Spine and Pain Management

# WELCOME TO OUR OFFICE

We are looking forward to seeing you at your upcoming appointment. Our goal is to provide our patients the best health care and service available. In order to help us achieve that goal, we are requesting that you complete the attached forms and present them when checking in for your first appointment. Please arrive 30 minutes prior to your appointment time. If you need assistance with completing the form, our staff will gladly help.

**Your appointment with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been scheduled for**

**­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* We will be taking a complete history to better understand your health care needs.
* You will be asked to change into a gown as we conduct a physical exam that includes an evaluation of your abdomen, back, muscles, joints, and your heart and lungs. We ask that you undress down to your undergarments (please remove socks/stockings) and use the gown provided.
* We request you not bring children to your appointment as we want to focus on your health and may have sensitive discussions.
* As a courtesy, please set your cell phone to off, silent, or vibrate.

There is a possibility that we may need to reschedule your appointment if you do not arrive on time. It is necessary for you to honor the appointment time that has been scheduled. **We ask you to show consideration by notifying our office at least 24 hours in advance if you are unable to keep an appointment.** We would like to have the option to offer that appointment to another patient who needs to see the doctor.

The office hours are Monday – Friday 8:00 AM - 5:00 PM.

We look forward to seeing you.

Sincerely,

The associates of Spectrum Health Medical Group Spine and Pain Management Center.

1900 Wealthy St SE, Suite 290

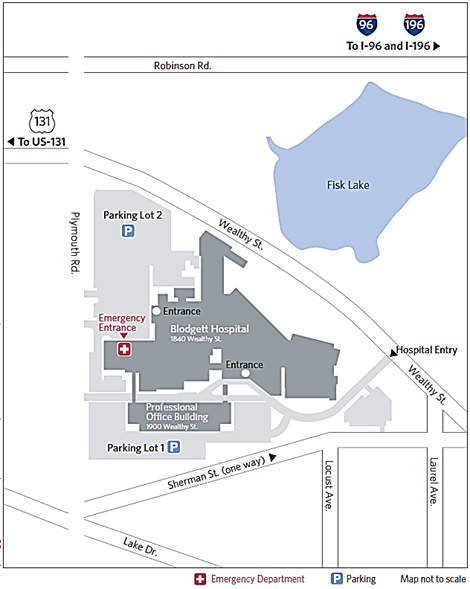
Grand Rapids MI 49506

Ph: 616-774-8345

Fax: 616-774-8350

[www.shmg.org](http://www.shmg.org)





Radiology

**Spine and Pain Management Center**

**1900 WEALTHY SE SUITE 290**

**GRAND RAPIDS MI 49506**

**PARKING LOT – TO TOP DECK/HANDICAP RAMP ENTRANCE or C ENTRANCE (STAIRS)**

* Enter Parking **Lot #1** from Wealthy St
* Drive between the Professional Office Building (POB) and Blodgett Hospital
* Parking Lot Entrance is located on the **LEFT** just past the Chemist Shoppe
* Turn **LEFT** into the Parking Structure
* Turn **LEFT** at the ‘arm’ in the Parking Ramp
* Follow through level 1, turn **LEFT** at the ‘LEFT TURN ONLY’ sign
* Follow curve – you are now on the TOP DECK
  + ‘Floor 2 Accessible Ramp’ is located between the EAST and CENTRAL entrances to the POB
    - Handicap Accessible ramp can ***only*** be opened by pushing the Handicap ‘button’ – located on the left
  + Enter the Central Entrance – There will be five (5) stairs up to the 2nd Floor – Suite 290 is located on the RIGHT

Please note: Suite 290 is accessible from East and West entrances from the top deck. There will be five (5) stairs up to the second floor.



On this map we have highlighted various routes to better assist you on your journey to the Spine and Pain Management Center.

