chronic pain Institute

Kuldip Deogun, MD
Medical Director

43145 Schoenherr • Sterling Heights, MI 48313 • Phone: (586) 997-5048 • Fax: (586) 997-5049

Welcome to our office. We are happy to have you as a new patient.
Please take a minute to fill in the spaces.

Name: _____ Date: _____

City: _____ Zip: _____

Please indicate how you heard of our office.

_____ Brochure/announcement in the mail

_____ Friend/Relative

_____ St. John Physician Referral Service

_____ Ad/Article in News Paper

_____ Yellow Pages

_____ Health insurance provider directory

_____ Referred by another Dr. _____

_____ Other

Please turn into receptionist. Thank you for your time.

Chronic Pain Institute

Patient Questionnaire

Last Name: _____ First Name: _____ Middle Initial _____

Date of Birth _____ Age_____ Social Security #: _____ Sex: _____ M _____ F

Street Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone #: _____

Cell Phone #: _____ Work Phone #: _____ Alt Phone #: _____

Primary Insurance: _____ Contract #: _____

Secondary Insurance: _____ Contract #: _____

Does your insurance require?

Preauthorization?	Yes	No
Referral from your PCP	Yes	No

If yes did you bring a copy of the referral with you Yes No

Referring Physician: _____ Phone #:_____

Address: _____

Primary Care Physician_____ Phone #:_____

Address: _____

Reason for your referral to the Institute: _____

_____

_____

Expectations of treatment: _____

_____

_____

How would you rate your overall satisfaction with the care and treatment that you have received for your pain to date?

____ Very Satisfied ____ Somewhat Satisfied ____ Barely Satisfied

____ Dissatisfied ____ Very Dissatisfied

1. Pain History

A. Where is your pain located? _____

B. When did your pain begin? _____

C. Did your pain begin: Gradually? _____ Suddenly? _____

D. Under what circumstances did your pain begin?

____ Accident at work
____ At work, but not an accident
____ Following an illness
____ Pain just began, can't relate it to anything
____ Accident at home
____ Other accident
____ Following Surgery
Other: _____

2. Past Medical History

Type	Please Circle			Do not write in this area
Cardiovascular	None	Heart Attack	Chest pain/ Angina	
	Heart failure	High Blood pressure	Arrhythmia	
	Other:			
Circulation	None	Blood clots	Phlebitis	
	Swelling	Blockage	Bleeding tend	
	Other:			
Respiratory	None	Asthma	Bronchitis	
	Pneumonia	Shortness of Breath	COPD/Emphysema	
	Other			
Gastrointestinal	None	Ulcers	Nausea/Vomiting	
	Diarrhea	Constipation	Hepatitis	
	Other			
Urinary	None	Kidney Failure	Kidney Infection	
	Bladder Infection	Other		
Neurological	Seizures	TIA	Stroke	
	Paralysis	Numbness	Head Injury	
	Other			
Musculoskeletal	Weakness	Pinched Nerve	Arthritis	
	Other			
Endocrine/Metabolic	None	Diabetes	Insulin Dependency	
	Hypoglycemia	Thyroid		
	Other			
Gynecological (Females)	Last menstrual period:			
	Pregnancy or suspicion of pregnancy			
Other	Alcohol Abuse	Drug Abuse	Depression	
	Anxiety	Tension	Family Conflict	

3. **Surgical History**
List Year and Surgical Procedure

_____

_____

4. **Medications**
List all medications, including over –the counter (non-prescription) pain medications:

A. Pain Medications (include dosage and duration)

_____

_____

_____

B. Medications (include dosage and duration)

_____

_____

_____

C. Allergies (list each medication with the type of reaction)

_____

_____

_____

5. **List all pain medication you have used in the past and their effectiveness:**

Pain medication and dose used in past	Amount of pain relieved	Problems/ Side effects

