WELCOME NEW PATIENT!

*PLEASE COMPLETE THE ATTACHED FORMS AND BRING THEM TO YOUR APPOINTMENT ALONG WITH ANY IMAGING DISKS

(MRI/CT Scan/EMG/Ultrasound/Xray).

*THIS PACKET MUST BE COMPLETED IN FULL PRIOR TO YOUR SCHEDULED APPOINTMENT OR YOU WILL BE RESCHEDULED.

*PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR APPOINTMENT TIME.

THANK YOU

Matthew Vasko, M.D. **Michael Sikorsky, D.O.** **Room #_____**

Name_____ _____

Address_____City/State_____Zip Code_____

Home (_____)-_____ Cell (_____)-_____ Consent to text? ____yes _ ___no

Social Security #_____ Date of Birth _____

Pharmacy Name _____Pharmacy Phone #_____

Email Address_____ Marital Status _____

Referring Physician_____

Primary Care Physician_____

Preferred Language _____

Ethnicity _____Hispanic/Latino _____ NOT Hispanic/Latino _____ Decline to report

Race _____ Asian _____Native Hawaiian _____Other Pacific Islander _____ Black/African American

_____ American Indian/Alaskan Native _____White _____Decline to report

Emergency Contact _____Relationship_____Telephone (_____) _____

Insurance Policy Holder & Date of birth_____

Occupation_____ Employer_____

YES/NO Auto Accident - State occurred _____ Auto Insurance_____Date of Accident___/___/_____

Case Worker Name, phone & fax _____ Injured body part_____

YES/NO Workers Comp *Employer-*Required to process claims*_____

YES/NO Other Accident _____

YES/NO Other Responsible Party _____

I hereby assign my insurance benefits to be paid directly to the physician and understand that I am financially responsible for all non-covered services, copays, deductibles and co-insurances. I authorize and give consent for my provider to bill me directly for recommended services performed but not covered under the terms of my health plan, I authorize the physician to release any medical information required to process this claim. I authorize my provider's office to contact me by telephone to remind me of my appointments. A fee for no shows may apply. I authorize St John to download my current medications for purposes of insurance payment. I have received a notice of Privacy Practice, Patient Rights and Responsibility and Notice of Financial policy.

You must have your insurance cards and picture identification or you will be asked to reschedule your appointment.

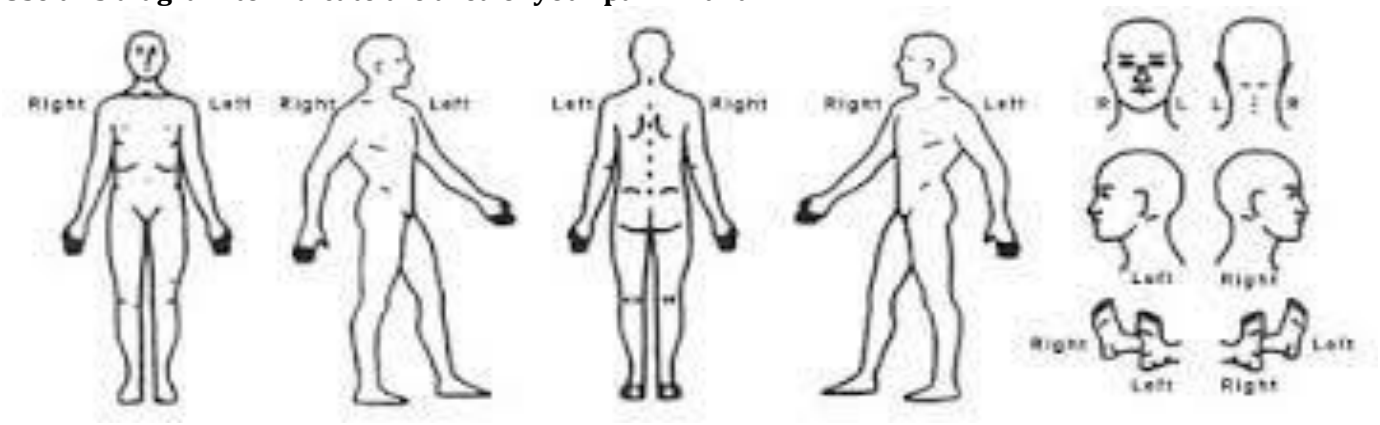
Sign_____ Date_____

Blue Water Pain Specialists **21000 12 Mile Rd, Suite 100, St Clair Shores, MI 48081**
46591 Romeo Plank Rd, Suite 137, Macomb, MI 48044

Matthew Vasko, M.D. **Michael Sikorsky, D.O.** **Room #_____**

NAME_____ Date_____

Use this diagram to indicate the area of your pain with an "X".



