



Interventional Pain Center

At MGH

Dear Patient,

You have been referred to the Interventional Pain Center at MGH for treatment of acute and chronic pain. The center does not prescribe pain medications for pain management, but focuses on providing interventional procedures.

Under the direction of Dr. Christopher J. Mehall, a board certified Interventional Radiologist, the IPC offers comprehensive percutaneous treatment options for patients with both acute and chronic pain. Dr. Richard Vermeulen, specialty-trained in physical medicine and rehabilitation, and a long time member of the Marquette General medical staff, also evaluates patients at the Interventional Pain Center. They bring together their expertise to care for patients in a comprehensive manner, utilizing their skills and all of the resources the Marquette General Health System has to offer pain patients in Upper Michigan. The IPC is also the only pain center in Michigan to be able to perform pain procedures utilizing four different imaging options: CT, Ultrasound, Fluoroscopy, and 3-D imaging.

Some treatment options offered include the following:

- Discography
- Epidural Steroid Injections (Cervical, Thoracic, Lumbar)
- Facet Injection (Cervical, Thoracic, Lumbar)
- Intrathecal Pump Placement
- Ganglion Blocks for Chronic Oncologic Pain
- Nerve Blocks & Neurolysis Techniques
- Spine & Neural Stimulators
- Vertebroplasty/Kyphoplasty

The IPC is offered as an option for those who have pain involving the neck, back, or extremities, which is, perhaps, difficult to evaluate or control. The Interventional Pain Center is also offered as a gateway to the variety of services available to pain patients throughout the MGH system, including neurosurgery, physical medicine and rehabilitation, orthopedics, and psychiatric care.

If you have questions, please feel free to call the Interventional Pain Center at 906-225-3054 or toll free at 1-800-562-9753, extension 3054.

Sincerely,

Christopher J. Mehall, MD
Interventional Pain Center

**SUPERIOR IMAGING SPECIALISTS
PATIENT INFORMATION**

Name: _____ Birth Date: _____ Age: _____

SEX: Male Female MARITAL STATUS: Married Single Widowed Divorced Separated

Address _____ Soc. Sec. #: _____

City _____ State _____ Zip Code _____ Home Phone: _____

Employer Name: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____

RESPONSIBLE PARTY
(If other than self)

Name: _____ Relationship: _____

Address _____

City _____ State _____ Zip Code _____ Phone: _____

INSURANCE INFORMATION
(Office staff will photocopy your insurance cards)

1st Insurance: _____ Policy Holder: _____ Birth Date: _____

2nd Insurance: _____ Policy Holder: _____ Birth Date: _____

INSURANCE AUTHORIZATION/MEDICARE OR MEDICAID AUTHORIZATION

I authorize Superior Imaging Specialists to furnish information to insurance carriers concerning this illness and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

I CERTIFY that information given by me in applying for payment under Title XVIII or XIX of the Social Security Act is correct and request that said payment of authorized benefits be made on my behalf. This assignment will continue as long as I remain eligible for such benefits. I understand I am responsible for any benefit co-pays or deductibles not covered by these plans.

X _____
Signature of patient or authorized representative Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

The notice of Privacy Practices for Marquette General Health System has been made available to me for my review. I understand that I may request a copy of the notice or obtain a copy from their website at www.mgh.org at any time.

X _____
Patient/Representative Signature Date

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL



Interventional Pain Center
At MGH

NEW PATIENT QUESTIONNAIRE

Please complete and bring this questionnaire with you to your appointment. Do not mail.

Name: _____ Date: _____

Date of Birth: _____ Marital status: Single Married Divorced Widowed

Sex: _____ Age: _____ Height: _____ Weight: _____

Address: _____ Home Phone: _____

City: _____ State: _____ ZIP: _____ Work Phone: _____

Occupation: _____ Is This Visit Workers Comp. Related? YES NO

Referring Physician: _____ Phone: _____

Address: _____

Primary Care Physician (if different): _____ Phone: _____

Address: _____

How did you hear about the Interventional Pain Center?

