Grand Rapids Pain

Patient Information – PLEASE PRINT

Name____ Date of Birth _______________ Age ______
Last First MI

Address___________________________________ City____________________ State_____ Zip_______

Home Phone ( )____________Work/Other Phone ( ) _______________ Cell Phone ( )____________

Email ____________________ Social Security Number____________ Driver's License # _________________

Race/Ethnicity ___________________________ Primary Language _________________________________

Employer ____ Marital Status______________ Male/Female
mandatory for worker compensation patients

Referring Physician __________________________ Primary Care Physician __________________________
First Last First Last

Emergency Contact Information:
Name ____ Phone ( ) __________________

Address ____ Relationship _________________

Insurance Card Holder's Information

Name____ Relationship to Patient___________________
Last First MI

Date of Birth _______________ Home Phone ( )_____________Cell/Work/Other Phone ( ) ______________

Address___________________________________ City_________________ State_____ Zip__________

Employer _______________________________________ Employer Phone Number ( ) _________________

Employer Address___________________________ City____________________ State_____ Zip__________

Primary Insurance Carrier ________________________ Insurance Card Holder ________________________

Policy No_____________________ Group No _______________ Phone No (_____) __________________

Secondary Insurance Carrier ________________________ Insurance Card Holder ________________________

Policy No_____________________ Group No _______________ Phone No (_____) __________________

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a mucous membrane or open wound exposure to blood or other body fluids from myself that a HIV and Hepatitis-B (HBV) blood test will be performed.

Signature____ Date______________________

I authorize payment of medical benefits by the insured directly to Grand Rapids Pain. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself, including deductible, insurance co-payments, or extended office visit charges, that may be necessary for my care.
I understand this agreement authorizes Grand Rapids Pain to appeal my denied pre-service request (pre-auth) on my behalf to my designated insurance carrier. I agree to pay all services within 30 days unless a payment plan is negotiated in advance. I authorize Grand Rapids Pain to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature____ Date______________________

Grand Rapids Pain

Name: ______________________________________ Date of Birth: _______________ Patient ID: _______
Last First MI

Authorization for Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: ______________________________ Relationship to Patient ____________________
Name: ______________________________ Relationship to Patient ____________________
Name: ______________________________ Relationship to Patient ____________________
Name: ______________________________ Relationship to Patient ____________________

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- Medical Care / Treatment: **Yes ___ No ___ Level of Information** ____
- Billing Information **Yes ____ No ____**
- Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes ___ No ___**
- Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.) ____
____

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Grand Rapids Pain, 4024 Park East Court SE, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I request that all communications to me (by telephone, mail, etc.) by Grand Rapids Pain and/or its staff be handled in the following manner:

* For **written** communications: Address to: ____

* For **oral** communications: Call: ____________________ May we leave a message? YES ☐ NO ☐
(telephone number)

If the above address is not a street address or is not your home address, please provide us with a (home) street address for purposes of ensuring payment:

____
(street number and address) City State Zip

______________________________________ ______/______/______
Patient Signature Date

______________________________________ ______/______/______
Parent/Guardian Signature Date

**Needed for alternative written or oral communication listed in above box only.*
For Practice Use Only: Practice: Accepts ☐ Denies ☐

Privacy Officer's Signature ________________________________ Date: ____________

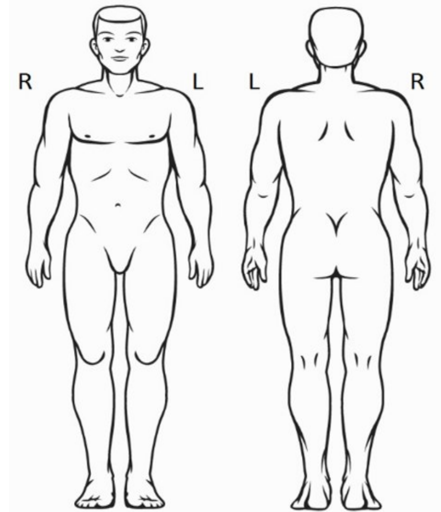
 ID#______________

Patient Name:________________________________ Date of Birth__________________

Primary Care Dr.______________________________Referred by____________________________________

For intake staff only	BP	HR	RR	T	Wt.	Ht	O2

Mark all areas of pain on the diagram



Where is your pain today?

How long have you had this problem?

Describe how your pain first began?

