## Michigan Pain Specialists

Patient Name: ____________________
DOB: ____________________
Age: ____________________
Gender: ____________________

### Office Visit Questionnaire

Date:
Please fill out all pages completely. This occurs at each visit. Thank you.

Prim Ins: ____________________
Sec Ins: ____________________

Patient Name: ____________________

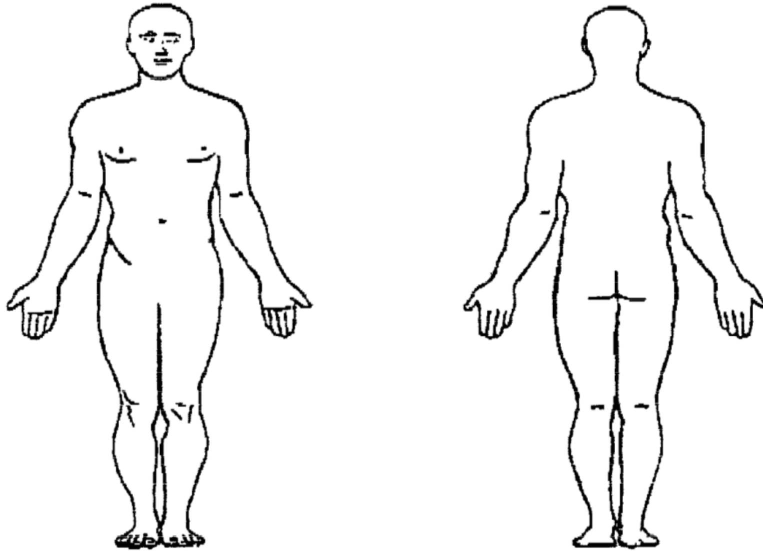
Referring Physician: ____________________

Primary Care Physician: ____________________

What is your current insurance? ____________________

Why have you come here today? ____________________

***Please show the location of your pain by drawing on the figures below:***



| | |
|---|---|
| ______ | Ankle Clonus |
| ______ | Babinski's |
| ______ | EHL Strength |
| ______ | Facet Loading |
| ______ | Gait / Toe / Heel _______ |
| ______ | Hoffman's |
| ______ | ROM ________________ |
| ______ | Sensation ____________ |
| ______ | Straight Leg Raise |
| ______ | Strength ______________ |
| ______ | Swelling / Edema |
| ______ | Tenderness ___________ |
| ______ | Diabetic Foot Exam |

Has your pain improved since your last visit? **Yes** / **No** If yes, how long did your pain improve?

____________________

What was the maximum percent improvement? ____________________%

What activities are you able to do as a result of your treatments?

____________________

____________________

Have you had any side effects from the treament(s)? NO YES Explain:

____________________

Do you have any fever, chills, or active infections? NO YES Explain:

____________________

Do you need a prescription refill today? **Yes** / **No** If Yes, what medication? ____________________

Do you need a note for missing work today? **Yes** / **No**

Do you have any questions about your insurance coverage or your account balance? **Yes** / **No** Do you have new insurance? **Yes** / **No**

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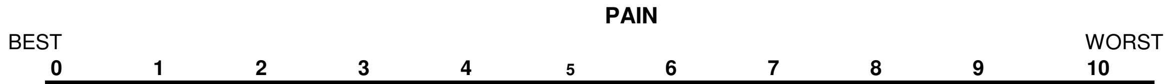
**Please mark where you are on the following scales (on average):**

**PAIN**




**Have you had any of the following problems? Please circle Yes or No.**

**Yes** / **No** Missing work because of pain
**Yes** / **No** Do you use alcohol with opioid medicines
**Yes** / **No** Involved in a lawsuit
**Yes** / **No** Do you use cocaine
**Yes** / **No** Do you use street drugs
**Yes** / **No** Do you smoke marijuana
**Yes** / **No** Arrested for drug-related crimes
**Yes** / **No** Selling your medications

**Do you take any of the following medications?**

Coumadin (warfarin)
Plavix (clopidrogrel)
Ticlid (ticlodipine)
Pletal (cilostazol)
Eliquis (apixaban)
Lovenox (enoxaparin)
Innohep (tinzaparin)
Fragmin (dalteparin)
Pradaxa
HEP SQ 5,000 Units
Aggrenox
NSAIDS
Aspirin
Trental (pentoxifylline)
Pentoxil
Xarelto (rivaroxaban)
Brilinta
Arixtra (fondaparinux)
Effient (prasugrel)
Savaysa (edoxaban)

**List ALL drugs that have CHANGED since your last visit:**

| Drug | Dose | How often do you take it? | Physician Who Ordered |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**List all Allergies:**

______________________________
______________________________
______________________________

**Have you had any tests done since your last visit (x-rays, MRI, blood tests)?** **YES** **NO**
**Please list:**

______________________________
______________________________

**SINCE YOUR LAST VISIT:**

1. **Have you been hospitalized, had any surgeries, or any illnesses?** **YES** **NO** **(If yes, please explain):**

______________________________
______________________________
______________________________

2. **Has any doctor given you any new diagnosis?** **YES** **NO** **(If yes, please explain):**

______________________________
______________________________

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**Are you diabetic?** **YES** **NO**

**Are you, or could you, be pregnant?** **YES** **NO**

**Do you have any current issues with constipation?** **YES** **NO**

____________________________
Patient Signature

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Tobacco Use (Circle Each That Apply)
Current Smoker Never Smoker
Former Smoker Other Tobacco User
Date Started:
Date Quit:

AGE __________ HEIGHT __________ WT __________

______ BP ______ SpO2 __________ Time

______ HR ______ RR

______ Temp

____________________ M.A.

**Yes** All other systems negative except those noted above.

**Yes** Imaging **films** available and reviewed.

**Yes** Imaging **report** available and reviewed.

______ (please initial) Confirmatory physical exam performed by physician

____________________________
Physician signature

I have personally reviewed this entire document.

Total time spent with patient: __________
Percent of time spent in
counseling/ coordinating care: __________

Level 2- 10 minutes
Level 3- 15 minutes
Level 4- 25 minutes
Level 5- 40 minutes