NIPM
NEUROINTERVENTIONAL PAIN MANAGEMENT

Dr. Ariel Majjhoo **Dr. Bryant Ittiara**
1030 N. Monroe Street, Monroe, MI 48162
18707 Ecorse Road, Allen Park, MI 48101
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): _____

Marital Status: □ Single □ Married □ Separated

□ Divorced □Widowed

Work Status: □ Working □ Not Working □ Disabled

Occupation: _____

Employer Name:_____

Work phone: (_____) _____ - _____

Injury/Illness related to:

□ Work □ Auto-related □ Slip-&-fall

□ Other _____

Pharmacy Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Information:

Primary Insurance: _____

Phone: (_____) _____-_____

ID/Contract Number: _____

Group Number: _____

Subscriber: □Self □Spouse □Parent □Other:

Subscriber's Name: _____

Subscriber's Date of Birth: ____/ ____/ ____

Secondary Insurance: _____

Phone: (_____) _____-_____

ID/Contract Number: _____

Group Number: _____

Subscriber: □ Self □ Spouse □ Parent □ Other:

Subscriber's Name: _____

Subscriber's Date of Birth: _____/ _____/ ___

Auto Insurance Name: _____ Claim Number: _____

Worker's Comp Name: _____ Claim Number: _____

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 **Age:** _____

Where is the specific pain that brings you to our office located? ***Please mark on the images below***

Briefly describe how your pain started:

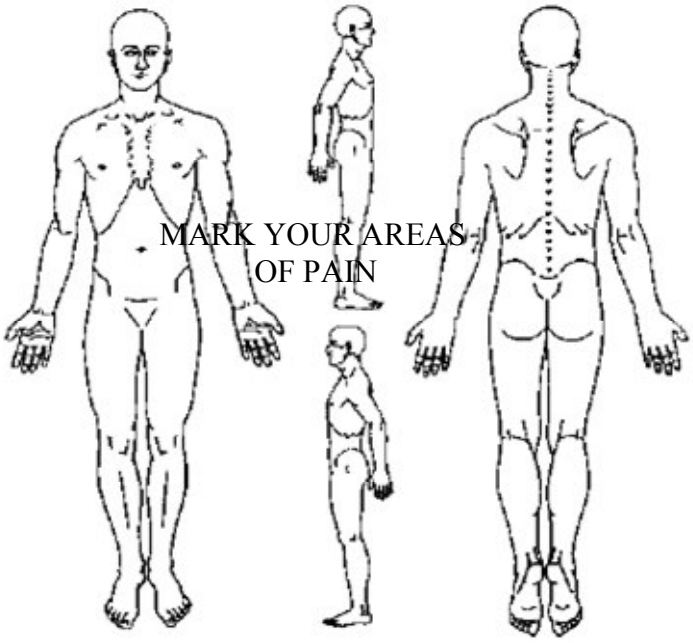
How long have you had your pain?

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

Rate how your pain has interfered with your daily activities and how it affects you personally.

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 my pain
Heat	□	□	□
Cold	□	□	□
Damp/Weather change	□	□	□
Massage/Pressure	□	□	□
Lying Down	□	□	□
Standing	□	□	□
Sitting	□	□	□
Walking	□	□	□
Traveling in the Car	□	□	□
Turning/Twisting	□	□	□
Bending Forward	□	□	□
Bending Backward	□	□	□
Climbing or going down stairs	□	□	□
Exercise	□	□	□
Coughing/Sneezing	□	□	□
Urination	□	□	□
Bowel Movement	□	□	□

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

Medical History: ***Please select all that you have been <u>diagnosed</u> with***					
□ Cancer – Type:					
□ Heart Attack	□ Heart Stents	□ CHF	□ Angina	□ Hypertension	□ Pacemaker
□ Heart Murmur	□ Asthma	□ COPD	□ Emphysema	□ Sleep Apnea	□ Tuberculosis
□ Kidney Problem	□ Dialysis	□ Diabetes	□ Liver Problems	□ Hepatitis	□ Cirrhosis
□ Mini Stroke (TIA)	□ Stroke (CVA)	□ Headaches	□ Seizures	□ Blood clots	□ Dementia
□ Gastritis	□ Heartburn/GERD	□ IBS	□ Gastric Ulcers	□ Bowel/Bladder Incontinence	
□ Lupus	□ Rheumatoid Arthritis	□ Osteoarthritis	□ Gout	□ Fibromyalgia	□ Psoriasis
□ Bleeding Disorder	□ Anemia	□ Pancreatitis	□ Thyroid Disease	□ Shingles	□ HIV/AIDS
□ Depression	□ Anxiety	□ Bipolar Disorder	□ Others:		

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Allergies:

□ No Known Allergies
□ Latex □ Contrast Dye □ Tape/Adhesive □ Shellfish □ Balloons □ Medications: _____
□ Other: _____

Medications: *please list ALL medications you are currently taking*

Medication Name	Strength	Directions on bottle

*If you need more space, please continue your medication list on the last page of the packet.

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

Who prescribes your blood thinner? _____

Surgical History:

Date	Type of Surgery	Hospital	Surgeon

*If you need more space, please continue your surgical history on the last page of the packet.

Family History:

□ No significant family history	□ Cancer- Type: _____	□ Diabetes	□ Blood Disorder
□ Arthritis: □ OA □ RA	□Cardiovascular Disorder: □ Hypertension □ Heart Disease □ Other:_____		
□ Autoimmune Disorder	□Neurological Disorder: □Stroke □Migraines □Multiple Sclerosis □Other:_____		

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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? _____

Do you drink alcohol? □ No □ Yes:

If yes, how much and how often do you drink? (ex: 2 glasses of wine per day) _____

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

If yes, please describe: _____

Do you exercise regularly? □ No □ Yes:

If yes, how often? _____

Are you employed? □ No □ Yes:

If yes, where? _____ For how many years? _____

Please briefly describe your job duties: _____

If no, where were you previously employed? _____ For how many years? _____

Previous Diagnostic Imaging Completed: *please select all that apply*

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

Review of Systems: *please circle all of the following signs or symptoms you have experienced in the <u>past 2 weeks</u>*

CONSTITUTIONAL: weight loss, fever, chills, weakness, or fatigue
HEENT: Eyes: visual loss, blurred vision, double vision, or yellow sclera; Ears, Nose, & Throat: hearing loss, sneezing, congestion, running nose, or sore throat
SKIN: rash or itching
CARDIOVASCULAR: chest pain, chest pressure, or chest discomfort; palpitations or edema
RESPIRATORY: shortness of breath, cough, or oxygen use
GASTROINTESTINAL: anorexia, nausea, vomiting, diarrhea, constipation, abdominal pain or blood
GENITOURINARY: burning with urination, change in urinating habits or stream; pregnancy
NEUROLOGICAL: headache, dizziness, syncope, paralysis/weakness, ataxia, numbness or tingling in the extremities; change in bowel or bladder control
MUSCULOSKELETAL: muscle pain, muscle weakness, back pain, joint pain, or joint stiffness
HEMATOLOGIC: anemia, bleeding, or easy bruising
LYMPHATICS: enlarged nodes, swelling in extremities; history of splenectomy
PSYCHIATRICS: history of depression, anxiety, or bipolar; suicidal or homicidal thoughts
ENDOCRINOLOGIC: reports of sweating, cold or heat intolerance, polyuria (frequent urination), or polydipsia (excessive thirst)

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Additional Information:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

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/Physician Signature:_____ **Date:** ____/ ____/ ____