OF INSURANCE COMPANY _____ PHONE _____

ADDRESS _____ NAME OF ADJUSTER _____

AUTHORIZATION/RESPONSIBILITY AGREEMENT

1. I hereby authorize any insurance company to pay the proceeds of any benefits due me for medical services provided by Neuro Pain Consultants P.C., directly to Neuro Pain Consultants, P.C. I authorize the release of any medical or other information necessary to process my claim. A copy of my signature below can be considered an original for insurance claims processing purposes.
2. I have been informed of the HIPAA Notice of Privacy.
3. I acknowledge and understand the following: I am responsible for all of the charges for all services rendered to me or any member of my family. Although I have requested the doctor (or physical therapist) to bill my insurance company on my behalf, I clearly understand that it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason, any portion of my bill is not paid by my insurance carrier(s), I further agree to make arrangements for prompt payment of outstanding balances. • Payment is due at the time of service. • It is my responsibility to obtain any written referrals and/or authorizations prior to my scheduled visit. • I will be charged for each returned check to cover bank and other costs.

Patient Signature _____ Date _____

New Patient History

Date: Name:

Address: City: State:

Zip: Home Phone: Work:

Male: Female: Date of Birth: Age:

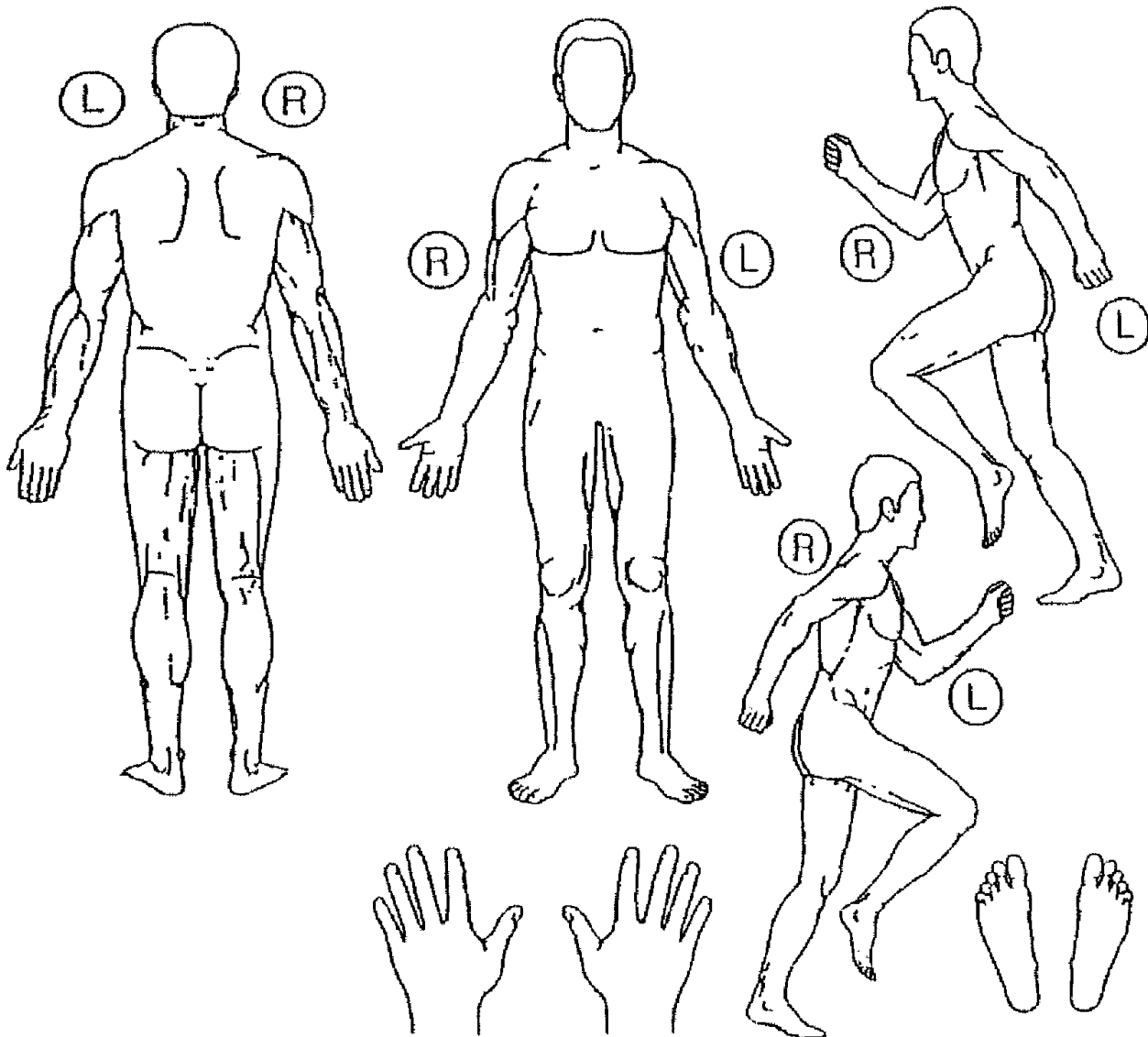
Occupation:

Referring Physician: Phone: Fax:

Family Physician: Phone: Fax:

Current Problem _____

Shade in the area(s) below where you experience pain:



Circle (Present pain intensity): (Severity)

- No pain
- Mild
- Discomforting
- Distressing
- Horrible
- Excruciating

Place an "X" on the line below that describes your pain today.

No Pain _____ **Worse Pain**

Review the words below that are commonly used to describe pain. Review each word and indicate by a check mark the highest severity you experienced in the past week.

Pain Inventory: (Quality)

	None	Mild	Moderate	Severe
A) Throbbing	0)___	1)___	2)___	3)___
B) Shooting	0)___	1)___	2)___	3)___
C) Stabbing	0)___	1)___	2)___	3)___
D) Sharp	0)___	1)___	2)___	3)___
E) Cramping	0)___	1)___	2)___	3)___
F) Gnawing	0)___	1)___	2)___	3)___
G) Hot-Burning	0)___	1)___	2)___	3)___
H) Aching	0)___	1)___	2)___	3)___
I) Heavy	0)___	1)___	2)___	3)___
J) Tender	0)___	1)___	2)___	3)___
K) Splitting	0)___	1)___	2)___	3)___
L) Tiring-Exhausting	0)___	1)___	2)___	3)___
M) Sickening	0)___	1)___	2)___	3)___
N) Fearful	0)___	1)___	2)___	3)___
O) Punishing-Cruel	0)___	1)___	2)___	3)___

When did it start? _____

What makes the pain worse? _____

What makes the pain better? _____

(Modifying factors)

What treatment have you had for this problem? (Therapy, Medications, Blocks, etc.....) _____

Have you had any of the following studies to evaluate your pain?

- () X-Ray () MRI Scan () Myelogram
- () Bone Scan () EMG () CAT Scan

Did/Does anyone in your family have a family history of chronic pain, disability or illness?

() Yes () No Relationship _____

Please explain: _____

What do you hope to achieve through participating in the Pain Management Program?

Which of the following do you feel would help you manage your pain and improve your quality of life?
Please check all that apply.

- | | |
|--|---|
| <input type="checkbox"/> Stress Management | <input type="checkbox"/> Better Understanding of Chronic Pain |
| <input type="checkbox"/> Improve Family Relationship | <input type="checkbox"/> Creating a Healthy Life Style |
| <input type="checkbox"/> Improve Social Relationship | <input type="checkbox"/> Improve Sleep |
| <input type="checkbox"/> Increase Enjoyable Activities | <input type="checkbox"/> Improve Fitness |
| <input type="checkbox"/> Improve Mood | <input type="checkbox"/> Return to Work |
| <input type="checkbox"/> Pain Coping Strategies | <input type="checkbox"/> Understanding Medication Use |

MEDICAL HISTORY

Please list all surgeries that you have had:

A) _____ B) _____ C) _____
D) _____ E) _____ F) _____
G) _____ H) _____ I) _____

Have you been diagnosed or experienced problems with anything listed below?

- | Yes | No | Yes | No | Yes | No |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fever, Wt. loss | | Muscles | | High Blood Pressure | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fatigue, Fainting | | Fibromyalgia | | Alcohol/Drug Abuse | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Visual | | Seizures/Stroke | | Lung/Asthma/COPD | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear, Nose, Throat | | Headache | | Abdomen/Liver/Intestinal | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart/Chest Pain | | Psychiatric | | Chronic Infections | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidneys/Bladder | | Diabetes/Thyroid | | Cancer | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin | | Bleeding Problems | | Other | |

List your current medications (include how much and when taken):

A) _____ B) _____ C) _____
D) _____ E) _____ F) _____
G) _____ H) _____ I) _____

Do you take blood thinners (Coumadin, Plavix, Ticlid)? () Yes () No

Allergies: _____

Are you or could you be pregnant? () Yes () No Do you smoke? () Yes () No

Do you drink alcohol? () Yes () No

A) How many drinks per day? _____

B) How many days of the week? _____

Family History of medical Problems: _____

Employment/Social History

1) Marital status: Married Divorced Widowed Single

2) Number of children ____ Ages: _____

3) What is your highest level of education completed? _____

4) Is your pain cause from a work related injury? () Yes () No

5) Are you receiving any of the following? (Check all those that apply?)

