MIPM
Michigan Institute of
Pain Management, P.C.

- 24430 Ford Road, Suite A, Dearborn Heights, MI 48127
- 11650 Belleville Road, Suite 105, Belleville, MI 48111
- 1030 North Monroe Street, Monroe, MI 48162
- 19725 Allen Road, Suite 102, Brownstown, MI 48183

888.389.4115 www.mipmpc.com

Personal Information:

Last Name: _____
First Name: _____
Middle Initial: _____
Previous Name(s): _____
Address: _____
City: _____ State: WY Zip: _____
Date of Birth: _____
Social Security: _____ - _____ - _____
Gender: □ Male □ Female
Home Phone: (_____) _____ - _____
Cell Phone: (_____) _____ - _____
Email: _____

Emergency Contact: _____
Relation: _____
Phone: (_____) _____ - _____

Primary Care Physician: _____
Office Location (***city/state***): _____
Referring Physician: _____
Office Location (***city/state***): _____
Work Status: □ Working □ Not Working □ Disabled
Occupation: _____
Employer Name: _____
Work Phone: (_____) _____ - _____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Injury / illness related to:
□ Work □ Auto-related □ Slip-&-fall
□ Other _____

Pharmacy Name: _____
Address: _____
City: _____ State: WY Zip: _____

Insurance Information:

Primary Insurance Name: _____
Phone: (_____) _____-_____
ID/Contract No. _____
Group No. _____
Subscriber: □ Self □ Spouse □ Parent □ Other: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____

Secondary Insurance Name: _____
Phone: (_____) _____-_____
ID/Contract No. _____
Group No. _____
Subscriber: □ Self □ Spouse □ Parent □ Other: _____
Subscriber's Name: _____
Subscriber's Date of Birth: _____

Auto Insurance Name: _____ Claim No.: _____

Worker's Comp Name: _____ Claim No.: _____

Adjustor's Name: _____ Adjustor's Phone: (_____) _____ - _____

Attorney's Name: _____ Attorney's Phone: (_____) _____ - _____

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HT: _____ **WT:** _____, Please check one: □ R □ L - handed, or □ ambidextrous

Is there a specific question that you or your doctor would like answered regarding your pain?

_____

The specific pain that brings you to our center today is located where? – *mark the locations on the drawing below*

_____

How long have you had your pain?

_____

Briefly describe how your pain started:

_____

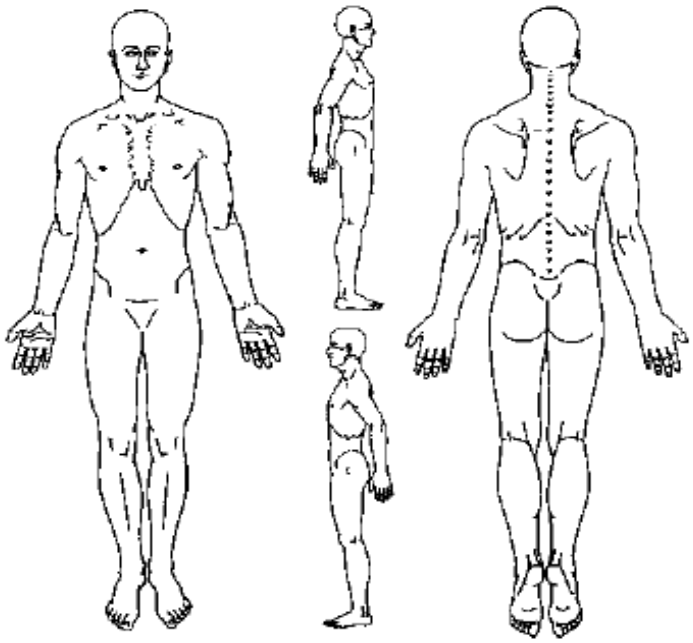
_____

_____

Rate how your pain has interfered with your daily activities and how it affects you personally? *On a scale of 0-10*

0 = Does not interfere, 10 = Total interference

___/ 10 Usual work routine
___/ 10 Social Life
___/ 10 Mood
___/ 10 Routine home chores
___/ 10 Enjoyment of life
___/ 10 Sleep



0 = No Pain, 10 = Worst pain imaginable

I would rate my pain today at ____/10
I would rate my worst pain at ____/10
I would rate my pain when it is under control at ____/10
I could accept or live with my pain level at a ____/10

When does your pain occur most?

□ Morning □ Night □ All day □ Comes & Goes

Does your pain affect your sleep? *No, Yes – If yes, how?*

□ Trouble falling asleep
□ Trouble staying asleep
□ Awakening frequently because of the pain

Check off the words that best describe your pain:

□ Aching	□ Throbbing
□ Cramping	□ Dull
□ Grinding	□ Excruciating
□ Burning	□ Severe
□ Cutting	□ Sharp
□ Itching	□ Squeezing
□ Shooting	□ Piercing
□ Stabbing	□ Numbness
□ Electric shock	□ Tingling

