Wellness Physical Medicine Center
43650 Garfield Rd.
Clinton Township, MI 48038
(586) 263-0820

Name: _____ Age: _____ Hand you write with: _____
Occupation: _____ Employer: _____
Date of Injury: _____ Last Date Worked: _____
Years employed: _____ Activities you engage in: _____
Married: _____ Divorced: _____ Single: _____

Chief Complaint: (The reason for your office visit)

What are your symptoms:

How severe & often are your symptoms: (Example: unbearable, every day 5-6 times a day, can't sleep, can't work)

When did your symptoms start? How frequently do symptoms arise? When does it mostly happen? Is it better or worse now?

Aggravating & Alleviating Factors: What makes it better? What makes it worse?

Treatment: What medications have you tried or what treatments have been done?

Special Tests: (Example: CT scan/MRI, EMG)

I hereby certify that the above information is correct to the best of my knowledge.

Signature: _____ Date: _____

# PATIENT HISTORY QUESTIONNAIRE

DATE: _____

PATIENT NAME: _____ DOB: _____

CHIEF COMPLAINT:

_____

_____

1. What medications are you currently taking?

   _____

   _____

2. Have you had any surgeries in the past?

   _____

   _____

3. Do you have any medical conditions? (Example: Hypertension, Diabetes)

   _____

   _____

4. Do you have any allergies to any medications? What happens?

   _____

   _____

5. Do you drink alcohol? How much/often? _____

6. Do you smoke or have you previously smoked?

   _____

7. Do you currently use any tobacco or vape products? How much/often?

   _____

8. Are you currently taking or have you previously taken any illicit drugs?

   _____

**FAMILY HISTORY (First degree relatives parents, siblings only)**

9. Are your parents living or deceased? If deceased, what was the cause of death?

   _____

   _____

Wellness Physical
Medicine Center

# RELEASE OF INFORMATION

Each time you are seen by a medical professional, a written report is generated detailing your visit and treatment recommendations. We need your signed authorization to release medical information. Please complete the information below.

1. Who referred you to our office? Please note, if this area is completed, a written report MUST be sent.

   Name:_____

   Address:_____

   _____

   Phone:_____

2. Do you have a primary care (family) physician?

   Name:_____

   Address:_____

   _____

   Phone:_____

3. Can we speak to family members/other individuals regarding your medical condition? Yes_____

   No_____

   Name:_____Relationship:_____

   Name:_____Relationship:_____

4. By initialing here, you do **NOT** want medical information released to anyone _____

*PLEASE NOTE: By law, we must send our reports to Workers Compensation or Auto Insurance carriers if your care is related to a work or auto injury*

I, confirm all information listed on this sheet is correct to the best of my knowledge. This authorization will stay in effect until revoked by myself.

_____ _____

Print Name Date

_____ _____

Patient Signature Date

_____ _____

Witness Date

Wellness Pain
Medicine Center

# Patient Contract for Treatment of Chronic Pain
# Using
# Controlled: Substance Medications

This document is about your use of controlled substance medications prescribed by your physician to help relieve pain and improve function. Most patients who use these drugs find them very helpful and use them without problems. These medications cannot completely relieve pain, but allow patients to become more functional and improve the quality of their life.

This document is to help you understand our medication policies (affected by state laws) and your part in the pain management team.

**By signing below, you acknowledge that you have read and understand the following guidelines on the reverse side. For your best results and safety, you agree to follow the guidelines and understand that failure to follow these guidelines can result in discontinuance of medications. These guidelines apply to opioid pain medicines, some anti-anxiety medications and some tranquilizers.**

