Chronic Pain Relief
of Brighton
810-225-7246

Patient Information

Date: _____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____City_____State_____Zip _____

Phone # (Cell)_____ (H) _____ (W) _____

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor
Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other _____
Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Emergency contact: Name: _____ Relation: _____ Phone #: _____

How did you hear about our practice? _____

Health Information

Please tell us what brings you in today?_____

Check off any of the following symptoms you have experienced in the past 6 months:

- ❒ Low Back Pain
- ❒ Pain Between Shoulder Blades
- ❒ Neck Pain
- ❒ Tension Headaches
- ❒ Fibromyalgia
- ❒ Tension Across Top of Shoulders
- ❒ Numbness/Tingling in Arms/Hands
- ❒ Numbness/Tingling in Legs/Feet
- ❒ Pain in Legs
- ❒ Pain in Feet
- ❒ Tired/Fatigued
- ❒ Difficulty Sleeping
- ❒ Allergies
- ❒ Digestive Problems
- ❒ Carpal Tunnel

Other (explain)

_____

Which of the above is the worst? _____

How long have you had it? _____How often does it occur? _____

What does it feel like? (describe) _____

_____

What activities would you like to do if you did not have this problem?

_____

Does this cause you to be: Does this affect your work: Does this affect your life:

- ❒ Moody
- ❒ Irritable
- ❒ Interrupt sleep
- ❒ Restrict your daily activities
- ❒ Interferes with work
- ❒ Lose patience with spouse/children
- ❒ Restricted household activities
- ❒ Decrease productivity
- ❒ Exhausted at end of the day
- ❒ Find yourself sitting/resting more
- ❒ Decision making
- ❒ Poor attitude
- ❒ Hinders exercise
- ❒ Unable to do hobbies
- ❒ Unable to work long hours

What have you tried to help relieve/get rid of this problem and how much did it help? (circle one)

- ♦ Medications helped: Little Some Much
- ♦ Physical Therapy helped: Little Some Much
- ♦ Chiropractic helped: Little Some Much
- ♦ Exercise helped: Little Some Much
- ♦ Nutrition helped: Little Some Much
- ♦ Stretching helped: Little Some Much

Other (explain)

_____

_____

Are you currently under medical care? ❑ Yes ❑ No

Who is your primary care Doctor? _____

*Please list all medications: (**Be sure to include dosage and frequency**)* _____

_____

_____

_____

Are you on any **anti-inflammatory meds**? (Aleve, Naproxen, Motrin, Ibuprofen, Celebrex, Meloxicam, Mobic, Voltaren, Diclofenac)
Other: _____

Do you take **blood thinners** (Coumadin, Plavix, Asprin, Xarelto, Eliquis, Pradaxa)? _____

Supplements (vitamins/herbs/minerals): _____

Allergies: _____

WOMEN ONLY: Date of LMP:_____ ***Any possibility of pregnancy: YES or NO***

Surgical History: (Please note ALL joint replacement surgeries!) _____

_____

_____

Family History: Is there a family history of any of the following conditions? (Indicate parents, grandparents, children, & siblings)

❑ Heart Disease_____ ❑ Diabetes _____
❑ Cancer _____ ❑ Arthritis _____
❑ Other _____

Social History:
Intake of following:
Cigarettes _____ packs/day Alcohol _____drinks/week
Caffeine _____ cups/day

Exercise frequency: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Please check to indicate if you are currently or have ever experienced any of the following conditions:

Medical

- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ **Diabetes**
- ❑ Asthma
- ❑ Bronchitis
- ❑ **Cancer**
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Hepatitis
- ❑ Kidney Disease
- ❑ Loss of Memory
- ❑ Measles
- ❑ Mononucleosis
- ❑ Nausea
- ❑ Pneumonia
- ❑ Polio
- ❑ Psychiatric Care
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Tuberculosis
- ❑ **Tumors/Growths**

Please list all medical conditions NOT Listed elsewhere on this form:

_____

_____

_____

_____

_____

_____

Metabolic/Nutritional

- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis
- ❑ Cold Sores
- ❑ **Bleeding Disorders**
- ❑ Constipation
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Bulimia
- ❑ Cold Feet/Hands
- ❑ Dizziness
- ❑ Fatigue
- ❑ Goiter
- ❑ Weight gain
- ❑ Gout
- ❑ Hair Loss
- ❑ Headaches
- ❑ Insomnia
- ❑ Liver Disease
- ❑ Light Bothers Eyes
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
- ❑ Sudden Weight Loss
- ❑ Ulcers
- ❑ Food cravings
- ❑ Vitamin D deficiency
- ❑ Abdominal Pain

Physical

- ❑ Arthritis
- ❑ Neck Pain/Stiffness
- ❑ Mid Back pain/stiffness
- ❑ Low Back pain/stiffness
- ❑ Sciatica
- ❑ Hip pain
- ❑ Knee pain
- ❑ Foot pain
- ❑ Numbness/tingling
- ❑ Wrist pain
- ❑ Shoulder pain

Hormonal

- ❑ Depression
- ❑ Low Body Temp
- ❑ Migraines
- ❑ Miscarriage
- ❑ Nervousness
- ❑ Osteoporosis
- ❑ Prostate Problems
- ❑ **Breast Lump**
- ❑ Suicide Attempt
- ❑ Vaginal Infections
- ❑ Low libido
- ❑ Oral contraceptive use
- ❑ Thyroid Problems

Cardiology

- ❑ Ankle Swelling
- ❑ Arm/Hand Pain
- ❑ Cold Sweats
- ❑ Chest Pain
- ❑ Fainting
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ **Pacemaker**
- ❑ Varicose Veins
- ❑ Carotid artery blockage
- ❑ Palpitations
- ❑ Shortness of Breath
- ❑ Low magnesium
- ❑ Low potassium
- ❑ Stroke
- ❑ Anemia

- ❑ Diabetes
- ❑ PCOS
- ❑ Fibroids
- ❑ Breast Cancer
- ❑ Prostate cancer
- ❑ Triglycerides >300

Additional Notes:

I acknowledge that all answers regarding my current and past health history are true and that I am of sound mind and body while filling out this form.

Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Superior Healthcare, LLC (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
Signature of Patient/Guardian Date
X_____ _____
Witness (Office Staff) Date

Informed Consent to Examination Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan. We also do not prescribe or refill ANY controlled substances. All prescriptions should be refilled by your original prescriber and any new prescriptions should be issued by your primary care provider.

The patient assumes all responsibility/liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration in the state of Michigan under the current malpractice terms which can be obtained by written request.

Due to the nature of the examination, any and all copies of x-rays requested by the patient will be provided after personal payment of full charges for the area(s) requested, for a processing fee.

A scanned copy will replace an original copy.

Sign here: X_____I have read and understand the above consent form.