Please circle any of the following that describe the quality of your pain:

Throbbing Tightness Numbness Burning Aching Cramping Sharp Dull Tingling

Please rate the severity of your pain: Worst _____/10 Currently_____/10

Please circle any of the following that apply to your pain:

It is improving It is getting worse It interferes with sleep It interferes with work

Please circle any of the following that apply to your pain:

Constant Intermittent Gradual onset Sudden onset

How long ago did your pain start? _____

What caused your pain? _____

Was this related to a work or auto accident? ☐ NO ☐ YES **If yes, please indicate:** Auto Work

Please circle any of the following that help your pain feel better:

Nothing helps Heat Ice Medication Sitting Standing Stretching Position change
Rest Lying down Chiropractic care ESI Physical Therapy

Please circle any of the following that make your pain worse:

I'm not sure Extension Flexion Carrying Twisting Lifting Getting out of bed
Going from sit to stand Sitting Standing Walking Lying down

Please circle any of the following if you have experienced the symptoms:

Weakness Numbness Bladder compromise Bowel compromise

Blue Water Pain Specialists **21000 12 Mile Rd, Suite 100, St Clair Shores, MI 48081**
46591 Romeo Plank Rd, Suite 137, Macomb, MI 48044

Matthew Vasko, M.D. **Michael Sikorsky, D.O.** **Room #_____**

NAME_____ Date_____

Are you able to perform your normal daily living activities without assistance? Yes / No

If yes, please circle the following that apply:

Limited Unlimited With symptoms With deficit / compensation

Have you had any of the following imaging procedures?

X-rays CT Scan Discogram MRI Myelogram EMG Bone Scan Other _____

If you've had an EMG: Normal Peripheral Neuropathy Radiculopathy No recent EMG

Have you had any of the following surgeries? Discectomy Fusion Laminectomy Other _____

Have you had physical therapy? Yes / No **If yes, did it help?** Yes / No

Have you had any chiropractic care? Yes / No **If yes, did it help?** Yes / No

Have you had any of the following injections? Yes / No **If yes, did it help?** Yes / No

Epidural Trigger Point SI joint Facet injection Other _____

Please circle any of the following medications you have previously tried for pain:

Opioids/Narcotics: Morphine OxyContin Percocet Norco Vicodin Methadone Dilaudid Suboxone Fentanyl Tramadol Other_____

NSAID's (anti-inflammatory): Ibuprofen Aleve Tylenol Aspirin Celebrex Mobic Other_____

Muscle Relaxers: Skelaxin Soma Zanaflex Flexeril Robaxin Valium Baclofen Other_____

Oral Steroids: Medrol Dose pack prednisone, Other_____

Anti-Convulsion: Gabapentin/Neurontin Lyrica Lamictal Topomax Other_____

Topical Medications: Lidocaine ointment Lidoderm Capsaicin Bio-Freeze Other_____

Other Medications: Cymbalta Elavil/Amitryptyline Effexor Pamelor/Notriptyline Savella Other_____

Please list any medications you are currently taking for pain: _____

_____

Please circle which of the following describes your pain after taking your pain medication:

Stable Unchanged Improved Worse

Blue Water Pain Specialists **21000 12 Mile Rd, Suite 100, St Clair Shores, MI 48081**
46591 Romeo Plank Rd, Suite 137, Macomb, MI 48044

Matthew Vasko, M.D. **Michael Sikorsky, D.O.** **Room #_____**

NAME_____ Date_____

Primary Care Doctor_____

Referring Doctor_____

Medication list ***if you have a list, have the front desk make a copy

1._____ 6._____
2._____ 7._____
3._____ 8._____
4._____ 9._____
5._____ 10._____

Do you take a Blood Thinner? ☐Yes ☐No

Drug Allergies/Reaction_____ ☐ None

Family History

☐Back Pain ☐Heart Disease ☐Diabetes
☐High Blood Pressure ☐Cancer ☐Bleeding Disorder
☐Stroke ☐Alcohol/drug abuse ☐Other_____

