



Welcome to Javery Pain Institute! Thank you for choosing our office for your pain management needs.

We are excited to embark on this journey with you and are focused on improving your function in the midst of pain. Upon your arrival at JPI, you will be greeted by our caring staff who will make you feel welcome in our office. At your first visit Dr. Javery or Dr. Suderman will take the time to listen to your individual experience with pain, understand your perspective on how you have been coping and how pain has affected your day to day life.

Once we have taken the time to listen to your story and review the information from your referring doctor, we will develop a personalized and focused treatment plan to improve your pain and function. We often use multiple treatment options such as injection procedures and medications. We also collaborate with other specialties such as physical therapy and pain psychology as a part of your treatment plan. We take a holistic approach to pain knowing it cannot only affect you physically but also alter your mood and outlook, which may not allow you to be the person you want to be for yourself, family, and friends. Our goal is to help you manage your long-term pain. Even though your pain may not completely go away, we will work to improve your pain and ability to enjoy life with the treatments we have to offer.

You may be challenged to think about pain in a new way or to take a different direction with your treatment compared to what you have been doing with previous health care providers. We always strive to have your best interest in mind, while helping you get your life back as quickly, fully, and safely as possible.

We may see patients frequently in order to repeat treatments or check up on you to ensure that you are making the most progress possible with a condition that affects your daily life.

We look forward to meeting you and establishing a partnership to address your pain management needs so you can get your life back!

Sincerely,

Dr. Keith Javery, DO

Dr. Josh Suderman, MD





Please remember to:

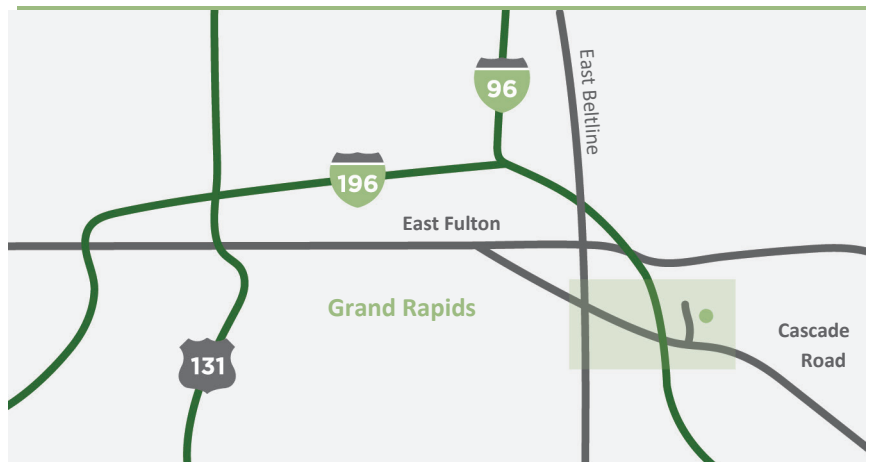
- Bring your completed new patient paperwork to your appointment.
- Please arrive 15 minutes prior to your appointment to fill out necessary paperwork or we may ask you to reschedule.
- You must bring all of your insurance cards and a picture ID or your appointment will be rescheduled.
- Bring a list of all the medication(s) you take, or if it's easier you may bring the medication bottles with you.

From I-96

- Exit 40 Cascade Road, head East
- Turn Left (North) at the first traffic light onto Kenmoor Avenue
- Proceed North on Kenmoor to Javery on the Right (East) side of Kenmoor Avenue

From East Beltline

- Turn East on Cascade
- Follow Cascade over I-96
- Turn Left (North) at the first traffic light onto Kenmoor Avenue
- Proceed North on Kenmoor to Javery on the Right (East) side of Kenmoor Avenue



Javery Pain Institute, PC

Patient Information – PLEASE PRINT

Name _____ Date of Birth _____ Age _____
Last First MI

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work/Other Phone () _____ Cell Phone () _____

Email _____ Social Security Number _____ Driver's License # _____

Race/Ethnicity _____ Primary Language _____

Employer _____ Marital Status _____ Male/Female
mandatory for worker compensation patients

Referring Physician _____ Primary Care Physician _____
First Last First Last

Emergency Contact Information:

Name _____ Phone () _____

Address _____ Relationship _____

Insurance Card Holder's Information

Name _____ Relationship to Patient _____
Last First MI

Date of Birth _____ Home Phone () _____ Cell/Work/Other Phone () _____

Address _____ City _____ State _____ Zip _____

Employer _____ Employer Phone Number () _____

Employer Address _____ City _____ State _____ Zip _____

Primary Insurance Carrier _____ Insurance Card Holder _____

Policy No _____ Group No _____ Phone No () _____

Secondary Insurance Carrier _____ Insurance Card Holder _____

Policy No _____ Group No _____ Phone No () _____

I understand according to the State of Michigan, Department of Health, Act 488 of 1988 that if a health care professional in this practice sustains a coetaneous, mucous membrane or open wound exposure to blood or other body fluids from myself that a HIV and Hepatitis-B (HBV) blood test will be performed.

