

Michigan Pain Specialists

(734) 995-7246
3520 Green Court, Suite 100
Ann Arbor, MI 48105

Patient Name:
DOB:
Age:
Gender:

Treatment Return

Date:
Please fill out all pages completely. This occurs at each visit. Thank you.

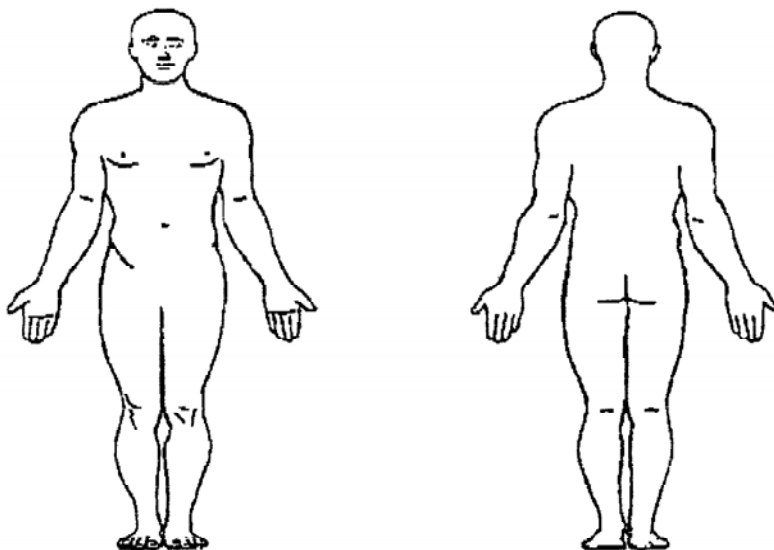
Patient Name: _____

Referring Physician: _____

Primary Care Physician: _____

What is your current insurance? _____

Please show the location of your pain by drawing on the figures below:



Has your pain improved since your last visit? **Yes / No** If yes, how long did your pain improve?

What was the maximum percent improvement? _____ %

What activities are you able to do as a result of your treatments?

Have you had any side effects from the treatment(s)? NO YES Explain:

Do you have any fever, chills, or active infections? NO YES Explain:

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Please mark where you are on the following scales (on average):

AVERAGE PAIN

BEST 0 1 2 3 4 5 6 7 8 9 WORST 10

PAIN TODAY

BEST 0 1 2 3 4 5 6 7 8 9 WORST 10

Do you take any of the following medications?

- | | | |
|---|---|---|
| <input type="checkbox"/> Coumadin (warfarin) | <input type="checkbox"/> Lovenox (enoxaparin) | <input type="checkbox"/> Aggrenox |
| <input type="checkbox"/> Plavix (clopidogrel) | <input type="checkbox"/> Innohep (tinzaparin) | <input type="checkbox"/> NSAIDS |
| <input type="checkbox"/> Ticlid (ticlodipine) | <input type="checkbox"/> Fragmin (dalteparin) | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Pletal (cilostazol) | | <input type="checkbox"/> Trental (pentoxifylline) |

List ALL drugs that have CHANGED, and how they have changed, since your last visit:

Drug	Dose	How often do you take it?	Physician Who Ordered

List all Allergies:

Are you, or could you, be pregnant? YES NO

Name of Driver _____ Patient signature _____

_____ I have personally reviewed this entire document.
Physician signature