Social History

Smoker ☐No ☐Former - Year Quit_____ ☐Yes - If yes, _____packs/day _____years of use
Alcohol ☐Daily-amount _____ ☐Weekly-amount _____ ☐Socially ☐ Never
Illicit Drugs ☐No ☐ Yes (please circle type) Cocaine Heroin Marijuana Other_____

Other

Do you have pending litigation as a result of this injury? ☐No ☐ Yes

Are you currently working? ☐ No ☐Yes Are you on or seeking Disability? ☐No ☐Yes

Are you currently taking pain medications from another doctor? ☐No ☐ Yes

Do you have an Advanced Directive? Yes / No

If **No**, do you have a surrogate decision maker? Name: _____

If no surrogate decision maker, Why?_____

Past Surgical History ☐ NONE

_____

_____

Have you had any surgeries on your back? Please specify

_____

_____

Blue Water Pain Specialists **21000 12 Mile Rd, Suite 100, St Clair Shores, MI 48081**
46591 Romeo Plank Rd, Suite 137, Macomb, MI 48044

NAME_____ Date_____

Past Medical History (Please check all that apply)

☐Bleeding Disorders	☐Cancer (type)_____	☐AIDS/HIV
☐Vision Problems	☐Hearing Difficulties	☐Osteoporosis
☐Arthritis	☐Lupus	☐High Cholesterol
☐High Blood Pressure	☐Rheumatoid Arthritis	☐Recent Steroid Use
☐Irregular heart beat	☐Heart Disease/Heart attack	Do you have stents? ☐ yes ☐ no
☐Atrial Fibrillation	☐Pacemaker/Defibrillator	☐ Blood Clots (DVT/PE)
☐Valvular heart disease	☐Heart Surgery (type)_____	☐Congestive Heart Failure
☐Vascular Disease	☐Asthma	☐Pneumonia
☐COPD/Emphysema	☐OSA/Sleep Apnea	☐Depression
☐Anxiety	☐Bipolar	☐Schizophrenia
☐Acid Reflux/GERD	☐ADHD/ADD	☐Migraine Headache
☐Stomach Ulcer	☐Colitis	☐Irritable Bowel Syndrome
☐Kidney Disease	☐ESRD on Dialysis	☐Liver Disease
☐Kidney Stones	☐Diabetes ☐on Insulin ☐ Oral Medication	☐Diet Controlled
☐Peripheral Neuropathy	☐Hypothyroid	☐Hyperthyroid
☐Fibromyalgia	☐Stroke	☐TIA
☐Multiple Sclerosis	☐Seizure (if yes, date of last_____)	☐Parkinson's Disease

Please circle any of the following symptoms that CURRENTLY apply to you:

Constitutional:	Fever , night sweats , weight gain , weight loss , exercise intolerance
Eyes:	Dry eyes , vision changes , irritation
ENMT:	Difficulty hearing , ear pain , nosebleeds , sinus problems , sore throat , bleeding gums , snoring , dry mouth , teeth problems
Cardiovascular:	Chest pain , arm pain on exertion , shortness of breath with walking , shortness of breath with lying down , palpitations , heart murmur
Respiratory:	Cough , wheezing , shortness of breath , coughing up blood , sleep apnea
Gastrointestinal:	Abdominal pain , vomiting , diarrhea , Reflux (GERD) , constipation
GU:	Incontinence , difficulty urinating , hematuria , increased frequency
Musculosketal:	Muscle aches , weakness , arthralgia , joint pain , back pain , swelling in extremities,
Skin:	abnormal mole , jaundice , rashes , lacerations
Neurologic:	Depression , sleep disturbances , feeling unsafe in relationship , restless sleep , history of alcohol abuse
Endocrine:	Fatigue , increased thirst , increased hair growth , cold intolerance
Hematolgic:	Swollen glands , bruising , excessive bleeding
Allergic:	Runny nose , sinus pressure , itching, hives , frequent sneezing

Matthew Vasko, M.D. **Michael Sikorsky, D.O.** **Room #_____**

NAME_____ Date_____

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers

	Never	*Seldom*	*Sometimes*	*Often*	*Very Often*
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

NAME_____ Date_____

Blue Water Pain Specialists **21000 12 Mile Rd, Suite 100, St Clair Shores, MI 48081**
46591 Romeo Plank Rd, Suite 137, Macomb, MI 48044

	Never	*Seldom*	*Sometimes*	*Often*	*Very Often*
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers. Thank you.