**Please note: While Wealthy Street is a more direct route, it involves multiple round-a-bouts and a cobblestone section, which can make for an uncomfortable ride. We recommend taking exit 83B, GREEN route for a smoother trip that is easier on the spine and a more comfortable ride.**

*Affix Label Here*

**New Patient Intake Form**

*We know that completing forms may be difficult and time consuming, but we ask that you please complete them as fully and honestly as possible. Your accurate responses will give us a better understanding of you and your health, so we can provide you with the best health care possible. Thank you for helping us with this.*

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for visit:**

Back pain Leg pain Neck pain Arm Pain  Widespread pain  Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What do you hope to get from your visit today?**

**1.**

**2.**

**When did your CURRENT problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What event(s) caused your current spine problem?** (*Check all that apply*)

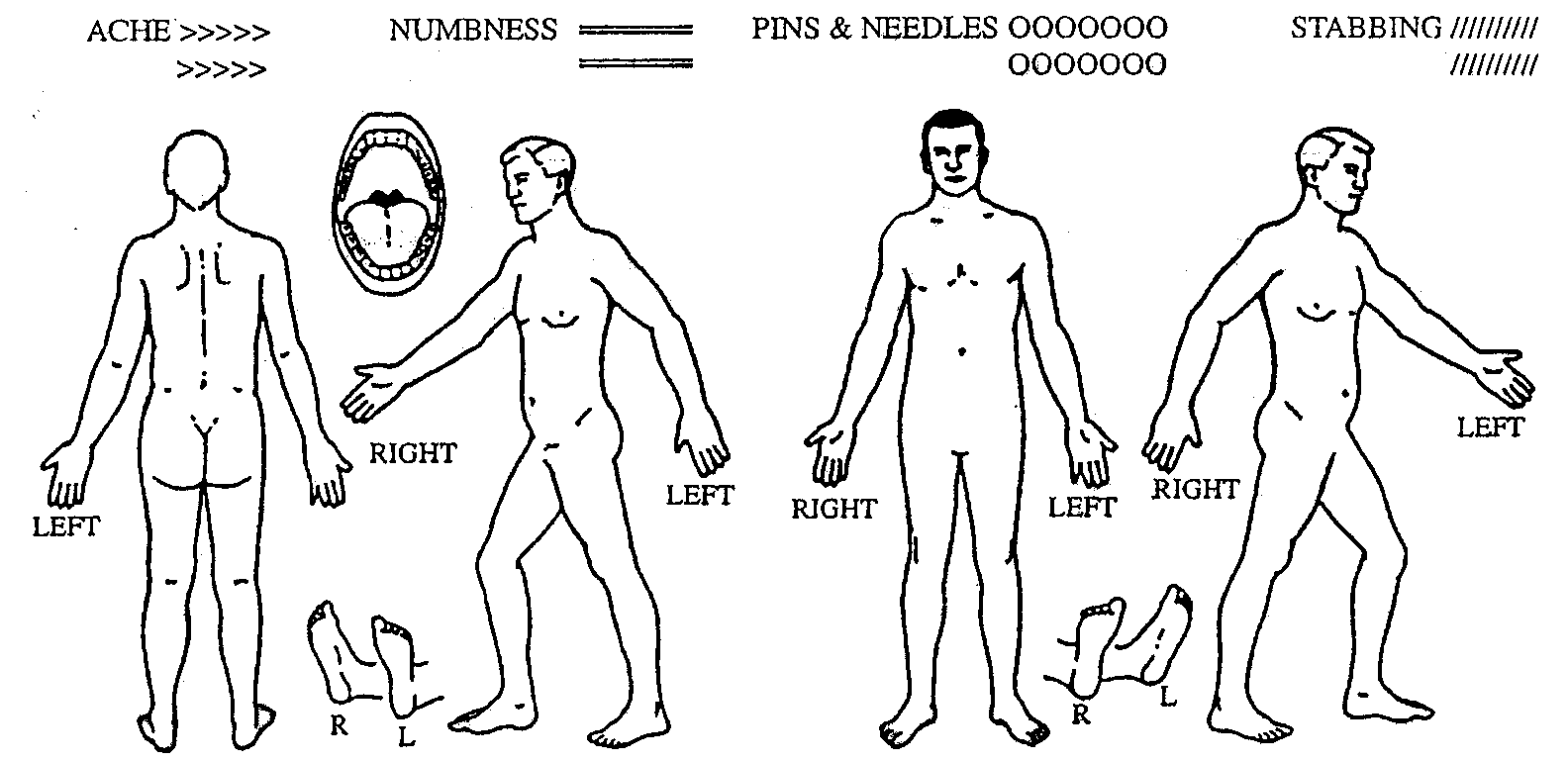
No known cause  Motor vehicle accident  Recreation/ sport