_____ _____

Patient Signature Date/Time

_____ _____

Provider/Representative Signature Date/Time

## PATIENT CONTRACT FOR TREATMENT OF CHRONIC PAIN AND USING CONTROLLED SUBSTANCE MEDICATIONS

1. You are responsible for your medications. You are expected to take them only as prescribed by your provider. Please communicate any questions or concerns, such as side effects to your physician or physician extender.
2. You should not obtain medications from other doctors, or pharmacies unless you are a patient in the hospital. You should tell any hospital, or emergency room doctors, as well as your dentist, that you receive these pain medications from us. These guidelines are designed to protect you from the danger of receiving too much medication.
3. You may not change your medication without first getting your provider's permission. Changing the dose without permission may endanger your health. Your provider will get you instructions about what to do if the office is not open when you need advice.
4. You are expected to make sure that your prescriptions are filled on time. You will be given enough medication to last a fixed amount of time, usually 30 days. Refill can only be given during regular office hours, in person, or during a scheduled visit. To avoid interruption in your medications, please schedule regular appointments for medication refill. Make sure that you schedule each appointment far enough in advance to avoid running out of medications. Prescriptions cannot be filled early. Prescriptions will not be sent by mail, faxed, or filled by telephone request.
5. Keep your pain medications in a safe and secure place. We advise you to keep them in a locked cabinet or safe. You are expected to protect your medications from loss or theft. Stolen medications should be reported to the police and to your provider immediately. If your medications are lost, misplaced, or stolen, your provider may choose to taper and discontinue the medications.
6. You may not give or sell your medications to any other person under any circumstances. If you do so, you may endanger that person's health. It is also against the law.
7. You should not use alcohol, or illegal drugs while taking these medications. You should not use sleeping pills, cold medicines, or other medications that might cause drowsiness, dizziness, or changes in thinking unless you first discuss it with your provider.
8. You should not drive or operate heavy machinery, or drive an automobile if you feel tired, mentally foggy, or are experiencing other side effects from your medications. It is your responsibility to keep yourself and others from harm.
9. It is sometimes necessary for your provider to check your medication levels. At such times, you may be asked to provide blood and/or urine specimens for testing.
10. Your medications are only a portion of a larger treatment plan. We ask that you participate fully in treatment and follow your providers' advice regarding physical therapy, psychotherapy, vocational rehabilitation, counseling, other medications, or other prescribed or recommended treatment.
11. So that your other doctors understand and can help with your treatment, we ask that you let your provider contact other providers and pharmacists about your use of medications.
12. These medications are very helpful to many patients, but are not right for everybody. It is sometimes necessary for a provider to stop prescribing these medications for a patient. Your provider might choose to taper and discontinue your medications if:
    - The treatment is not helpful
    - The treatment loses its effectiveness
    - You have serious side effects from the medication
    - You become less able to function physically, socially, or emotionally as a result of the treatment
    - You are unable to follow the other guidelines listed in this document
13. If your mediation must be stopped for any reason, your provider will taper you off the medication (slowly decrease the dose) in a controlled fashion to avoid withdrawal symptoms. Suddenly stopping the medications can produce flu-like symptoms such as nausea, vomiting, diarrhea, aches, sweating, and chills occurring within 24-48 hours of the last dose.
14. For Women Only: Your use of these medications may adversely affect a fetus if you are pregnant, or a child, if you are breastfeeding. If you are pregnant, or breast feeding now, or if you are considering becoming pregnant, you should discuss your use of these (and any other) medications with your primary provider, or obstetrician.
15. I understand that there is a small risk that opioid addiction could occur. This means that I might become psychologically dependent on the medication, using it to change my mood, get high, or be unable to control my use of it. People with a past history of alcohol, or drug abuse problems are more susceptible to addiction. If this occurs, the medication will be discontinued and I will be referred to a drug treatment program for help with this problem.

Thank you. We look forward to working with you to help relieve your pain and improve your function

Wellness Physical Medicine Center

**Wellness Physical Medicine Center**
**Patients' Right to Privacy**

This notice describes how medical information about you may be disclosed and how you obtain access to the information. Please review it carefully. It is the right of this office to change this policy at any time as long as the changes are in accordance with applicable laws. If you receive this notice via website or by email, you are also entitled to receive this notice in written form from our office.

**Healthcare Privacy:**
Each time you visit a hospital, physician or other healthcare providers, a written electronic record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment and a plan for future care or treatment. Protecting your privacy is very important to us. All of our patients have the right to considerate and respectful care.

**Privacy Practices for Protected Health Information:**
The provision of high-quality healthcare requires the exchange of personal, often sensitive information between an individual and a skilled practitioner. Vital to that interaction is the patients' ability to trust the information shared will be protected and kept confidential.

**Consent Agreement:**
Providing "Consent" allows for the use and disclosure of protected health information only for treatment, payment and healthcare operations.
As part of your healthcare, we originate and maintain health records describing your health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment.

**This information is a Basis For:**

- Planning a future care or treatment
- A means of communication among many health professionals who contribute to your care
- A source of information for applying your diagnosis and medical information to your bill
- A means by which a third-party payer can verify that services were billed were actually provided
- A tool routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

**Your Health Information Rights:**

Although your health record is the physical property of the healthcare practitioner in the facility that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of our information
- Obtain a paper copy of this notice upon request
- Inspect a copy of your health record
- Request to amend your health record
- Obtain an accounting of disclosures
- Request communication of your health information by alternative locations
- Revoke your authorization to use or disclose health information except to the extent action has already been taken
- Receive notification if ever there is a breach of unsecured public health information

**You have the right to:**

- Take part in decisions about your care. Before agreeing to any treatment, your doctor will tell you about your plan of care in terms you can understand
- Refuse further medical care. If you make this decision, it is important that you understand the risks and how it can affect your health. If you refuse care, you become responsible for your future health outcome. If you and your doctor cannot agree about your care, which meets ethical and professional standards, you may be asked to seek treatment elsewhere.

Wellness Physical
Medicine Center

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE HEALTHCARE INFORMATION DISCLOSURE

**Wellness Physical Medicine Center**

By signing below, I acknowledge that I have received a notice of privacy practices from: Wellness Physical Medicine Center.

I consent (the above named organization) to disclose and receive pharmacy clearinghouse healthcare information. This request is effective until revoked by the beneficiary.

Wellness Physical Medicine Center have consent through routine use and disclosure of health records whether communicated electronically, on paper, or orally.

_____ _____

Printed Name of Patient: Date:

_____ _____

Signature of Patient: Date:

_____ _____

Witness (Staff Member) Date: