JAVERY
PAIN INSTITUTE

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

SCAN ME

JAVERY
PAIN INSTITUTE

Please remember to:

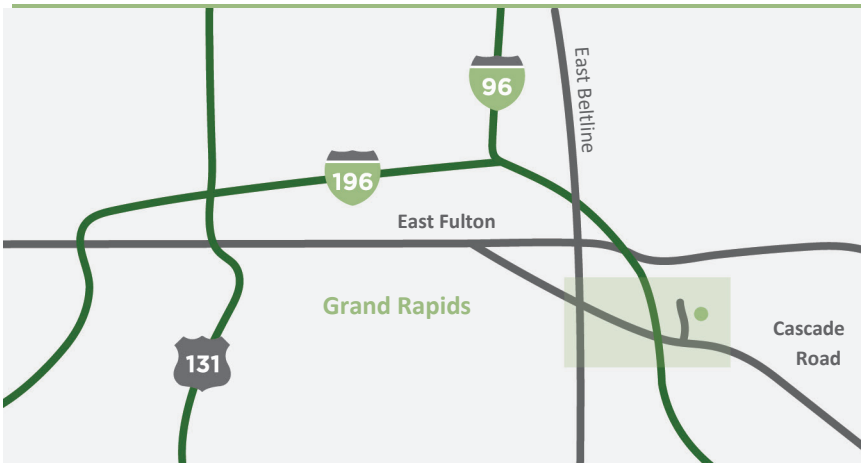
- Bring your completed new patient paperwork to your appointment.
- Please arrive 15 minutes prior to your appointment to fill out necessary paperwork or we may ask you to reschedule.
- You must bring all of your insurance cards and a picture ID or your appointment will be rescheduled.
- Bring a list 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, including deductible, insurance co-payments, or extended office visit charges, that may be necessary for my care. 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 30 days 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_____

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:

o Medical Care / Treatment: **Yes ___ No ___** **Level of Information** _____
o Billing Information **Yes ____ No ____**
o Pick up PHI: (such as prescriptions, billing statements, labs etc.) **Yes ___ No ___**
o 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_____

JAVERY PAIN INSTITUTE

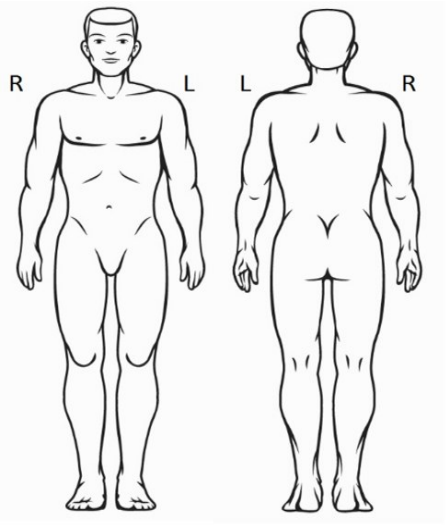
For intake staff only	BP	HR	RR	T	Wt.	Ht	O2

Where is your pain today?

How long have you had this problem?

Describe how your pain first began?

Mark all areas of pain on the diagram



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_____
_____

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			

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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)?	□ Mild □ Moderate □ Moderately Severe □ Severe	□ Mild □ Moderate □ Moderately Severe □ Severe
What is your current activities of daily living that you have difficulty with? (select all that apply)	□ sitting □ standing □ walking □ lifting □ bending □ twisting □ self-care □ sleeping □ job activities □ school activities □ exercise □ recreational activities □ none	□ sitting □ standing □ walking □ lifting □ bending □ twisting □ self-care □ sleeping □ job activities □ school activities □ exercise □ recreational activities □ none
What is your current severity of difficulty with activities of daily living (see pain scale/severity scale)? →	□ Mild □ Moderate □ Moderately Severe □ Severe	□ Mild □ Moderate □ Moderately Severe □ Severe