On the job injury  Repetitive injury  Fall

Other

If any of the above apply, did you have pain in the same area **before** the event/injury occurred?  Yes  No

**On the diagram below, mark the area of your body where you feel your TYPICAL pain.**  **Include all affected areas.**



**Describe how your pain FEELS.** (*Circle all that apply.*)

sharp dull aching burning throbbing shooting stabbing lightning tight pressing gnawing cramping heavy pinching sore terrifying

**If 10 is the worst pain imaginable, and 0 is no pain, please rate your pain over the last SEVEN DAYS:**

0 1 2 3 4 5 6 7 8 9 10

Average\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at its worst\_\_\_\_\_\_\_\_\_\_\_\_\_ at its best\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much did the pain/condition interfere with your daily activities this past week?**

0 1 3 4 5 6 7 8 9 10

None Mild Moderate Severe Completely

**Where do you feel the worse pain?**  Back  Neck  Leg  Arm

Pain is equal in back/leg Pain is equal in neck/arm

**What does each of the following activities do to your pain?**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **No Change** | **Relieves Pain** | **Increases Pain** |
| Sitting |  |  |  |
| Standing |  |  |  |
| Walking |  |  |  |
| Lying down |  |  |  |
| Bending forward |  |  |  |
| Bending backward |  |  |  |
| Lifting |  |  |  |
| Turning head to side |  |  |  |
| Bending neck back |  |  |  |
| Bending neck forward |  |  |  |
| Coughing / sneezing |  |  |  |

Are there other things you do to relieve your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Since the pain/condition began has it:ImprovedRemained the sameWorsened

**Do you have any of the following symptoms?**

arm or leg weakness  difficulty sleeping : If yes, describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

arm or leg numbness or tingling  weight gain  weight loss  fever or chills

bowel or bladder problems: If yes, describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Put an “X” next to each treatment you have had for THIS condition. For each treatment, circle the effect you received on your pain.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Treatment** | **Effect of Treatment** | | |
| **Helped**  **Symptoms** | **No change** | **Increased Symptoms** |
| \_\_\_\_\_\_ Physical therapy | 1 | 0 | -1 |
| \_\_\_\_\_\_ Massage | 1 | 0 | -1 |
| \_\_\_\_\_\_ Chiropractic or Osteopathic treatment | 1 | 0 | -1 |
| \_\_\_\_\_\_ Spine injections | 1 | 0 | -1 |
| \_\_\_\_\_\_Counseling or Psychiatry | 1 | 0 | -1 |
| \_\_\_\_\_\_ Medications | 1 | 0 | -1 |
| \_\_\_\_\_\_ Other (list) | 1 | 0 | -1 |

When did you last have physical therapy for this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many sessions?\_\_\_\_\_\_\_\_\_

**Do you exercise?**  Yes  No If *yes*, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If *yes*, what do you do for exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you have had surgery on your BACK and/or NECK, please fill in the following for each operation:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date**  **(or Year)** | **Type of Surgery and Surgeon** | **Pain After Surgery** | | | ***(M.D. USE ONLY)*** |
| **Worse** | **Same** | **Better** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Please circle response:**

Worker's compensation case: Yes/No.

Automobile accident: Yes/No.

Legal case pending: Yes/No.

Thinking about the **last 2 weeks** check your response to the following questions:

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | **Disagree** | **Agree** |
|  |  | 0 | 1 |
| 1 | It’s really not safe for a person with a condition like mine to be physically active | □ | □ |
| 2 | **Worrying thoughts** have been going through my mind a lot of the time in the last 2 weeks | □ | □ |
| 3 | I feel that **my problem is terrible** and that **it’s never going to get any better** | □ | □ |
| 4 | In general, in the last 2 weeks, I have **not enjoyed** all the things I used to enjoy | □ | □ |

5. Overall, how **bothersome** has your condition been in the last 2 weeks?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Not at all | Slightly | Moderately | Very much | Extremely |
| □ | □ | □ | □ | □ |
| 0 | 0 | 0 | 1 | 1 |

**OCCUPATIONAL HISTORY**

**Are you currently:** employed without restrictions  employed with restrictions unemployed

retired on disability student  worker’s compensation  homemaker

**Briefly describe your job (if applicable):**  \_\_\_\_\_\_\_\_

|  |
| --- |
|  |
|  |
|  |

1. **How satisfied are you with your job?**

Very satisfied  Satisfied  Dissatisfied

Worst job I’ve ever had  N/A

1. **Are you on or planning to apply for permanent disability such as Social Security Disability (SSDI) or other disability?** *(e.g., worker’s compensation)*

Yes  No  Not sure

1. **Is a lawyer helping you with a claim or lawsuit related to your current pain or other symptoms?**

Yes  No If *yes*, explain briefly

**SOCIAL/ENVIRONMENTAL HISTORY**

**Education:** What is your highest level of education or training?

**Marital Status:**  Single  Married/Partner  Divorced/Separated  Widowed

**Living Situation:**  Live alone  With family  With friends  Homeless  Other

**What are the ages of your children?**  No children

**Habits:**

**1. Do you smoke?**  Yes  No If *no*, did you ever smoke regularly in the past?  Yes  No

If *yes*, how many packs/day? For how many years?

If you quit smoking how long ago was that? \_\_\_\_\_\_\_\_\_\_

**2. How often do you have a drink containing alcohol?**

never  monthly or less  2-4 times a month  2-3 times a week  4 or more times a week

If you drink, how many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2  3 or 4  5 or 6  7 to 9  10 or more

**3. Do you now, or have you ever used, recreational drugs?**  Yes  No

If *yes*, which drugs have you used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often did you use them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Have you ever considered yourself a victim of physical, emotional or sexual abuse?**  Yes  No

If yes, please explain**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REVIEW OF SYSTEMS:**

**Please circle any of the following symptoms if you have noticed them in the last four weeks:**

dry mouth chills difficulty urinating shortness of breath anxiety

weight changes fever constipation heart racing low mood

sweating tiredness bloody stools difficulty sleeping

blurred vision skin rash bleeding problems

frequent falls black tarry stools difficulty staying awake

problems with balance sexual difficulties difficulty concentrating

**MEDICATIONS**: Please list all the medications or supplements you take (include prescribed, over-the–counter, and holistic) and the doses. Use a separate list, if needed.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please circle any of the medications below that you have **tried IN THE PAST.** If possible write the dose next to the circled medication.