Signature _____ Date _____

I authorize payment of medical benefits by the insured directly to Javery Pain Institute, PC. I also request payment of government benefits directly to the party who accepts assignment. I understand that I am financially responsible for payment of all services or materials provided to myself and for any yearly deductible or co-payment amounts. I understand this agreement authorizes Javery Pain to appeal my denied preservice request (pre-auth) on my behalf to my designated insurance carrier. I agree to pay all services within 30days unless a payment plan is negotiated in advance. I authorize Javery Pain Institute, PC to release any information required to process my claim. This request shall remain in effect until revoked by myself in writing.

Signature _____ Date _____

How did you hear about our office? ☐ Doctor ☐ Friend/Relative ☐ Web Search ☐ Other _____

Would you like to receive our monthly Newsletter? ☐ No ☐ Yes – Email Address: _____

Javery Pain Institute, PC

Name: _____ Date of Birth: _____ Patient ID: _____
Last First MI

Authorization for Specific Confidential Communications

I authorize my physician and/or administrative and clinical staff to disclose the following protected health information to:

Name: _____	Relationship to Patient _____
Name: _____	Relationship to Patient _____
Name: _____	Relationship to Patient _____
Name: _____	Relationship to Patient _____

Select the Protected Health Information to be used or disclosed to the above listed individual(s) from the list below:

- ☐ Medical Care / Treatment: **Yes** ___ **No** ___ Level of Information _____
- ☐ Billing Information **Yes** ___ **No** ___
- ☐ Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes** ___ **No** ___
- ☐ Other (specify in detail – such as date of service, type of service, level of detail to be released, origin of information etc.) _____

This authorization shall be in force and effect and does not expire until it is revoked in writing. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at: Javery Pain Institute, PC, 710 Kenmoor Ave SE, Suite 200, Grand Rapids, MI 49546. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I request that all communications to me (by telephone, mail, etc.) by Javery Pain Institute, PC. and/or its staff be handled in the following manner:

- * For **written** communications: Address to: _____
- * For **oral** communications: Call: _____ May we leave a message? YES ☐ NO ☐
(telephone number)

If the above address is not a street address or is not your home address, please provide us with a (home) street address for purposes of ensuring payment:

(street number and address) City State Zip

Patient Signature

_____/_____/_____
Date

Parent/Guardian Signature

_____/_____/_____
Date

**Needed for alternative written or oral communication listed in above box only.*

For Practice Use Only: Practice: Accepts ☐ Denies ☐

Privacy Officer's Signature _____ Date: _____

New Patient Visit Form: Page 1 of 4 ID# _____

Patient Name: _____ Date of Birth _____

Primary Care Dr. _____ Referred by _____



For intake staff only

BP

HR

RR

T

Wt.

Ht

O2

Where is your pain today?

How long have you had this problem?

Describe how your pain first began?

How often do you have pain? (Select all that apply)

☐ constantly ☐ comes and goes ☐ daily ☐ once in a while ☐ other _____

My pain is? (Select all that apply) ☐ sharp ☐ dull ☐ aching ☐ throbbing

☐ burning ☐ shooting ☐ electrical ☐ other: _____

Do you have any of the following?

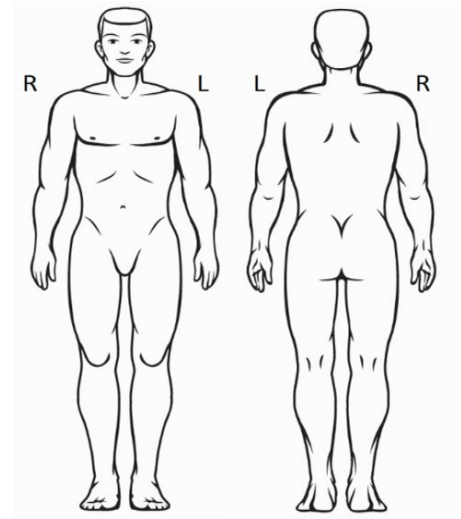
Numbness or tingling ☐ yes ☐ no **Swelling in affected area** ☐ yes ☐ no

Muscle weakness ☐ yes ☐ no **Muscle spasms or cramps** ☐ yes ☐ no

What makes your pain worse? (Select all that apply) ☐ sitting ☐ standing ☐ walking

☐ lying down ☐ bending ☐ climbing stairs ☐ lifting ☐ squatting ☐ other _____

Mark all areas of pain on the diagram



What are you doing to reduce your pain? (Select all that apply) ☐ medication ☐ massage ☐ physical therapy ☐ ice ☐ heat

☐ walking ☐ chiropractic care ☐ avoiding activity ☐ rest more ☐ weight loss ☐ stretching ☐ other _____

Is your pain worse at night? ☐ yes ☐ no **New loss of bowel or bladder function?** ☐ no ☐ yes

If yes, please explain: _____

Are you on any anti-coagulants or any blood thinning medicines? ☐ yes ☐ no

If yes, please list? _____

Please list Allergies: _____

PREVIOUS TREATMENTS	YES/NO	WHEN/WHERE?	HOW HELPFUL WAS THIS?
Nerve Blocks			
Surgery			
TENS Unit			
Physical Therapy			
Chiropractic			
Biofeedback/Hypnosis			
Previous Pain Doctor			
Other Treatment			

What pain medication have you trialed, include the length of trial & when? _____

Please list your current medications (Antibiotic, over the counter, Vitamins/Herbal Supplements and prescription)
Include dose and how often you take them, why you take them:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please explain how pain affects the activities of daily living/function in your life?

If you are going to be treated for more than one area, please document separately	Pain Area 1 (Example: low back pain)	Pain Area 2 (Example: neck pain)
List Pain Area Here? →		
What is your pain TODAY on a scale of 1 out of 10 (see pain scale/severity scale for reference on page 3)?	/10	/10
What is your current severity of pain (see pain scale/severity scale for reference on page 3)?	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately Severe <input type="checkbox"/> Severe	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately Severe <input type="checkbox"/> Severe
What is your current activities of daily living that you have difficulty with? (select all that apply)	<input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> walking <input type="checkbox"/> lifting <input type="checkbox"/> bending <input type="checkbox"/> twisting <input type="checkbox"/> self-care <input type="checkbox"/> sleeping <input type="checkbox"/> job activities <input type="checkbox"/> school activities <input type="checkbox"/> exercise <input type="checkbox"/> recreational activities <input type="checkbox"/> none	<input type="checkbox"/> sitting <input type="checkbox"/> standing <input type="checkbox"/> walking <input type="checkbox"/> lifting <input type="checkbox"/> bending <input type="checkbox"/> twisting <input type="checkbox"/> self-care <input type="checkbox"/> sleeping <input type="checkbox"/> job activities <input type="checkbox"/> school activities <input type="checkbox"/> exercise <input type="checkbox"/> recreational activities <input type="checkbox"/> none
What is your current <u>severity</u> of difficulty with activities of daily living (see pain scale/severity scale)? →	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately Severe <input type="checkbox"/> Severe	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Moderately Severe <input type="checkbox"/> Severe

What activities/hobbies not listed above would you like to start doing again, once you are feeling better?

List any tests/imaging you have had done?

JPI'S PAIN & SEVERITY SCALE		0	Pain Free	N/A		With Definitions
		1	Very Mild	MILD PAIN	Nagging, annoying, but doesn't interfere with <u>most</u> daily living activities	
		2	Discomforting			
		3	Tolerable	MODERATE PAIN	Interferes moderately with daily living activities. Requires <u>some</u> lifestyle changes.	
		4	Distressing			
		5	Very Distressing	MODERATELY SEVERE	Interferes significantly with daily living activities. Requires <u>many</u> lifestyle changes, but patient remains independent.	
		6	Intense			
		7	Very Intense	SEVERE PAIN	Disabling, unable to perform daily activities, unable to engage in normal activities, patient is disabled and unable function independently.	
		8	Utterly Horrible			
		9	Excruciatingly Horrible	EMERGENT ONLY	Not usually Chronic: Acute Pain experienced during Severe Car Accident, Severe Broken Bone, Giving Child Birth, Being Crushed by a Truck, etc...	
		10	Unimaginably Unspeakeable			
PAIN SCORE						
SEVERITY SCORE						

Test	Date/Place	Results
X-Rays		
CT Scan		
MRI		
EMG		
Bone Density		
Other		

Please list any surgeries you have had?

