NorthStar Rehab + Pain Clinics

Dear Patients,

Thank you for choosing NorthStar Rehab + Pain Clinics. We look forward to helping you through your recovery. To help us meet this goal please bring the following to your first visit:

- Health Insurance Card/Information with referral if needed
- State licensed photo ID or passport
- A list of all medications you are taking
- A list of your treating physicians including phone numbers
- A copy of your MRI / XRAYS / CT scan reports with the films on CD
- A record of your previous treatments
- Complete the forms below
- Complete Consent forms found on Website/Patient Portal
- Worker's Comp Information if applicable
- Auto Injury related paperwork including legal representation if applicable

Please arrive at least 10 minutes prior to your scheduled visit. If you have any additional questions, please contact our office at (616) 729-7290.

Free Parking is available on the premises.

Anjum S. Khan, MD

PATIENT INFORMATION

Patient Name _____ Date of Birth ____/____/_____
Street Address _____ City, State _____ Zip _____
Home Phone **( )** _____ Work **( )** _____ Cell **( )** _____
Email Address _____
Social Security Number _____ **-** _____**-**_____
Patient Sex: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

In case of Emergency, please contact:
Name _____ Phone**:** _____
Relationship to Patient _____

Referring Physician _____ Phone: _____
Primary Care Physician _____ Phone: _____

How did you hear about NorthStar Rehab + Pain, PLLC?

☐ Family/Friend _____ ☐ Physician
☐ Insurance ☐Website _____ ☐Other _____

INSURANCE INFORMATION

Primary Insurance _____ ID# _____

Insured's Name: _____ Relation to Patient _____ Date of Birth: ___/___/____

Secondary Insurance _____ ID# _____
Insured's Name: _____ Relation to Patient _____ Date of Birth: ___/___/____
Person Responsible for any balances _____
Address (If different from patient) _____

WORMAN'S COMP/LIABILITY

If today's exam applies to a Workman's Comp case or Liability case, please fill this section out in its entirety.

WORKMAN'S COMP:
Date of Injury _____/_____/_____ Claim # _____ Contact _____
Employer _____ Phone # _____
Address _____ City _____ State _____ Zip _____
W/C Insurance _____ Phone # _____
Address _____ City _____ State _____ Zip _____

LIABILITY:
Attorney Name _____ Phone # _____ Date of Injury ____/____/_____
Address _____ City _____ State _____ Zip _____

INITIAL EVALUATION FORM

On the picture below, mark the areas on your body where you are currently experiencing pain or other symptoms.

How would you describe your pain?

☐ Aching ☐ Numbness ☐ Pins and Needles ☐ Burning ☐ Stabbing ☐ Other _____

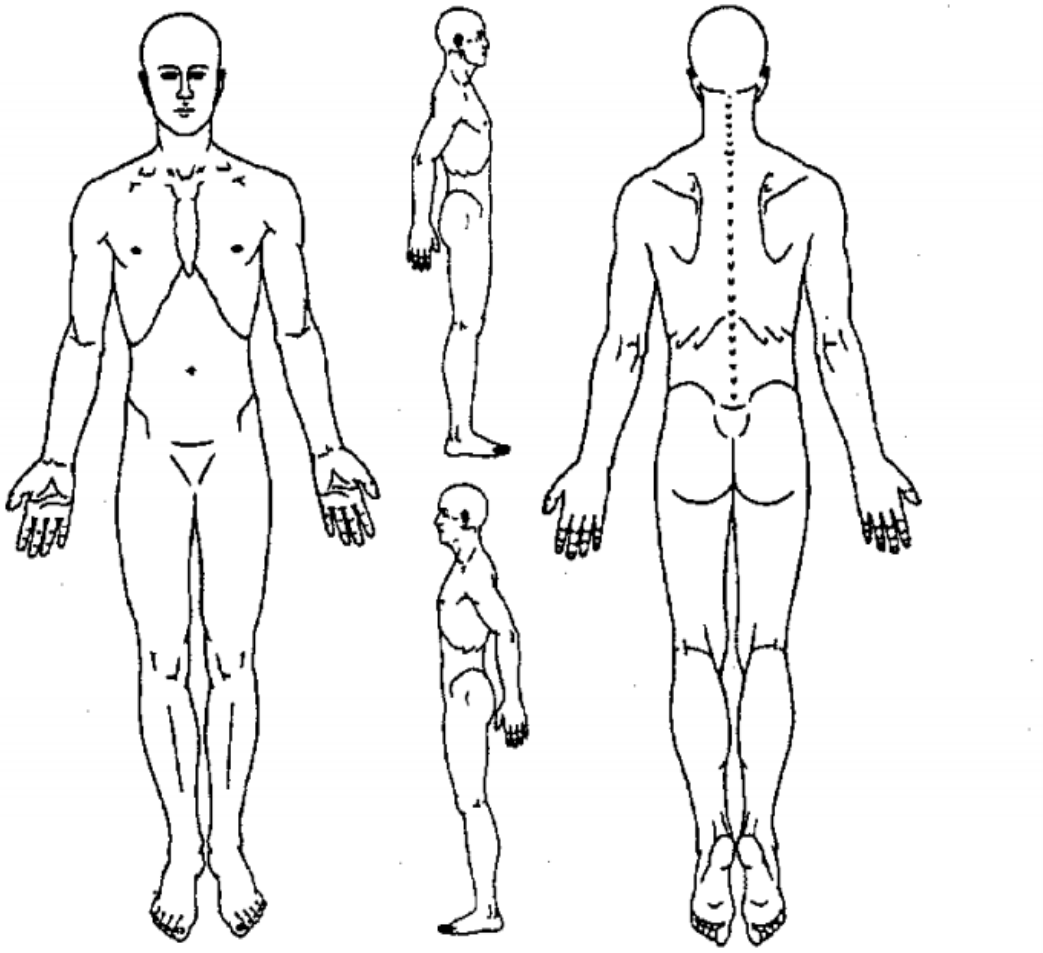
Approximately when did your pain start? _____