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

_____

_____

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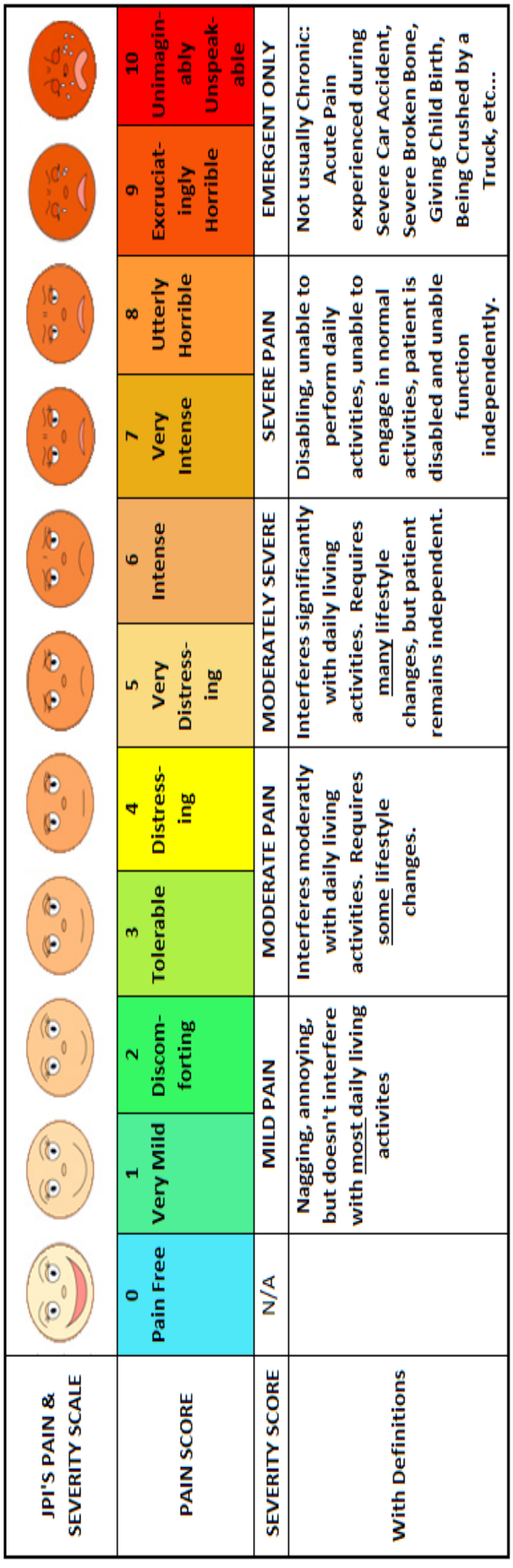
 Patient Name:_____ Date of Birth_____



List any tests/imaging you have had done?

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

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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 /Lymbphatic
- □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**_____

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For Office Use Only	
Patient ID:	**Score:** / 50

JAVERY PAIN INSTITUTE

OSWESTRY NECK PAIN QUESTIONNAIRE

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday activities. Please answer every section and mark in each section the ONE which applies to you at this time. We realize you may feel more than one statement may relate to you, but **please circle the ONE which most closely describes your current condition**.

1. PAIN INTENSITY
0- I have no pain at the moment.
1- The pain is very mild currently.
2- The pain is moderate currently.
3- The pain is fairly severe currently.
4- The pain is very severe at the moment.
5- The pain is the worst imaginable at the moment.

2. PERSONAL CARE (e.g., Washing, Dressing)
0- I can look after myself normally without extra pain.
1- I can look after myself normally but it causes extra pain.
2- I am slow and careful because it is painful for me to look after myself.
3- I need some help but manage most of my personal care
4- I need help every day in most aspects of care
5- I do not get dressed, I wash with difficulty and stay in bed.

3. LIFTING
0- I can lift heavy weight without extra pain
1- I can lift heavy weight, but it causes extra pain.
2- I cannot lift heavy weight off the floor, but I can manage if they are conveniently positioned like on a table.
3- I cannot lift heavy weight, but I can manage light to medium weights if they are conveniently positioned
4- I can lift very light weigh.
5- I cannot lift any weight due to neck pain.