Surgery	Date/Surgeon

Review of Systems/Medical History: Please check any that you currently have or had in the past

Constitutional

- ☐ Recent fever/sweats
☐ Unexplained weight loss/gain
☐ Unexplained fatigue/weakness

Eye/Ear/Nose/Throat

- ☐ Vision changes
☐ Difficulty Hearing
☐ Hay fever/allergies
☐ Difficulty swallowing

Endocrine

- ☐ Cold/Heat intolerance
☐ Increased thirst/appetite
☐ Thyroid problems
☐ Diabetes
☐ Severe Diabetes

Genitourinary

- ☐ Painful/bloody urination
☐ Night-time urination
☐ Discharge: penis or vagina
☐ Unusual vaginal bleeding
☐ Kidney problems
☐ Concern with sexual function

Gastrointestinal

- ☐ Stomach/intestinal problems
☐ Nausea/Vomiting/diarrhea
☐ Changes in bowel movement
☐ Blood in stool

Other

- ☐ Implantable Device

Review of Systems Continued

Respiratory

- ☐ Emphysema/COPD
- ☐ Asthma
- ☐ Coughing/wheezing
- ☐ Coughing up blood

- ☐ Communicable disease-TB

Skin

- ☐ Sores
- ☐ Psoriasis
- ☐ Eczema
- ☐ Rash
- ☐ Communicable disease-MRSA

Blood /Lymphatic

- ☐ Unexplained lumps
- ☐ Easy bruising/bleeding
- ☐ Cancer
- ☐ Communicable disease (HIV,AIDS, Hep B or C)
- ☐ Other:_____

Musculoskeletal

- ☐ Arthritis
- ☐ Muscle/Joint Pain
- ☐ Recent back pain
- ☐ Muscle weakness
- ☐ Osteopenia

Psych/Behavioral

- ☐ Anxiety/stress
- ☐ Depression
- ☐ Substance abuse/addiction
- ☐ Sleep problems

- ☐ Other:_____

Neurological

- ☐ Headaches
- ☐ Numbness
- ☐ Tremors
- ☐ Poor balance
- ☐ Epilepsy

Neurological (continued)

- ☐ Stroke
- ☐ Loss of balance
- ☐ Other:_____

Cardiovascular

- ☐ Chest pain/discomfort
- ☐ Shortness of breath
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Palpitations/irregular heart
- ☐ Pacemaker/defibrillator
- ☐ Other:_____

Please give further detail on selection listed above? _____

How often do you drink alcohol? ☐ Never ☐ Monthly # of drinks _____ ☐ Weekly # of drinks _____
☐ Daily # of drinks _____ ☐ Other:_____

Have you felt you ought to cut down on your drinking?

Have people annoyed you by criticizing your drinking?

Have you felt bad or guilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves, get rid of a hangover,
or as an eye opener?

Patient Signature _____ Date _____

Javery Pain Institute Patient Policies

Prescription Renewal Policy

If a medication refill is needed, please contact our office during regular business hours, which are 8:30 AM to 5:00 PM, Monday – Thursday, and 8:30 AM to 12:00 PM on Friday. Leave a message on the prescription line or send a request through the Patient Portal. Please note our office will not call to notify patients when a prescription is ready for pick-up, unless there is a problem or issue with the request. **We ask patients to give us 24-48 hours to process their request. Renewal requests will not be processed outside of normal business hours.**

Patients are advised to call the nursing line if they have questions about how to take a prescription. If you are prompted to leave a message, one of our staff members will call you back within 24-48 hours.

Designated Driver Policy

Patients may be offered sedation to make them more comfortable during procedures. In order for a patient to receive sedation, an adult designated driver, must be present during the patient's entire appointment.

Payment Policy

Payment is expected at the time of a patient's visit in the office. As a courtesy to patients, if the physician participates with the patient's insurance policy and the visit is a covered benefit under the policy, our office will submit any charge(s) to their insurance carrier for payment. Any co-payment and/or deductible amount will be collected prior to your appointment. Cash and credit card are accepted for your convenience.

No Children in The Exam Rooms

For many reasons we had to make it a policy that children are not allowed into our exam rooms. Due to the type of specialty there may be a considerable amount of time spent waiting, and the Javery Pain Institute is not very enjoyable for young children. If there is no other alternative and a patient must bring child(ren) to their appointment, they will need to make prior arrangements to have their adult driver care for their child(ren) while in the waiting room. If a patient comes to an appointment and does not have an adult to supervise his/her child(ren), they will have to reschedule their appointment. We are not able to make exceptions to this. We are sorry for any inconveniences this may cause.

Lost/Stolen Property

JPI is not responsible for lost or stolen items and we recommend that valuable items be left at home or with the adult driver.

Inappropriate Behavior

JPI's mission is to provide a safe environment for care in our office. We have a **Zero Tolerance** for inappropriate or threatening behavior towards staff, patients, or visitors.