Great Lakes Pain Center

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. Anticipate being at our office for your initial appointment for approximately two or three (2-3) hours.

5. 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.

6. When calling our offices, if you are unable to connect with one of our staff members, it is important to leave a message and your call will be returned in the order it was received.

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

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 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

Patient Intake Information

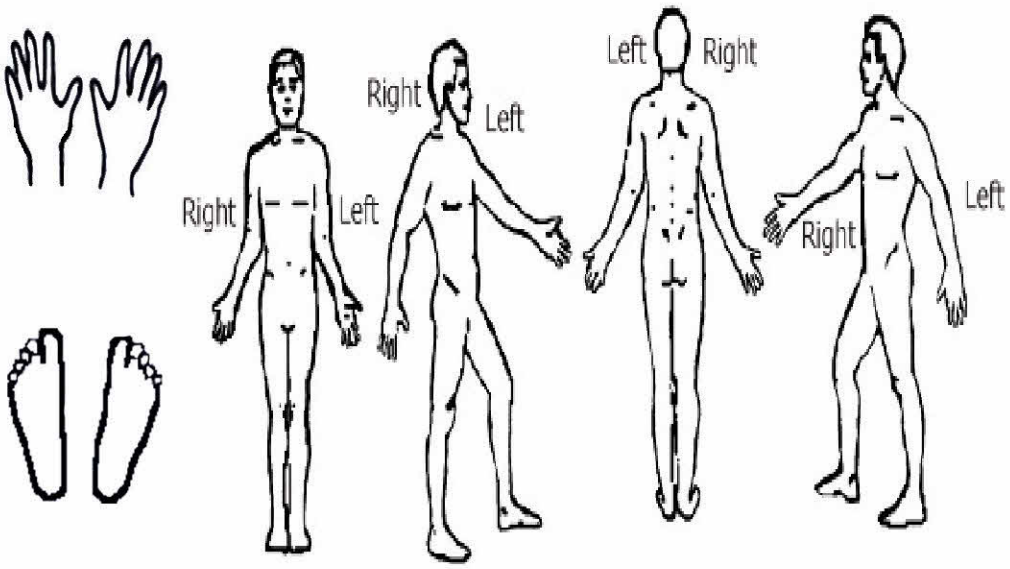
Great Lakes Pain Center

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?

				Weather
Heat	Sitting	Bending	Climbing Stairs	Lifting
Cold	Standing	Twisting	Touch	Moving affected limb
Physical Activity	Walking	Lying Down	Running	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?	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 Type 1 O Type 2
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

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

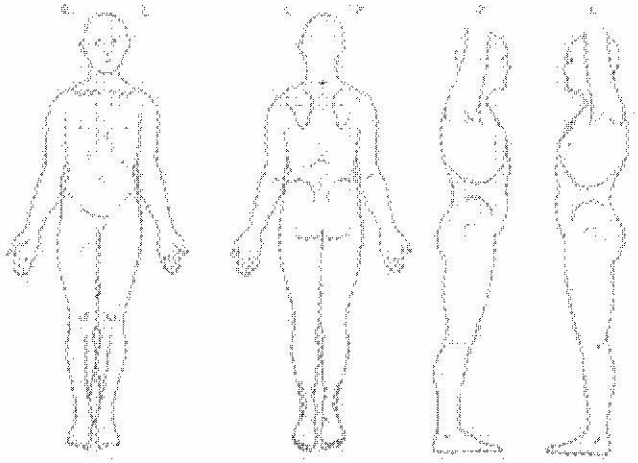
- Lesbian, gay, or homosexual
- Straight or heterosexual
- Bisexual
- Don't know
- Choose not to disclose

Patient Signature: _____Date:_____

Nurse's Signature: _____Date:_____

BRIEF PAIN INVENTORY

1. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts most.



2. Please rate your pain by circling the one number that best describes your pain at its worst in the last week.

No Pain — Pain as bad as you can imagine

◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

3. Please rate your pain by circling the one number that best describes your pain at its least in the last week.

No Pain — Pain as bad as you can imagine

◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

4. Please rate your pain by circling the one number that best describes your pain on average.

No Pain — Pain as bad as you can imagine

◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

5. Please rate your pain by circling the one number that tells how much pain you have right now.

No Pain — Pain as bad as you can imagine

◯0 ◯1 ◯2 ◯3 ◯4 ◯5 ◯6 ◯7 ◯8 ◯9 ◯10

6. What treatments or medications are you receiving for your pain?

_____

_____

BRIEF PAIN INVENTORY (Continued)

7. In the last week, how much relief have pain treatments or medications provided? Please circle the one percentage that best shows how much relief you have received.

No Relief — Complete Relief

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

8. Select the one number that describes how, during the past week, pain has interfered with your:

	Does Not Interfere										Completely Interferes
A. General Activity	0	1	2	3	4	5	6	7	8	9	10
B. Mood	0	1	2	3	4	5	6	7	8	9	10
C. Walking Ability	0	1	2	3	4	5	6	7	8	9	10
D. Normal Walk	0	1	2	3	4	5	6	7	8	9	10
E. Relations with Other People	0	1	2	3	4	5	6	7	8	9	10
F. Sleep	0	1	2	3	4	5	6	7	8	9	10
G. Enjoyment of Life	0	1	2	3	4	5	6	7	8	9	10

Great Lakes Pain Center

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