MICHIGAN INTERVENTIONAL PAIN ASSOCIATES

Please fill out the following questionnaire and bring it with you to your appointment. In addition, bring your medication list and REPORTS of any X-rays, MRI or Cat scans.

Patient's name: _____

Age: _____ Birthdate: _____

Appointment date: _____ Arrival time: _____

Referring Physician _____

Address/Phone Number _____

_____

_____

Primary Physician _____

Address/Phone Number _____

_____

_____

IF YOUR INSURANCE REQUIRES A PRE – AUTHORIZATION / REFERRAL FORM, PLEASE OBTAIN PRIOR TO YOUR VISIT.

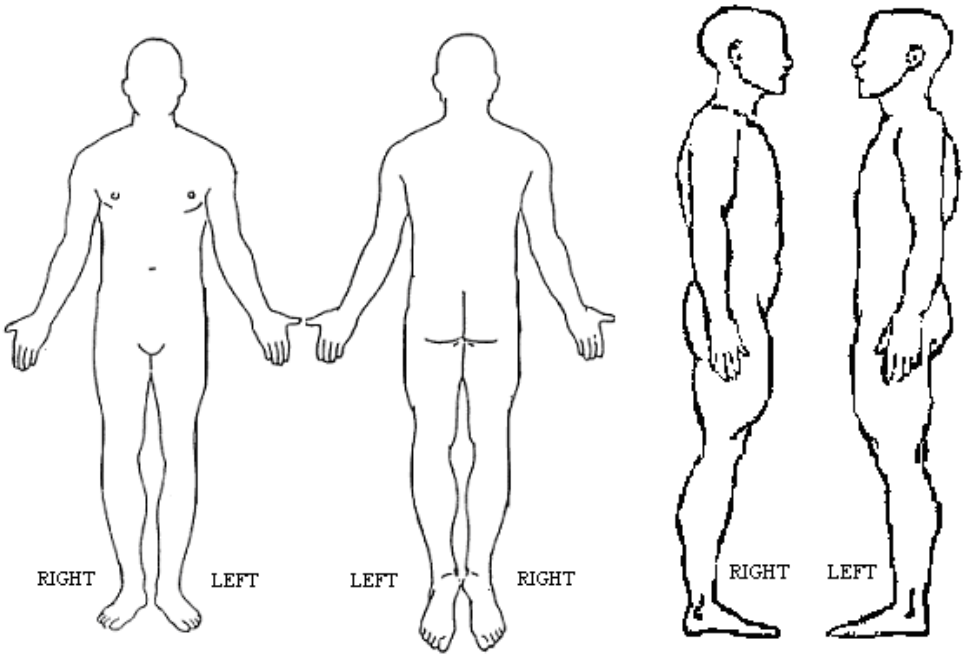
In order to facilitate your care, it is essential you complete all attached forms. While we understand this may be difficult, it is important we learn as much about you as we can.

Some questions may seem unrelated to your problem, but pain is a very complex issue, so please complete this document to the best of your ability.

Upon your arrival, a member of MIPA will review this questionnaire with you. You will then be evaluated by a physician.

Sam George DO **Sharon Minott MD** **Steven Wiener MD**

PLEASE SHADE IN THE AREA WHERE YOUR PAIN OCCURS



HISTORY OF PRESENT ILLNESS

Under what circumstances did your pain begin? (Check all that applies)

[ ]accident at work [ ]accident at home [ ]work related [ ]pain just began
[ ]motor vehicle accident [ ]following surgery [ ]following illness

If your pain began with a work related accident, please provide the following:
Place of employment_____
Date of injury _____
Type of work_____

What were you doing when the pain occurred

_____
_____
_____
_____
_____

On the scale below, place a mark on the graph to represent the severity of your pain. "0" is no pain and "10" is the worse pain imaginable

Currently, what is your pain score?

!--------!--------!--------!--------!--------!--------!--------!--------!--------!--------!--------!
0 1 2 3 4 5 6 7 8 9 10

What is the highest your pain score that you have ever had?

!--------!--------!--------!--------!--------!--------!--------!--------!--------!--------!--------!
0 1 2 3 4 5 6 7 8 9 10

What is the lowest pain score that you have ever had?