- Friend/Family Member Website/Internet Newspaper Television
- Referring Physician Yellow pages Health Fair Other: _____

Main reason for your visit today: _____

Where is your pain located? (Select all the apply)

- NECK UPPER BACK LOWER BACK SHOULDER/ARM KNEE/HIP/FOOT WHOLE LEG

Other complaints: _____

Which pain is the worst? _____

How long have you had these symptoms? (Months/Years) _____

Briefly describe how your pain & symptoms started: _____

Can you ever find a comfortable position? YES NO

Did your symptoms follow an injury? YES NO

If yes, select one: AT WORK AUTO ACCIDENT OTHER _____

Have you missed work because of this problem? YES NO

If yes, how much? _____

When is your pain worst? (Select only one)

- NIGHT MORNING END OF DAY/SHIFT
 NO DIFFERENCE BETWEEN DAY & NIGHT ON A WET/CLOUDY DAY

Which of the following activities change the nature of your pain?

	<u>AGGRAVATES PAIN</u>	<u>RELIEVES PAIN</u>	<u>NEITHER</u>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Which of the following activities are affected by your pain the most?

- BATHING WALKING DRESSING SEXUAL FUNCTION ABILITY TO WORK
 SOCIAL/FAMILY INTERACTIONS MOOD SLEEP LEISURE ACTIVITY

Please indicate the most appropriate statement about your pain symptoms:

- My symptoms have remained the same since the time of onset.
- My symptoms are more severe since the time of onset.
- My symptoms are less severe since the time of onset.

Which of the following best describes the ratio of your back & leg or neck & arm discomfort? (If applicable)

- | | |
|--|--|
| <input type="checkbox"/> 100% Back and 0% Leg Pain | <input type="checkbox"/> 100% Neck and 0% Arm Pain |
| <input type="checkbox"/> 90% Back and 10% Leg Pain | <input type="checkbox"/> 90% Neck and 10% Arm Pain |
| <input type="checkbox"/> 75% Back and 25% Leg Pain | <input type="checkbox"/> 75% Neck and 25% Arm Pain |
| <input type="checkbox"/> 50% Back and 50% Leg Pain | <input type="checkbox"/> 50% Neck and 50% Arm Pain |
| <input type="checkbox"/> 25% Back and 75% Leg Pain | <input type="checkbox"/> 25% Neck and 75% Arm Pain |
| <input type="checkbox"/> 0% Back and 100% Leg Pain | <input type="checkbox"/> 0% Neck and 100% Arm Pain |

❖ PREVIOUS TREATMENT

Indicate each type of treatment you have previously had for your back/neck. Then, indicate the effect of that treatment.

<u>Treatment</u>	<u>Select if you have had this</u>	<u>&</u>	<u>Did it make things:</u>		
			<u>Better</u>	<u>Worse</u>	<u>No Change</u>
Anti-Inflammatory	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxant	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic Pain Medication	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pool Therapy	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Adjustments	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger Point Injections	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Injections	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet Joint Injections	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SI Joint Injections	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spine Surgery	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

❖ **PAIN CHART**

Circle your least and greatest pain levels over the past 2 weeks: (0= no pain, 10= most severe)

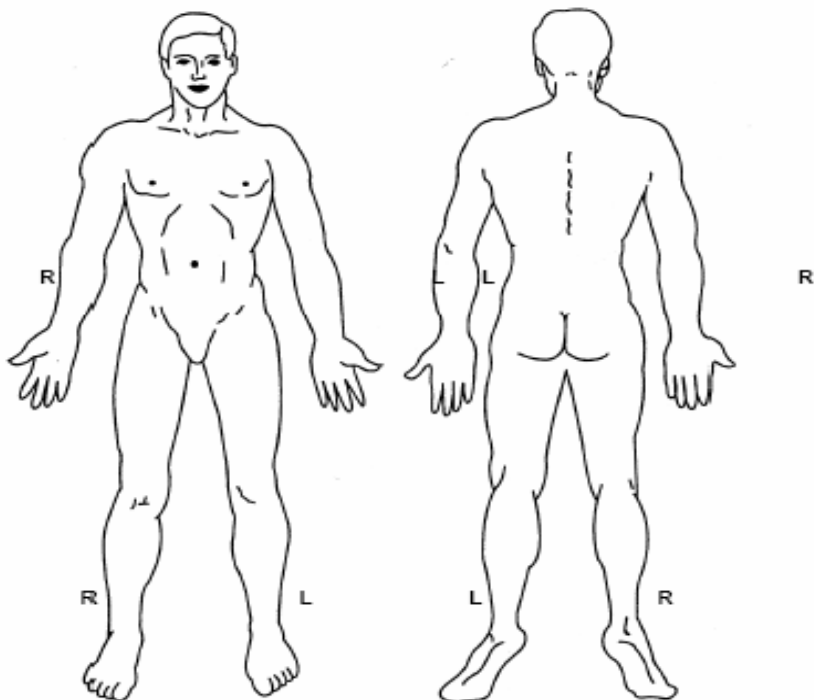
(None) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Indicate all areas of your body where you typically feel discomfort. Use the appropriate symbols indicated below on the chart provided.