NAME_____ Date_____

PCS

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

1 - not at all
2 – to a slight degree
3 – to a moderate degree
4 – to a great degree
5 – all of the time

_____ I worry all of the time about whether the pain will end

_____ I feel that I can't go on

_____ It is terrible and I think that it overwhelms me

_____ I feel I can't stand it anymore.

_____I become afraid that the pain will get worse

_____ I keep thinking of other painful events

_____ I anxiously want the pain to go away

_____ I can not seem to keep it out of my mind

_____ I keep thinking about how much it hurts

_____ I keep thinking about how badly I want the pain to stop

_____ There is nothing that I can do to reduce the intensity of the pain

_____ I wonder whether something serious may happen

_____ TOTAL

NAME_____ Date_____

Matthew Vasko, M.D. Michael Sikorsky, D.O. Room #_____

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. Please answer every section and mark only **1** box which applies to you. We realize you may consider that 2 of the statements in any one section relate to you, but please mark **ONLY ONE** statement which most closely describes your problem.

Section 1 – Pain Intensity

- I have no pain at the moment
- The pain is very mild at the moment
- The pain is moderate at the moment
- The pain is fairly severe at the moment
- The pain is very severe at the moment
- The pain is the worst imaginable at the moment

Section 2 – Personal Care (washing, dressing, ect)

- I can look after myself normally but it is very painful
- It is painful to look after myself and I am slow and careful
- I need some help but manage most of my personal care
- I need help everyday in most aspects of my personal care
- I need help everyday in most aspects of self-care
- I do not get dressed, wash with difficulty and stay in bed.

Section 3 – Lifting

- I can lift heavy weights without extra pain
- I can lift heavy weights, but it gives extra pain
- Pain prevents me from lifting weights off of the floor, but I can manage is they are conveniently positions (i.e. on a table)
- I can only lift very light weights
- I can not lift or carry anything at all

Section 4 – Walking

- Pain does not prevent me from walking any distance
- Pain prevents me from walking more than 1 mile
- Pain prevents me from walking more than ¼ mile
- Pain prevents me from walking more than 100 yards
- I can only walk using a stick or crutches
- I am in bed most of the time and have to crawl to the toilet

Section 5 – Sitting

- I can sit in any chair as long as I like
- I can sit in my favorite chair as long as I like
- Pain prevents me from sitting for more than 1 hour
- Pain prevents me from sitting for more than ½ hour
- Pain prevents me from sitting for more than 10 minutes
- Pain prevents me from sitting at all

NAME_____ Date_____

Blue Water Pain Specialists 21000 12 Mile Rd, Suite 100, St Clair Shores, MI 48081
46591 Romeo Plank Rd, Suite 137, Macomb, MI 48044

Section 6 – Standing

- I can stand as long as I want without extra pain
- I can stand as long as I want but it causes extra pain
- Pain prevents me from standing for more than 1 hour
- Pain prevents me from standing for more than ½ hour
- Pain prevents me from standing for more than 10 minutes
- Pain prevents me from standing at all

Section 7 – Sleeping

- My sleep is never disturbed by pain
- My sleep is occasionally disturbed by pain
- Because of pain, I have less that 6 hours of sleep
- Because of pain, I have less that 4 hours of sleep
- Because of pain, I have less that 2 hours of sleep
- Pain prevents me from sleeping at all

Section 8 – Sex life (if applicable)

- My sex life is normal and causes nor extra pain
- My sex life is normal but causes some extra pain
- My sex life in nearly normal but extremely painful
- My sex life is severely restricted by pain
- My sex life is nearly absent because of pain
- Pain prevents any sex life at all

Section 9 – Social Life

- My social life is normal and causes no extra pain
- My social life is normal but increases the degree of pain
- Pain has no significant effect on my social life apart from limiting my more energetic interests i.e. sports
- Pain has restricted my social life and I do not go out as often
- Pain has restricted social life to my home
- I have no social life because of pain

Section 10 – Traveling

- I can travel anywhere without pain
- I can travel anywhere but it gives extra pain
- Pain is bad but I manage journeys of over 2 hours
- Pain restricts me to short necessary journeys under 30 minutes
- Pain prevents me from traveling except to receive treatment

Section 11 – Previous treatment

Over the past 3 months have you received treatment or medicines of any kind for your back or leg pain?