- () Workers Compensation
- () No Fault auto wage reimbursement
- () Long Term Disability reimbursement
- () Short Term Disability reimbursement
- () Social Security Disability reimbursement
- () Retirement/Pension
- () Litigation
- () Other

6) Is your job still available? () Yes () No

7) Employer: _____ Address: _____

8) Contact: _____ Phone: _____

9) Job title: _____ How long? ____ years ____ months

10) Average number of hours per day: ____ Days per week? ____

11) My job requires me to (Check all those that apply?)

- () Work at a constant rate (i.e., assembly line)
- () Work outdoors () Work indoors () Both indoors/outdoors
- () Use hand tools () Use power tools () Operate computer
- () Climb () Stairs () Ladder
- () Bend ____ Constantly ____ Frequently ____ Occassionally
- () Grasp ____ Right hand ____ Left hand ____ Both hands
- () Reach ____ Above head ____ Shoulder level ____ Waist level ____ Below waist
- () Push ____ Above head ____ Shoulder level ____ Waist level ____ Below waist
- () Pull ____ Above head ____ Shoulder level ____ Waist level ____ Below waist
- () Carry ____ lbs (average) ____ lbs (Heaviest)

- () Lift ___ lbs (average) ___ lbs (Heaviest)
- () Stand ___ hours per day
- () Sit ___ hours per day
- () Walk ___ hours per day

Physical Exam

1. Height _____ Weight _____ Change from last visit? _____ BP _____ P _____ R _____

2. Appearance: Well Groomed Disheveled Obese Morbidly Obese _____

3. Coordination: WNL Normal Gait Antalgic Gait Cane/Walker Wheelchair/Stretcher

4. Orientation A & O _____

5. Mood: Bright Blunted Crying WNL for situation _____

6. Eyes: Pupils PERRLA Sclerae Anicteric Sclerae injected Sclerae icteric

7. CV: RRR Murmurs Pulses Edema _____

8. Pulm: CTA NI Effort Wheeze rales rhonchi _____

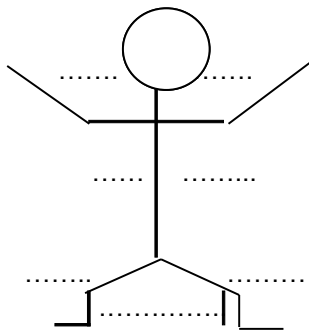
9. Lymph: neg pos where? _____

10-13.	Inspection	Range of motion	Stability	Strength/Tone
neck	___ WNL _____	WNL _____	WNL _____	WNL _____
back	___ WNL _____	WNL _____	WNL _____	WNL _____
RUE	___ WNL _____	WNL _____	WNL _____	WNL _____
LUE	___ WNL _____	WNL _____	WNL _____	WNL _____
RLE	___ WNL _____	WNL _____	WNL _____	WNL _____
LLE	___ WNL _____	WNL _____	WNL _____	WNL _____

14. Skin: Head/Neck _____ Trunk _____ RUE _____ LUE _____ RLE _____ LLE _____

15. Sensation: WNL RUE _____ WNL LUE _____ WNL RLE _____ WNL LLE _____

16. Reflex:



OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

This questionnaire has been designed to give your Physical Therapist information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark only the ONE box which best applies to you at this moment.

SECTION 1 - PAIN INTENSITY

- I can tolerate the pain that I have without the use of medication.
- The pain is bad but I manage without taking pain medication.
- Pain medication gives me complete relief from pain.
- Pain medication gives me moderate relief from pain.
- Pain medication gives me very little relief from pain.
- Pain medication has no effect on the pain and I do not use it.

SECTION 2 - PERSONAL CARE (Washing, Dressing, Etc.)

- I can take care of myself normally without an increase in pain.
- I can look after myself normally but it causes an increase in pain.
- It is painful to take care of myself, requiring me to be slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- I can lift heavy weights without increasing my pain.
- I can lift heavy weights but it does increase my pain.
- Pain prevents me from lifting heavy weights off the floor, but I can manage if conveniently positioned, e.g., on a table.
- Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights, if conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

SECTION 4 - WALKING

- Pain does not prevent me from walking any distance.
- Pain prevents me from walking more than one mile.
- Pain prevents me from walking more than 1/2 mile.
- Pain prevents me from walking more than 1/4 mile.
- I can only walk using a cane or crutches.
- I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - SITTING

- I can sit on any chair as long as I want.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than 1/2 hour.
- Pain prevents me from sitting more than 10 minutes.
- Pain prevents me from sitting at all.