!--------!--------!--------!--------!--------!--------!--------!--------!--------!--------!--------!
0 1 2 3 4 5 6 7 8 9 10

Duration: How long have you had this pain problem? _____ yrs /months/days
When did you first notice your pain?_____

Timing of your pain (when is it the worst):
[ ]First thing in the morning [ ]Later in the morning [ ]Afternoon
[ ]Evening [ ]Bedtime [ ]Pain is ALWAYS the same

Quality of your pain (how would you best describe your pain:
[ ]Burning [ ]Sharp [ ]Aching [ ]Throbbing [ ]Shooting [ ]Other

Associated signs and symptoms:
[ ]Numbness [ ]Tingling [ ]Pins and Needles [ ]Weakness [ ]Coldness
[ ]Swelling [ ]Muscle Spasm [ ]Tightness [ ]Skin Discoloration
[ ]Bowel or Bladder Problems.

What activities increase your pain:
[ ]Sitting [ ]Standing [ ]Lying [ ]Worry/Stress [ ]Driving
[ ]Walking [ ]Weather [ ]Time of Day [ ]Activities [ ]Sex

Which of the following decrease your pain:
[ ]Rest [ ]Lying [ ]Sitting [ ]Standing [ ]Drug/Alcohol
[ ]Physical Activity [ ]Time of Day

Please indicate which of the following you have tried if any.

	Was it helpful?	How long was it helpful	Date of last treatment / use
Acupuncture	Yes / No		
Biofeedback	Yes / No		
Chiropractor	Yes / No		
Heat	Yes / No		
Hypnosis	Yes / No		
Ice	Yes / No		
Illicit (street drugs)	Yes / No		
Massage	Yes / No		
Prescribed pain medicine	Yes / No		
Physical therapy Where did you go?	Yes / No		
Nerve blocks	Yes / No		
Therapy/counseling	Yes / No		
Surgery	Yes / No		
Steroid treatment	Yes / No		
TENS	Yes / No		

Please indicate which of the following you have tried if any.

Procedure/injection	Relief	How long
	Yes / No	
	Yes / No	
	Yes / No	
	Yes / No	

Do you currently use or have you ever used-

Walker	Yes / No	
Cane	Yes / No	
Wheelchair	Yes / No	

MEDICAL HISTORY

Have you had	Y	N	Comments	Have you had	Y	N	Comments
asthma/emphysema				angina			
hypertension				diabetes			
heart attacks				arthritis			
congestive heart failure				depression			
MVP or valvular disease				sleep apnea			

REVIEW OF SYSTEMS

Have you had	Y	N	Comments	Have you had	Y	N	Comments
weight gain or loss				constipation			
fevers/chills				bone/muscle pain			
issues with eyes/vision				snoring			
issues with nose/throat				chest pain			
problems breathing				thyroid trouble			
bowel Incontinence				bleeding/bruising			
bladder incontinence				stomach pain			

Females only

First day of your last menstrual period
Are you periods normal? Yes / No
Any abnormal vaginal / breast discharge? Yes / No
Number of pregnancies_____ Number of deliveries_____

PAST SURGICAL HISTORY

Please list all the operations you have undergone, including the year they were performed.

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS

Please list all the medications you are currently taking, including the dosage.

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

What pain medications have you tried in the past for your pain?

DRUG ALLERGIES/SENSITIVITY – REACTION

1. _____
2. _____
3. _____
4. _____
5. _____

Environmental / Food Allergies: (mold, dust, pollen, cats, dogs, eggs…)

1. _____
2. _____
3. _____
4. _____

PERSONAL HABITS:
Do you smoke? _____ how much per day _____
If no, are you a previous smoker? _____
Do you drink alcohol? _____ If yes, how much? _____
Have you ever had a problem with drugs or alcohol? _____
Do you have a history of illicit drug use?_____
How many caffeinated beverages do you consume daily_____
How often do you see a doctor?
[ ]3 or more times per month [ ]1 – 2 times per month [ ]less than once a month

SOCIAL/OCCUPATIONAL HISTORY
Marital Status: Single Married Widowed Divorced Separated Remarried

Spouse's name_____

Number of children? _____ Ages?_____

Who shares your home? _____

Occupation _____ How long at this position? _____

Brief description of job duties_____

Work Status: Full Time Part Time Student Disabled Unemployed Retired

If disabled, date last worked_____

If working less than full time is pain the reason?
_____
If you had no pain would you return to work?
_____
Has your employer been helpful and understanding of your problem?
yes or no?_____

What would you hope to be the end result of this evaluation? (Please circle)
Medical diagnosis / Recommendations for surgery / Recommendations for medications
Recommendations for rehabilitation

If you are treated here, what are the results you HOPE for? (Please circle)
Pain reduction / Increased recreation / Improved emotional well- being
Increased socialization / Return to work

If you are treated here, what are the results you EXPECT?
1._____
2._____
3._____