Pain = X

Numbness = O

Burning = +



❖ **MEDICAL HISTORY**

Indicate if you have ever had the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Migraine/Severe Head Pain |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Problem | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Currently taking Coumadin | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Fibromyalgia/Chronic Fatigue | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Problem | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Phlebitis/Blood Clots |
| <input type="checkbox"/> Other: _____ | | |

❖ **SURGICAL HISTORY**

List all Spinal and Non-Spinal surgeries:

<u>YEAR</u>	<u>OPERATION</u>	<u>HOSPITAL LOCATION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❖ **MEDICINES**

List all medicines you have taken recently, including vitamins and non-prescription medicine.

- | | |
|----------|-----------|
| 1. _____ | 7. _____ |
| 2. _____ | 8. _____ |
| 3. _____ | 9. _____ |
| 4. _____ | 10. _____ |
| 5. _____ | 11. _____ |
| 6. _____ | 12. _____ |

How long have you been taking pain medication? (Months/Years) _____

❖ **ALLERGIES**

Check box if you have no known drug allergies.

Indicate all of your known allergies:

<u>MEDICINE/SUBSTANCE</u>	<u>TYPE OF REACTION</u>	<u>DATE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

❖ **FAMILY HISTORY**

Indicate which medical issues run in your family. Family background may be related to medical conditions. Please fill in the following chart to the best of your ability. Please include your mother, father, siblings and children.

FAMILY MEMBER	DECEASED (Y/N)	CURRENT AGE OR AGE AT DEATH	CAUSE OF DEATH	ILLNESSES
Example: Mother	No	72	Not Applicable	Diabetes

❖ **SOCIAL HISTORY**

Who lives with you at home? _____

What is your occupation? _____

Are you currently: Working Not Working Student Disabled Retired

Do you Smoke? YES NO

Amount: _____ packs per day

of years: _____

If quit, when? _____

Do you consume alcohol? YES NO

Illicit Drug Use? YES NO

If Yes: Marijuana Cocaine Heroin

❖ **REVIEW OF SYSTEMS**

Indicate what applies to you.

Constitutional

Fever YES NO
 Chills YES NO
 Night Sweats YES NO
 Weight Loss YES NO
 Loss of Appetite YES NO

Neurologic

Paralysis YES NO
 Tremors YES NO
 Spasticity YES NO
 Double Vision YES NO

HEENT

Loss of Vision YES NO
 Eye Redness YES NO
 Headaches YES NO
 Dizziness YES NO

Skin/Integumentary

Rash YES NO
 Ulcer YES NO
 Eczema YES NO

Allergy/Immune

Drug Allergy YES NO
 Seasonal Allergy YES NO
 Food Allergy YES NO

Musculoskeletal

Joint Stiffness/Pain YES NO
 Joint Swelling YES NO
 Muscle Pain YES NO
 Fatigue YES NO

GI

Heartburn YES NO
 Nausea/Vomiting YES NO
 Diarrhea YES NO
 Blood in Stool YES NO

GU

Pain Urinating YES NO
 Incontinence YES NO
 Blood in Urine YES NO

Hemo-lymphatic

Anemia YES NO
 Excessive Bleeding YES NO
 Easy Bruising YES NO

CV/Respiratory

Short of Breath YES NO
 Chest Pains YES NO
 Leg Swelling YES NO
 Palpitations YES NO

Endocrine

Thyroid Disorder YES NO
 Diabetes YES NO

Psychiatric

Poor Sleep YES NO
 Depression YES NO
 Anxiety YES NO

❖ **RADIOLOGY STUDIES**

Please list & bring films with you.

DATE

LOCATION

Spinal or Brain MRI

Spinal or Brain CT Scan

Myelogram

Bone Scan

EMG & Nerve Conduction Study