Is your pain a result of an injury? ☐ **Yes** ☐ **No** If yes. What was the date of injury? ____/____/____

Please explain:

_____

Pain is: ☐ Constant ☐ Intermittent



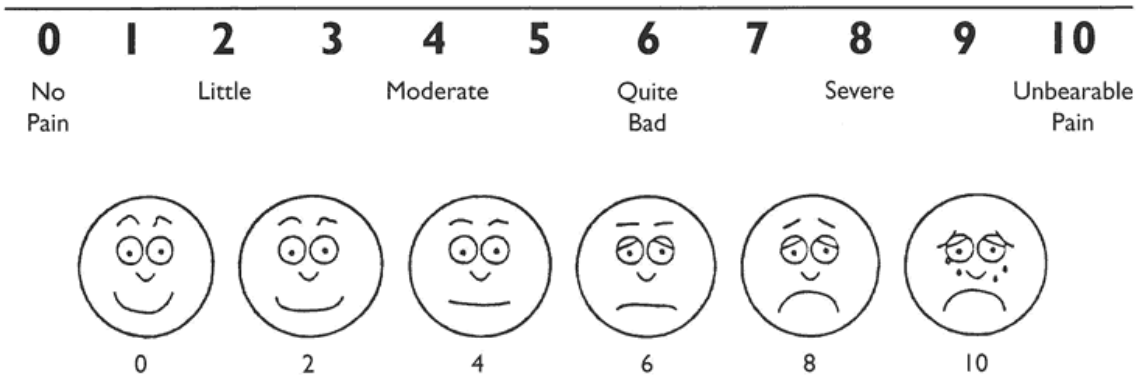
What increases your pain? _____

What decreases your pain? _____

Has your pain gotten worse with time? ☐ **Yes** ☐ **No**
Do you have difficulty sleeping because of the pain? ☐ **Yes** ☐ **No**

Do you have any bowl or bladder problems? ☐ **Yes** ☐ **No**

Using the pain scale below, **rate your pain.**



As of today, what have you done to help relieve your pain? (Check all that apply.)

☐ Physical Therapy ☐ Chiropractor ☐ Massage Therapy ☐ Medications

☐ TENS Unit ☐ Ice ☐ Heat ☐ Other:

Have you seen any pain physician for this problem in the past?

☐ **Yes** ☐ **No**

Name: _____

Have you ever had spine surgery?

☐ **Yes** ☐ **No**

If yes, what is the name of the surgery? _____
Have you ever had epidural steroid injections? ☐ **Yes** ☐ **No**
If yes, did it help? ☐ **Yes** ☐ **No**
Are you currently taking any blood thinners? ☐ **Yes** ☐ **No**

MEDICAL HISTORY

Do you have any of the following medical conditions? Please check all that apply.

☐ High blood pressure	☐ Liver disease	☐ Thyroid disease
☐ Bleeding problems	☐ Rheumatoid Arthritis	☐ Any contagious disease
☐ Kidney disease	☐ Cancer	☐ Stomach ulcers
☐ Seizure disorder	☐ Asthma	☐ Suppressed immunity
☐ Diabetes	☐ Heart disease	☐ Chest pain
☐ COPD	☐ Other:	

Please explain any of the above YES, or any other medical problems you may have:

_____

Please list all drug ***allergies***: _____

Please list all previous ***surgeries with corresponding dates (MM/YY)***:

_____

_____

_____

_____

Please list all pain medications you are currently taking:

_____

_____

_____

_____

Please list all other medications you are currently taking:

_____

_____

_____

_____

FAMILY HISTORY

Please list all medical illnesses or conditions in your family, if any:

_____

_____

_____

_____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No
If yes, how long have you smoked? _____ How much do you smoke per week? _____

Do you drink alcohol? ☐ None ☐ Rarely ☐ Socially

Do you have a social history of drug or alcohol abuse? ☐ Yes ☐ No
Drinks/Week: _____

With whom do you live? ☐ Alone ☐ Spouse/children ☐ Roommates

☐ Other: _____

Occupation _____ Name of Employer _____

VERIFICATION OF INFORMATION

I verify that the above information is true and accurate to the best of my knowledge.

_____ _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE ***DATE***

_____

RELATIONSHIP TO PATIENT