amitriptyline (Elavil) \_\_\_\_\_\_\_

baclofen (Gablofen, Kemstro, Lioresal) \_\_\_\_\_\_\_

botulinum toxin (Botox) \_\_\_\_\_\_\_

bupenorphine (Suboxone, Butrans) \_\_\_\_\_\_\_

carbamazepine (Tegretol ,Equetro) \_\_\_\_\_\_\_

carisoprodol (Soma) \_\_\_\_\_\_\_

celecoxib (Celebrex) \_\_\_\_\_\_\_

cilatropram (Celexa) \_\_\_\_\_\_\_

codeine/acetaminophen (Tylenol 3 or 4, Co-Codamol, Codrix) \_\_\_\_\_\_\_

cyclobenzaprine (Flexeril) \_\_\_\_\_\_\_

desipramine (Norpramin)\_\_\_\_\_\_\_

desvenlafaxine (Pristiq) \_\_\_\_\_\_\_

diclofenac (Arthrotec , Zipsor) \_\_\_\_\_\_\_

diclofenac gel (Voltaren gel) \_\_\_\_\_\_

doxepin (Silenor, Zonalon, Prudoxin) \_\_\_\_\_\_\_

duloxetine (Cymbalta) \_\_\_\_\_\_\_

eletriptan (Relpax) \_\_\_\_\_\_\_

escitalopram (Lexapro) \_\_\_\_\_\_\_

etodolac (Lodine) \_\_\_\_\_\_\_

fenoprofen (Nalfon) \_\_\_\_\_\_\_

fentanyl patch ( Butrans, Lidoderm, Flector) \_\_\_\_\_\_\_

fiorinal (Fioricet) \_\_\_\_\_\_\_

fluoxetine (Prozac, Sarafem) \_\_\_\_\_\_\_

fluvoxamine (Luvox) \_\_\_\_\_\_\_

gabapentin (Neurontin, Gralise, Horizant, Fanatrex) \_\_\_\_\_\_\_

hydrocodone (Lortab,Vicodin ,Vicoprofen, Norco) \_\_\_\_\_\_\_

hydromorphone (Dilaudid, Exalgo, Palladone) \_\_\_\_\_\_\_

ketorolac (Toradol) \_\_\_\_\_\_\_

levetiracetam (Keppra) \_\_\_\_\_\_\_

lidocaine cream (Pennsaid, Ketamine) \_\_\_\_\_\_\_

meloxicam (Mobic) \_\_\_\_\_\_\_

metaxalone (Skelaxin) \_\_\_\_\_\_\_

methadone (Methadose, Diskets) \_\_\_\_\_\_\_

methocarbamol (Robaxin) \_\_\_\_\_\_\_

morphine (Kadian, Avinza, MS Contin) \_\_\_\_\_\_\_

naproxen (Aleve,Vimovo) \_\_\_\_\_\_\_

nortriptyline (Pamelor) \_\_\_\_\_\_\_

oxycodone (Oxycontin, Roxicodone, Oxecta) \_\_\_\_\_\_\_

oxycodone/acetaminophen (Endocet, Percocet, Percodan, Tylox) \_\_\_\_\_\_\_

oxymorphone (Opana, Numorphan) \_\_\_\_\_\_\_

paroxetine (Paxil) \_\_\_\_\_\_\_

pentazocine (Talwin) \_\_\_\_\_\_\_

pregabalin (Lyrica) \_\_\_\_\_\_\_

propranolol (Inderal) \_\_\_\_\_\_\_

rizatriptan (Maxalt) \_\_\_\_\_\_\_

sertraline (Zoloft) \_\_\_\_\_\_\_

sumatriptan (Imitrex) \_\_\_\_\_\_\_

tapentadol (Nucynta) \_\_\_\_\_\_\_

tizanidine (Zanaflex) \_\_\_\_\_\_\_

topiramate (Topamax) \_\_\_\_\_\_\_

tramadol (Ultram, Ultracet, ConZip, Ryzolt) \_\_\_\_\_\_\_

trazodone (Desyrel, Oleptro) \_\_\_\_\_\_\_

valproic acid (Depakote/Depakene/Depacon) \_\_\_\_\_\_\_

venlafaxine (Effexor) \_\_\_\_\_\_\_

viibryd (Vilazodone) \_\_\_\_\_\_\_

vimpat (Lacosamide) \_\_\_\_\_\_\_

zolmitriptan (Zomig)\_\_\_\_\_\_

ibuprofen (Advil, Motrin) \_\_\_\_\_\_\_

imipramine (Tofranil) \_\_\_\_\_\_\_

indomethacin (Indocin) \_\_\_\_\_\_\_

ketoprofen (Orudis) \_\_\_\_\_\_\_

**Please Don’t Forget…**



If you had X-Rays, MRI or CT scan done at a facility **other than**:

* Spectrum Health Blodgett
* Spectrum Health Butterworth
* Spectrum Health Medical Group in Grand Rapids
* Spectrum Health Urgent Care

**PLEASE obtain a CD with these images and bring it to your appointment. If you DO NOT bring your CD, your appointment WILL BE rescheduled.**

**If you have been instructed to have X-Ray imaging done prior to your appointment please arrive 1 ½ hours prior to your scheduled time.**

*Thank you!*

*Please call if you have any questions about this: 616.774.8345*