How often do you have pain? (Select all that apply)
☐ constantly ☐ comes and goes ☐ daily ☐ once in a while ☐other_______________

My pain is? (Select all that apply) ☐ sharp ☐ dull ☐ aching ☐ throbbing
☐burning ☐ shooting ☐ electrical ☐ other:_______________________________

Do you have any of the following?

Numbness or tingling ☐ yes ☐ no **Swelling in affected area** ☐ yes ☐ no
Muscle weakness ☐ yes ☐ no **Muscle spasms or cramps** ☐ yes ☐ no
What makes your pain worse? (Select all that apply) ☐ sitting ☐ standing ☐ walking
☐ lying down ☐ bending ☐ climbing stairs ☐ lifting ☐ squatting ☐ other_____________
____

What are you doing to reduce your pain? (Select all that apply) ☐ medication ☐ massage ☐ physical therapy ☐ice ☐ heat
☐ walking ☐ chiropractic care ☐ avoiding activity☐ rest more ☐ weight loss ☐ stretching ☐other__________________
____

Is your pain worse at night? ☐ yes ☐ no **New loss of bowel or bladder function?** ☐ no ☐ yes
If yes, please explain:____

Are you on any anti-coagulants or any blood thinning medicines? ☐ yes ☐ no

If yes, please list? ____

Please list Allergies:____

PREVIOUS TREATMENTS	YES/NO	WHEN/WHERE?	HOW HELPFUL WAS THIS?
Nerve Blocks			
Surgery			
TENS Unit			
Physical Therapy			
Chiropractic			
Biofeedback/Hypnosis			
Previous Pain Doctor			
Other Treatment			

What pain medication have you trialed, include the length of trial & when? ______________________________

____

____

Please list your current medications (Antibiotic, over the counter, Vitamins/Herbal Supplements and prescription) Include dose and how often you take them, why you take them:

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

____________________ ____________________ ____________________ ____________________

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Please explain how pain affects the activities of daily living/function in your life?

If you are going to be treated for more than one area, please document separately	Pain Area 1 (Example: low back pain)	Pain Area 2 (Example: neck pain)
List Pain Area Here? →		
What is your pain TODAY on a scale of 1 out of 10 (see pain scale/severity scale for reference on page 3??	/10	/10
What is your current severity of pain (see pain scale/ severity scale for reference on page 3)?	☐ Mild ☐ Moderate ☐ Moderately Severe ☐ Severe	☐ Mild ☐ Moderate ☐ Moderately Severe ☐ Severe
What is your current activities of daily living that you have difficulty with? (select all that apply)	☐ sitting ☐ standing ☐ walking ☐ lifting ☐ bending ☐ twisting ☐ self-care ☐ sleeping ☐ job activities ☐ school activities ☐ exercise ☐ recreational activities ☐ none	☐ sitting ☐ standing ☐ walking ☐ lifting ☐ bending ☐ twisting ☐ self-care ☐ sleeping ☐ job activities ☐ school activities ☐ exercise ☐ recreational activities ☐ none
What is your current severity of difficulty with activities of daily living (see pain scale/severity scale)? →	☐ Mild ☐ Moderate ☐ Moderately Severe ☐ Severe	☐ Mild ☐ Moderate ☐ Moderately Severe ☐ Severe

What activities/hobbies not listed above would you like to start doing again, once you are feeling better?

____

____

New Patient Visit Form: Page 3 of 4 **Patient Name:**______________________________ **Date of Birth**_______________

JPI'S PAIN & SEVERITY SCALE	PAIN SCORE	SEVERITY SCORE	With Definitions
	0 Pain Free	N/A	
	1 Very Mild	MILD PAIN	Nagging, annoying, but doesn't interfere with most daily living activites
	2 Discom-forting		
	3 Tolerable	MODERATE PAIN	Interferes moderatly with daily living activities. Requires some lifestyle changes.
	4 Distress-ing		
	5 Very Distress-ing	MODERATELY SEVERE	Interferes significantly with daily living activities. Requires many lifestyle changes, but patient remains independent.
	6 Intense		
	7 Very Intense	SEVERE PAIN	Disabling, unable to perform daily activities, unable to engage in normal activities, patient is disabled and unable function independently.
	8 Utterly Horrible		
	9 Excruciat-ingly Horrible	EMERGENT ONLY	Not usually Chronic: Acute Pain experienced during Severe Car Accident, Severe Broken Bone, Giving Child Birth, Being Crushed by a Truck, etc…
	10 Unimagin-ably Unspeak-able		

List any tests/imaging you have had done?