SECTION 6 - STANDING

- I can stand as long as I like without increasing my pain.
- I can stand as long as I like but it increases my pain.
- Pain prevents me from standing for more than one hour.
- Pain prevents me from standing for more than 30 minutes.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

SECTIONS 7 - SLEEPING

- Pain does not prevent me from sleeping well.
- I can sleep well only using medication.
- Even when I take medication, I have less than 6 hours of sleep
- Even when I take medication, I have less than 4 hours of sleep
- Even when I take medication, I have less than 2 hours of sleep
- Pain prevents me from sleeping at all.

SECTION 8 - SEX LIFE

- My sex life is normal and causes no increase in my pain.
- My sex life is normal but causes some increase in my pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by my pain.
- My sex life is nearly absent because of my pain.
- Pain prevents any sex life at all.

SECTION 9 - SOCIAL LIFE

- My social life is normal and does not increase my pain.
- My social life is normal but increases my pain.
- My pain has no effect on my social life apart from limiting my more energetic interests, such as dancing, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted my social life to my home.
- I have no social life because of my pain.

SECTION 10 - TRAVELING

- I can travel anywhere without increasing my pain.
- I can travel anywhere but it increases my pain.
- My pain is bad but I manage trips over two hours.
- My pain restricts me to journeys of less than one hour.
- My pain restricts me to short, necessary trips under 30 minutes
- My pain prevents me from traveling except to my medical appointments or to the hospital.

Neuro Pain Consultants, P.C.

Neurosurgical Consultants
Pain Care Associates

Primary Pharmacy # _____

Emergency Pharmacy # _____

Agreement for Using Narcotics for Pain Control

1. I understand that using narcotics for non-cancer pain is currently controversial in both the public and medical communities.
2. I understand that the goal of using narcotics for pain is to decrease my pain and increase my functional level; therefore if my pain does not significantly decrease and my function significantly increases, the medications will be stopped.
3. I understand that using narcotics for a prolonged period of time may cause side effects including but not limited to lightheadedness, dizziness, nausea, constipation, fluid retention, swelling of the extremities, kidney and liver disease, depression, decrease in hormone levels, and physical dependence.
4. I understand the explanation that has been given to me about the difference between dependence and addiction.
5. I agree that I will inform the pain physician managing my narcotic maintenance program of **any and all changes** in my medical status including all changes in prescription and over the counter and herbal medications.
6. I understand it is my responsibility to inform my physician about any decrease in my ability to perform my daily activities.
7. I realize that it is my responsibility to keep others and myself from harm, including the safety of my driving. If there is any question of impairment of my ability to safely perform any activity, I agree that I will not attempt to perform the activity until I can perform it safely.
8. I will not share, sell, or trade my medication for money, goods, or services.
9. I will not use any illegal controlled substances, including marijuana, cocaine, etc. I am aware that use may result in my discharge from Pain Care Associates Medical Practice.
10. I agree to use the medications **only as prescribed** by my Pain Physician.
11. **I agree that I will not seek out or use narcotics or other controlled substances from a source other than the Medical Staff of Pain Care Associates.**
12. I will not attempt to get pain medication from any other health care provider without telling them that I am taking pain medication prescribed by my Pain Physician. I understand that it is against the law to do so. If my Primary Care Physician is willing to prescribe my medications, the Pain Physician will have to approve the arrangements to avoid duplication. I agree to discontinue all previously used pain medications, unless I am told otherwise by my Pain Physician.
13. I understand that it is a felony to obtain pain medications under false pretenses.
14. **I understand that if I over use and run out of my medication it will result in my being without medication for a period of time and my medication will not be filled early.**
15. I understand that over use of my medication may cause death.
16. I agree to waive any applicable privilege or right of privacy of confidentiality with respect to other treating physicians, any city, state, or federal law enforcement agency including the Michigan Board of Pharmacy, my insurance company, in the investigation of any possible misuse, sale, or other diversion of my pain medication. I authorize the physician to provide a copy of this agreement to any of the above.
17. I understand that it is my responsibility to make all scheduled appointments and if I am greater than 15 minutes late that I may not be seen and must reschedule to obtain my pain medications.
18. I understand that I cannot obtain my medications by phone.
19. **I understand that routine blood work and random drug screens will take place as part of my treatment program.**

I have read the above agreement and understand the content in its entirety. In addition, all of my questions have been adequately answered.

Patient Signature

Date