6. **Social History**

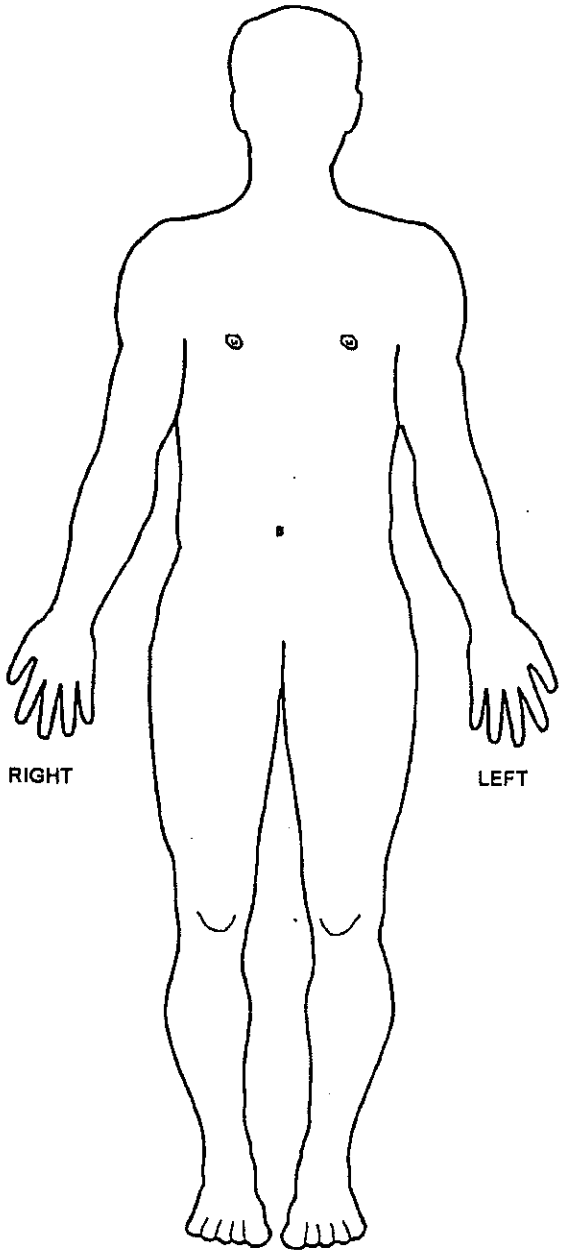
____ Smoker ____ ETOH ____ Street Drugs

7. **Previous History of:**

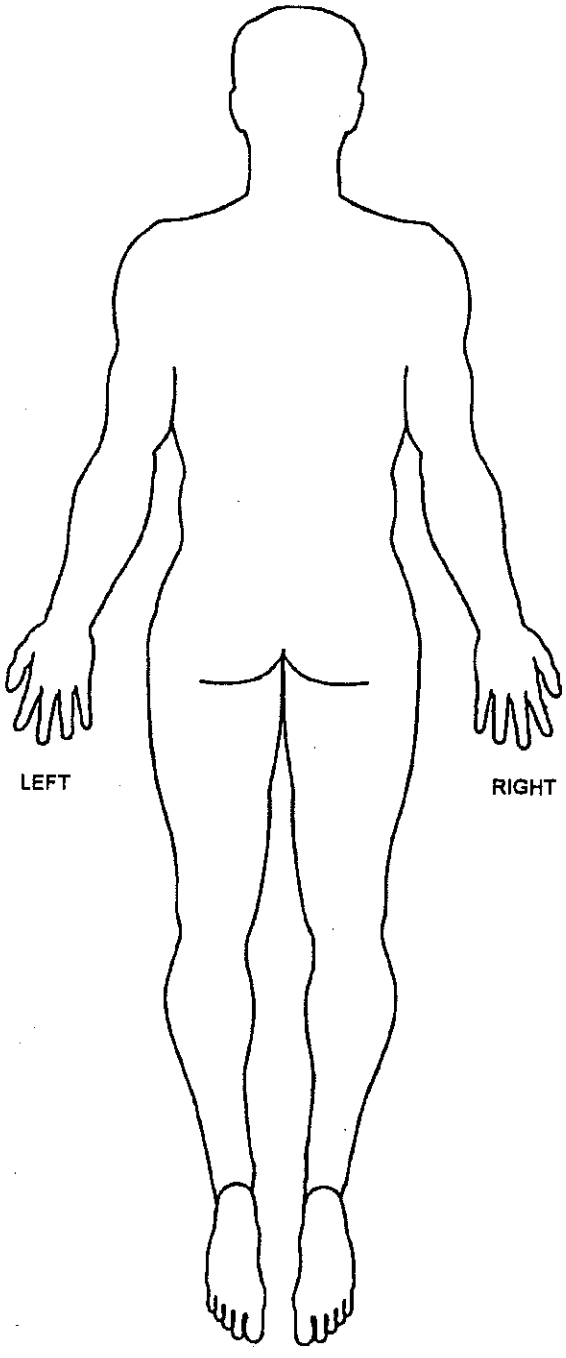
____ ETOH ____ Substance Abuse

Mark the area on your body where you feel the described sensations. Use the appropriate symbol. Mark any area of radiation. Include all affected areas.