Test	Date/Place	Results
X-Rays		
CT Scan		
MRI		
EMG		
Bone Density		
Other		

Please list any surgeries you have had?

Surgery	Date/Surgeon

Review of Systems/Medical History: Please check any that you currently have or had in the past

Constitutional
- □Recent fever/sweats
- □Unexplained weight loss/gain
- □Unexplained fatigue/weakness

Eye/Ear/Nose/Throat
- □Vision changes
- □Difficulty Hearing
- □Hay fever/allergies
- □Difficulty swallowing

Endocrine
- □Cold/Heat intolerance
- □Increased thirst/appetite
- □Thyroid problems
- □Diabetes
- □Severe Diabetes

Genitourinary
- □Painful/bloody urination
- □Night-time urination
- □Discharge: penis or vagina
- □Unusual vaginal bleeding
- □Kidney problems
- □Concern with sexual function

Gastrointestinal
- □Stomach/intestinal problems
- □Nausea/Vomiting/diarrhea
- □Changes in bowel movement
- □Blood in stool

Other
- □Implantable Device

Review of Systems Continued

Respiratory
□Emphysema/COPD
□Asthma
□Coughing/wheezing
□Coughing up blood
□Communicable disease-TB

Skin
□Sores
□Psoriasis
□Eczema
□Rash
□Communicable disease-MRSA

Blood /Lymbphatic
□Unexplained lumps
□Easy bruising/bleeding
□Cancer
□Communicable disease (HIV,AIDS, Hep B or C)
□Other:________________

Musculoskeletal
□Arthritis
□Muscle/Joint Pain
□Recent back pain
□Muscle weakness
□Osteopenia

Psych/Behavioral
□Anxiety/stress
□Depression
□Substance abuse/addiction
□Sleep problems
□Other:________________

Neurological
□Headaches
□Numbness
□Tremors
□Poor balance
□Epilepsy

Neurological (continued)
□Stroke
□Loss of balance
□Other:________________

Cardiovascular
□Chest pain/discomfort
□Shortness of breath
□Heart attack
□High blood pressure
□Palpitations/irregular heart
□Pacemaker/defibrillator
□Other:________________

Please give further detail on selection listed above?____

____

____

How often do you drink alcohol? □ Never □ Monthly # of drinks_______ □ Weekly # of drinks_______
□ Daily # of drinks _______ □Other:___________________________

Have you felt you ought to cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you felt bad or guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves, get rid of a hangover,

or as an eye opener?

Patient Signature____**Date**______________________

Grand Rapids Pain Patient Policies

Prescription Renewal Policy

If a medication refill is needed, please contact our office during regular business hours, which are 8:30 AM to 5:00 PM, Monday – Thursday, and 8:30 AM to 12:00 PM on Friday. Leave a message on the prescription line or send a request through the Patient Portal. Please note our office will not call to notify patients when a prescription is ready for pick-up, unless there is a problem or issue with the request. **We ask patients to give us 24-48 hours to process their request**. **Renewal requests will not be processed outside of normal business hours.**

Patients are advised to call the nursing line if they have questions about how to take a prescription. If you are prompted to leave a message, one of our staff members will call you back within 24-48 hours.

Designated Driver Policy

Patients may be offered sedation to make them more comfortable during procedures. In order for a patient to receive sedation, an adult designated driver, must be present during the patient's entire appointment**.**

Payment Policy

Payment is expected at the time of a patient's visit in the office. As a courtesy to patients, if the physician participates with the patient's insurance policy and the visit is a covered benefit under the policy, our office will submit any charge(s) to their insurance carrier for payment. Any co-payment and/or deductible amount will be collected prior to your appointment. Cash and credit card are accepted for your convenience.

No Children in The Exam Rooms

For many reasons we had to make it a policy that children are not allowed into our exam rooms. Due to the type of specialty there may be a considerable amount of time spent waiting, and the Grand Rapids Pain is not very enjoyable for young children. If there is no other alternative and a patient must bring child(ren) to their appointment, they will need to make prior arrangements to have their adult driver care for their child(ren) while in the waiting room. If a patient comes to an appointment and does not have an adult to supervise his/her child(ren), they will have to reschedule their appointment. We are not able to make exceptions to this. We are sorry for any inconveniences this may cause.

Lost/Stolen Property

GRP is not responsible for lost or stolen items and we recommend that valuable items be left at home or with the adult driver.

Inappropriate Behavior

GRP's mission is to provide a safe environment for care in our office. We have a **Zero Tolerance** for inappropriate or threatening behavior towards staff, patients, or visitors.