- No
- Yes (please state the type of treatment)_____

Payment Policy

Thank you for choosing Blue Water Pain Specialists as your provider. We are committed to providing you with quality care. Our clinic is a collaborative of Ascension St. John Hospital and Blue Water Pain Specialists.

As a patient of this clinic, you will receive separate bills from each of these entities. Copayments and payments for services rendered are expected at the time of service.

We accept many insurances, however, we may not participate with your plan and you may be subject to out of network benefit costs. It is your responsibility to know your insurance benefit details.

Our "No Show" policy was instituted to ensure fairness to all of our patients and physicians. If you miss an appointment (referred as a "No Show") you will be charged a $25.00 fee. This will be charged to you, not your insurance company.

Payment for the "No Show" fee is to be paid prior to your next scheduled visit with one of our physicians. If not collected in advance, we will collect the "No Show" fee upon your arrival, prior to being seen for your appointment.

If you are unable to keep a scheduled appointment, you can avoid this fee by simply calling us at least 24 hours prior to your scheduled appointment, to cancel or reschedule.

After 2 "No Show" appointments, we regret that we may dismiss you from ongoing care at our office. Thank you for your understanding in this matter.

Sincerely,
Blue Water Pain Specialists

Your signature acknowledges that you have been informed of these policies.

Print your name_____

Signature_____ Date_____

As a part of your Patient-Centered Medical Home Neighborhood, we welcome you to our Specialty Practice!

We are partnering with your Primary Care Physician (PCP) who is your *Patient Centered Medical Home*. We are sharing their commitment to effectively and efficiently work together to manage your care. As your Specialist, we will be sharing information about your condition and provide recommendations, guidance and periodic follow-up.

A Patient-Centered Medical Home - neighborhood (PCMH-N) is a system of care in which a team of health professionals work together to provide your entire healthcare needs. You, the patient, are the most important part of the PCMH-N. When you take an active role in your health and work closely with us, you can be

We trust you as our patient to:

- Keep your appointments as scheduled, or call and let us know when you are unable to keep your appointment.
- Make healthy decisions about your daily habits and lifestyle.
- Seek the advice of your PCP before you see other physicians.
- Follow the care plan that is agreed upon-or let us know why you cannot follow the plan so we can try to help you.
- Tell us what medications you are taking.
- See your PCP for all preventive services.

As your Specialist I will:

- Communicate with your Primary Care Physician (PCP) and provide timely written reports.
- Notify your PCP of no-shows, cancellations and other actions that may place your care in jeopardy.
- Notify your PCP if you are being referred to another specialist.
- Remind you of tests due and inform you of your test results.
- End every visit with clear instructions about expectations, treatment goals, and how I will coordinate with your PCP.

Coordination of care and communication back to your PCP is my priority. Should you have other physicians managing your care please inform them that I am the specialist managing your pain condition and that I require communication regarding any treatment that may affect my treatment plan.

PRACTICE HOURS

Monday, Tuesday, Wednesday, Thursday, Friday
8:00am – 4:00pm

- If you have an urgent issue that cannot wait for business hours, please go to St. John Urgent Care, located in the same building as our 12 Mile office or an urgent care closer to your home.
- Should you have an issue not pertaining to my care please contact your Primary Care Physician.
- Should you need a refill on a medication that I prescribed for you please contact my office during business hours. Please note: *All opioid refills require an office visit*

Ask any of our staff about Community Services or contact the following:

A listing of the area resources can also be found on this website: http://www.referweb.net/uwjc

If your life is impacted in any way be mental illness...NAMI can help: www.namimetro.org
HELP LINES: (248) 773-2296 or (248) 651-2578

Ask about our Patient Web Portal. We have a Patient Portal that supports two-way, secure and compliant communication.

Thank you,
Blue Water Pain Specialists