Aching △△△ △△△ △△△ Numbness --- --- --- Pins & Needles ooo ooo ooo Burning ××× ××× ××× Stabbing ///



FRONT



BACK

8. Treatment History

Have you ever had any of the following types of treatment for your pain and what were the results?

Occupational Therapy

Body Mechanics	No	Yes	Improved	No Change	Worse
Work Hardening	No	Yes	Improved	No Change	Worse

Physical therapy

Passive (Heat, gentle massage, ultrasound)	No	Yes	Improved	No Change	Worse
Mobilizations	No	Yes	Improved	No Change	Worse
Exercises	No	Yes	Improved	No Change	Worse

Chiropractic

Manipulation	No	Yes	Improved	No Change	Worse
Modalities (heat, ultrasound)	No	Yes	Improved	No Change	Worse
Deep Tissue Massage	No	Yes	Improved	No Change	Worse
Acupuncture	No	Yes	Improved	No Change	Worse
Trigger Point Injections	No	Yes	Improved	No Change	Worse
TENS	No	Yes	Improved	No Change	Worse
Psychological/Psychiatric Counseling for Pain	No	Yes	Improved	No Change	Worse
Biofeedback	No	Yes	Improved	No Change	Worse
Pain Management Program	No	Yes	Improved	No Change	Worse
Epidural Steroid Injections	No	Yes	Improved	No Change	Worse
Nerve Blocks	No	Yes	Improved	No Change	Worse

Have you ever had any of the following to investigate your pain problem?

X-Rays	No	Yes
MRI	No	Yes
CAT Scan	No	Yes
EMG	No	Yes
Bone Scan	No	Yes
Myelogram	No	Yes

9. Employment

Current Occupation:_____

Are You Currently Employed?

____ Yes, full time ____ Yes, Full time w/ restrictions

____ Yes, Part time ____ Yes part time with restrictions

____ No, but not because of pain _____ No, unable to work because of pain ____ Retired

Are you self-employed? _____

Has your pain caused any change(s) in your work? _____

If you are not working presently, would you go back to work if you did not have a pain problem?

10. Legal Proceeding (Litigation)

Are you currently involved in a lawsuit because of your pain? _____

Have you been involved in a legal suit in the past because of your pain? _____

Are you planning to sue because of your pain? _____

11. Education

Highest level of education completed:

____ Less than 8th Grade ____ Completed 8th Grade ____ Technical Business School

____ 9th thru 12th Grade ____ High School Graduate ____ Graduate of Professional School

____ Some College ____ College Graduate

12. Current Marital Status

____ Single, never married ____ Married ____ Divorced/Separated ____ Widowed

13. Living Arrangements

With whom do you live?

____ Live Alone ____ Parents ____ Spouse/Significant Other ____ Children

____ Spouse/Significant Other and children ____ Other Relatives

____ Friends/Roommate ____ Other

14. Pain Modifiers

Indicate if any of the following increase or decrease your pain

Increase	Decrease		Increase	Decrease	
		Bright Lights			Mild exercise
		Cold			Movement
		Coughing, sneezing			No movement
		Damp			Pressure
		Distraction (TV,ect..)			Rest, Sleep
		Eating			Sitting
		Fatigue			Standing
		Heat			Stimulants (coffee, etc.)
		Housework			Tension
		Intercourse (sex)			Urinating or moving bowels
		Liquor			Vigorous exercise
		Loud noises			Walking
		Lying down			Weather changes
		Massage			Work related

chronic pain Institute

Kuldip Deogun, MD
Medical Director

43145 Schoenherr • Sterling Heights, MI 48313 • Phone: (586) 997-5048 • Fax: (586) 997-5049

Patient Demographics

Name: _____

Address: _____

City, State & Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Date of Birth: _____

Social Security Number: _____

Emergency Contact Number (not living in same household): _____

Name & Relation: _____

Insurance Information

Primary Ins: _____

Contract: _____

Group: _____

Secondary Ins: _____

Contract: _____

Group: _____

Guarantor Profile (name insurance is under)

Name: _____

Relationship: _____

Employer: _____

Date of Birth: _____

Referring Physician

Referring Physician: _____

Street Address: _____

City, State & Zip: _____

Phone: _____

Fax: _____