NIPM
NEUROINTERVENTIONAL PAIN MANAGEMENT

Dr. Ariel Majjhoo
1030 N. Monroe Street, Monroe, MI 48162
24430 Ford Rd., Dearborn Heights, MI 48127
Phone: 734-682-3309
Fax: 734-682-1488

Personal Information:

Last Name: _____
First Name: _____
Middle Initial: _____
Previous Name(s):
Address: _____
City: _____ State: _____ 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: _____ 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*

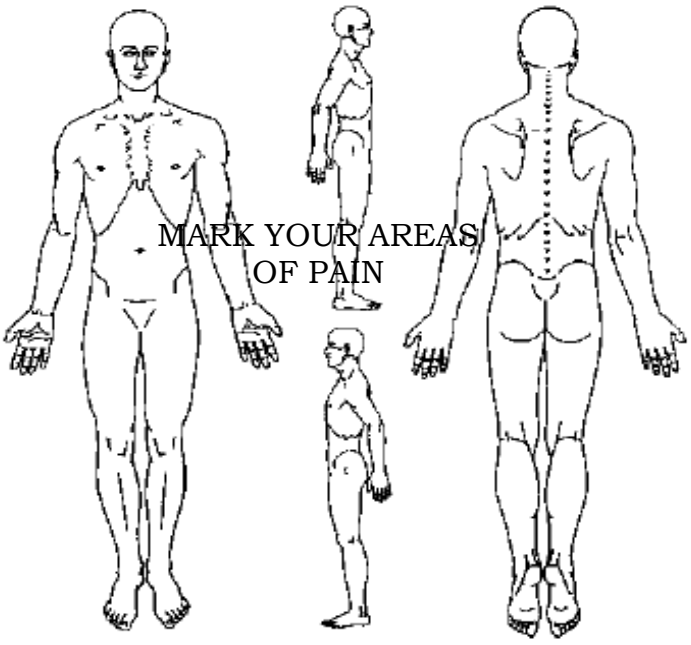
How long have you had your pain?

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. _____
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9. _____
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11. _____
12. _____
13. _____
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19. _____
20. _____