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How do the following affect your pain?			
	Decreases My Pain	*Increases My Pain*	*No Change in Pain*
Heat	☐	☐	☐
Cold	☐	☐	☐
Damp/Weather Change	☐	☐	☐
Massage/Pressure	☐	☐	☐
Being Still	☐	☐	☐
Movement	☐	☐	☐
Rest	☐	☐	☐
Lying Down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Traveling in the Car	☐	☐	☐
Turning	☐	☐	☐
Bending Forward	☐	☐	☐
Bending Backward	☐	☐	☐
Climbing stairs	☐	☐	☐
Going down stairs	☐	☐	☐
Exercise	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel Movement	☐	☐	☐

Which of the following have you tried in attempt to help alleviate your pain?					
☐ Physical Therapy	☐ Mobilization	☐ Occupational Therapy	☐ Exercises	☐ Traction	☐ Orthotics
☐ Acupuncture	☐ Prosthetics	☐ Relaxation Therapy	☐ Biofeedback	☐ TENS	☐ Nerve Blocks
☐ Aerobic	☐ Drug/Alcohol Detoxification		☐ Chiropractic/Massage		☐ Psychology
☐ Epidural Steroid Injection	☐ Facet Injection		☐ Radiofrequency	☐ Intrathecal Drug Delivery Pump	
☐ Spinal Cord Stimulation	☐ Kyphoplasty/Vertebroplasty		☐ Others:		

Medical History:					
☐ Cancer – Type:					
☐ Tuberculosis	☐ Asthma	☐ COPD	☐ Emphysema	☐ Heart Attack	☐ Sleep Apnea
☐ CHF	☐ Angina	☐ Pacemaker	☐ AICD	☐ Heart Stents	☐ Hepatitis
☐ Kidney Problem	☐ Dialysis	☐ Lupus	☐ Paralysis	☐ Headaches	☐ Seizures
☐ Mini Stroke (TIA)	☐ Stroke (CVA)	☐ Pancreatitis	☐ Cirrhosis	☐ Shingles	☐ Hypertension
☐ Bleeding disorder	☐ Heart Murmur	☐ Incontinence	☐ Easy Bruising	☐ Psoriasis	☐ Anemia
☐ Numbness	☐ Diabetes	☐ Oxygen Use	☐ Liver Problems	☐ Heartburn	☐ Fibromyalgia
☐ HIV/AIDS	☐ Gastritis	☐ Gastric Ulcers	☐ Thyroid Disease	☐ Arthritis	☐ Gout

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Allergies:

☐ Latex ☐ Contrast Dye ☐ Tape/Adhesive ☐ Shellfish ☐ Balloons ☐ None ☐ Other: _____

Medications:

Do you take a blood thinner? ☐ No ☐ Yes – If yes, what are they? _____

Who prescribes your blood thinner? _____

Please list below **ALL** medications that you currently are taking:

Medication Name	*Strength*	*Direction on Bottle*

~ if you need more space, please check box ☐ and write on ***last page***

Surgical History:

Date	*Type of Surgery*	*Hospital*	*Surgeon*

~ if you need more space, please check box ☐ and write on ***last page***

Family History:

☐ No Significant Family History	☐ Cancer	☐ Low Back Pain	☐ Diabetes	☐ Heart Disease
☐ Rheumatoid Arthritis	☐ Bleeding Disorder	☐ Hypertension	☐ Blood disorder	☐ Airway Disease

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Social History:

What is your marital status? □ Single □ Married □ Separated □ Divorced □ Widowed

How many children do you have? _____ How many children live with you at home? _____

Do you smoke? □ No □ Yes:

If yes, how many packs per day _____ How many years have you been smoking? _____ (yrs)

Do you drink alcohol? □ No □ Yes:

If yes, how much and how often do you drink? (e.g. 2 glasses of wine each day) _____

Do you use recreational or illicit drugs? □ No □ Yes:

If yes, please describe: _____

Do you exercise regularly? □ No □ Yes:

If yes, how often? _____

Previous Diagnostic Studies related to your pain? *Check all those that apply:*

□ MRI	When:	Where:
□ CT Scan	When:	Where:
□ Plain X-ray	When:	Where:
□ EMG/NCV	When:	Where:
□ Myelogram	When:	Where:
□ Bone Scan	When:	Where:

Have you had any of the following signs or symptoms in the ***past 2 weeks***?

□ Unintentional Wt Loss	□ Nausea/Vomiting	□ Fever (> 101° F)	□ Rash	□ Cough	□ Abdominal pain
□ Swelling of extremities	□ Appetite change	□ Blood in stool	□ Jaundice	□ Chest pain	□ Blood in urine
□ Muscle weakness	□ Shortness of breath	□ Wheezing	□ Dizziness	□ Abnormal Menstrual Cycle	
□ Ringing in ears	□ Chills	□ Headaches	□ Arrhythmia	□ Bleeding gums	□ Oxygen use
□ Hearing disturbance	□ Visual disturbance	□ Can't Urinate	□ Constipation		

~Please mail back or drop off this packet as soon as possible to avoid any delays with your appointment~

OFFICE USE ONLY:

By affixing my signature below I attest that I have reviewed the information contained in the entire questionnaire and that I have reviewed the key findings with the patient and/or their family. The pertinent findings are summarized in my progress notes; however, the questionnaire may be referenced for additional details.

Pain Consultant Signature: _____ **Date:** _____

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ADDITIONAL INFORMATION:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____

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