



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) 577-6227 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. Please 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.
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.



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) 577-6227 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. Please 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.
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 very important that you contact our Billing Office (877-577-6227) 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) 577-6227 and select option 2.

**[www.greatlakespain.com](http://www.greatlakespain.com)**



Welcome to GLPC. 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 respond to on a regular basis.

Our practice is not built on a single course of treatment, but on the best use of multiple team members and options. Your treatment with us may involve medications, injections, behavioral health and/or physical therapy. Our goal is to do what works for you; our recommendations are based on a thorough assessment of your current health and your goals for improvement.

Medications may be used to help manage pain, often times they can be a very effective part of a pain management plan. However, we are always looking to find the root cause of the problem so that we aren't masking the symptoms. Pain can be a major hurdle to many daily activities so behavioral therapy including biofeedback and counseling may be a vital component of care. In addition, physical therapy can provide just the right touch to compliment your overall treatment goals.

We use injections for two main reasons. One, is to help diagnose the source of the pain, the second is that it can be therapeutic in reducing pain. Back pain provides an example. Some sources of back pain may be very obvious such as a large disc herniation. In other cases the exact source of back pain may be less certain. I put medications at different spots in the back to help diagnose & treat the source. Not every patient is a good candidate for injections, 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 behavioral & physical therapy and/or medication 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 I hope this letter answers a few of your questions. I realize that you may have additional questions and I welcome the opportunity to address them when we meet at your first appointment. I appreciate the confidence you have by trusting your care to me and my entire team. We are all eager to meet you and to help you manage your pain.

Sincerely,

Great Lakes Pain Center



Welcome to GLPC. 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 treatment 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 example. Some sources of back pain may be very obvious, such as herniation. 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 address them when we meet 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.

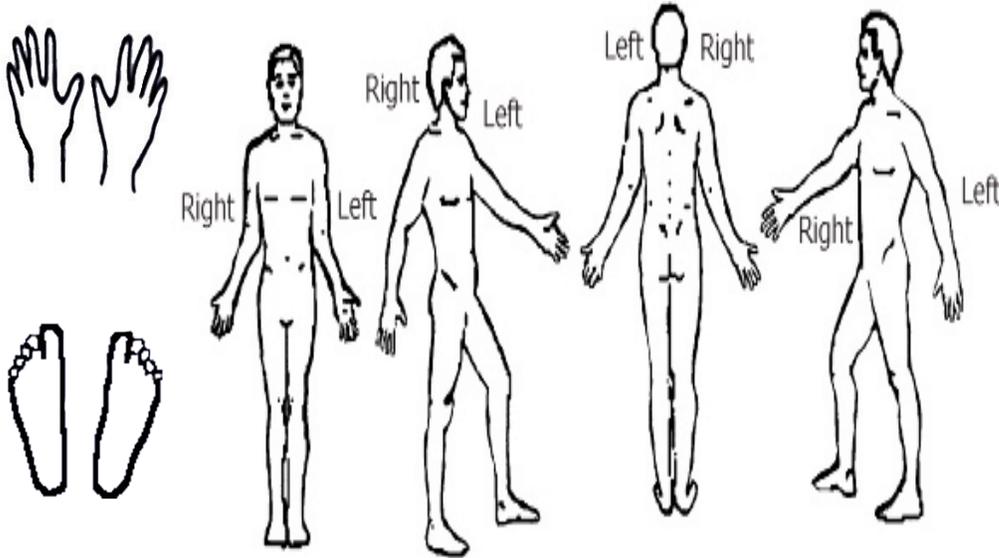
Healthy regards

# Patient Intake Information



## 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?

- |                   |          |            |                 |                      |
|-------------------|----------|------------|-----------------|----------------------|
| Heat              | Sitting  | Bending    | Climbing Stairs | Weather              |
| Cold              | Standing | Twisting   | Touch           | Lifting              |
| Physical Activity | Walking  | Lying Down | Running         | Moving affected limb |
|                   |          |            |                 | 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?          | <input type="radio"/> Yes | <input type="radio"/> No | Muscle weakness?         | <input type="radio"/> Yes | <input type="radio"/> No |
| Swelling in the affected area? | <input type="radio"/> Yes | <input type="radio"/> No | Muscle spasms or cramps? | <input type="radio"/> Yes | <input type="radio"/> No |

**Does your pain affect your:**

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

- Heart Attack/Heart Disease
- Irregular Heart Rate
- Chest Pain
- High Blood Pressure
- Stomach/Intestinal Problems
- Arthritis
- Substance Abuse/Addiction
- Bleeding/Bruise Easily
- Emphysema
- Asthma
- Thyroid Problems
- Diabetes  Type 1  Type 2
- Depression/Psych
- Other, \_\_\_\_\_
- Cancer
- Stroke
- Kidney Problems
- Epilepsy/Seizures
- Cigarette Use
- 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:  Never  Quit: date \_\_\_\_\_ Current smoker: packs/day \_\_\_\_\_ # of years \_\_\_\_\_  
Other Tobacco:  Pipe  Cigar  Snuff  Chew  
Are you interested in quitting?  No  Yes

**Alcohol Use**

Do you drink alcohol?  No  Yes, # of drinks/week \_\_\_\_\_  
Is your alcohol use a concern for you or others?  No  Yes

**Drug Use**

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

**Other Concerns:**

**Caffeine Intake:**  None  Coffee/tea/soda \_\_\_\_\_ cups/day

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

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

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

**Exercise:** Do you exercise regularly?  No  Yes

What kind of exercise? \_\_\_\_\_

How long (minutes)? \_\_\_\_\_ How often? \_\_\_\_\_

If you do not exercise, why? \_\_\_\_\_

**Marital Status/Support**

Single  Married  Widowed  Separated  Divorced

Is there any person or organization that you rely on to help you cope with your pain? \_\_\_\_\_

**Occupational History:**

Working full-time  Working part-time  On medical leave  Disabled  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?  No  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: \_\_\_\_\_



GLPC PAIN MANAGEMENT CENTER  
4121 Shrestha Drive  
Bay City, MI 48706 ~ (877) 577-6227

