



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. Hasnain Haider-Shah, a board certified Interventional Radiologist, fellowship-trained in neuroimaging and interventional pain techniques, 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,

A handwritten signature in black ink, appearing to be "H. Haider-Shah".

Hasnain Haider-Shah, 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: \_\_\_\_\_

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**INSURANCE INFORMATION**  
(Office staff will photocopy your insurance cards)

**1<sup>st</sup> Insurance:** \_\_\_\_\_ Policy Holder: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**2<sup>nd</sup> 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](http://www.mgh.org) at any time.

X \_\_\_\_\_  
Patient/Representative Signature      Date

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



**NEW PATIENT QUESTIONNAIRE**

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

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Record #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

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? (Select all that apply)

- Friend/Family Member
- Website/Internet
- Referring Physician
- Newspaper Ad
- Television
- Yellow pages
- 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>&amp;</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)

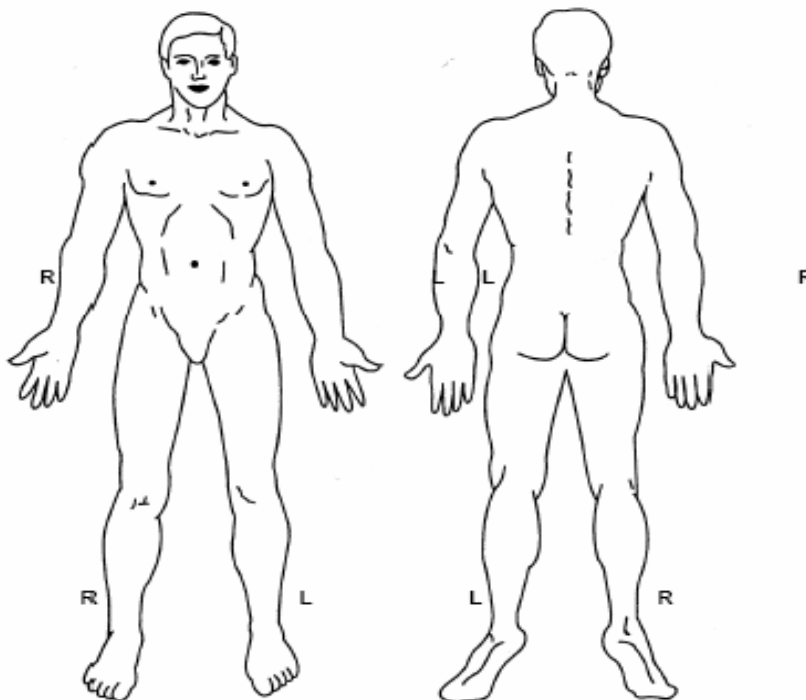
(None) 0    1    2    3    4    5    6    7    8    9    10 (Severe)

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. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

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:

- SPINAL PROBLEMS     BLEEDING DISORDERS     HEART DISEASE     CANCER     OTHER