4. READING
0- I can read as much as I want to with no pain in my neck.
1- I can read as much as I want to with slight neck pain.
2- I can read as much as I want to with moderate neck pain.
3- I cannot read as much as I want to due to moderate neck pain.
4- I cannot read as much as I want due to severe neck pain
5- I cannot read at all.

5. HEADACHES
0- I have no headaches at all.
1- I have slight headaches that occur infrequently.
2- I have moderate headaches that occur infrequently.
3- I have frequent moderate headaches.
4- I have frequent severe headaches.
5- I have severe headaches all the time.

6. CONCENTRATION
0- I can concentrate fully when I want to with no difficulty.
1- I can concentrate fully when I want to with slight difficulty.
2- I have a fair degree of difficulty in concentrating when I want.
3- I have a lot of difficulty concentrating when I want
4- I have a great deal of difficulty in concentrating when I want.
5- I cannot concentrate at all.

7. WORK
0- I can do as much work as I want to.
1- I can only do my usual work, but no more.
2- I can do most of my usual work, but no more.
3- I cannot do my usual work.
4- I can barely do any work at all.
5- I cannot do any work at all.

8. DRIVING
0- I can drive my car without any neck pain.
1- I can drive my car as long as I want with slight neck pain.
2- I can drive my car as long as I want with moderate neck pain.
3- I cannot drive my car as long as I want.
4- I can hardly drive at all because of severe neck pain.
5- I cannot drive my car at all.

9. SLEEPING
0- I have no trouble sleeping.
1- My sleep is slightly disturbed (less than 1 hour sleepless).
2- My sleep is mildly disturbed (1 hour sleepless).
3- My sleep is moderately disturbed (2 to 3 hours sleepless).
4- My sleep is greatly disturbed (4 to 5 hours sleepless).
5- My sleep is completely disturbed (6 to 7 hours sleepless).

10. RECREATION
0- I am able to engage in all my recreation activities with no neck pain.
1- I am able to engage in all my recreation activities with some neck pain.
2- I am able to engage in most, but not all of my usual recreation activities.
3- I am able to engage in a few of my usual recreation activities.
4- I can hardly do any recreation activities.
5- I cannot do any recreation activities due to neck pain.

Patient Name	**Patient Signature**	**Date**

For Office Use Only	
Patient ID: _____	Score: / 50

JAVERY
PAIN INSTITUTE

OSWESTRY LOW BACK PAIN QUESTIONNAIRE

This questionnaire has been designed to enable us to understand how your back pain has affected your ability to manage everyday activities. Please answer every section and mark in each section the ONE which applies to you at this time. We realize you may feel more than one statement may relate to you, but **please mark the ONE which most closely describes your current condition**.

1. PAIN INTENSITY
- ☐ 0 - I can tolerate the pain I have without having to use pain medication
- ☐ 1 - The pain is bad, but I manage without taking pain medication
- ☐ 2- Pain medication gives complete relief from pain
- ☐ 3- Pain medication gives moderate relief from pain
- ☐ 4 - Pain medication gives very little relief from pain
- ☐ 5 - Pain medications have no effect on the pain, and I do not use them

2. PERSONAL CARE (e.g., Washing, Dressing)
- ☐ 0- I can look after myself normally without extra pain
- ☐ 1- I can look after myself normally, but it causes extra pain
- ☐ 2- It is painful to look after myself and I am slow and careful
- ☐ 3- I need some help but manage most of my personal care
- ☐ 4- I need help every day in most aspects of self-care
- ☐ 5- Because of pain, I am unable to perform any personal care without help.

3. LIFTING
- ☐ 0- I can lift heavy weights without extra pain
- ☐ 1- I can lift heavy weights, but it gives extra pain
- ☐ 2- Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e., on a table
- ☐ 3- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned
- ☐ 4- I can lift very light weights
- ☐ 5- I cannot lift or carry anything at all

4. WALKING
- ☐ 0- Pain does not prevent me walking any distance
- ☐ 1- Pain prevents me walking more than one mile
- ☐ 2- Pain prevents me walking more than ½ mile
- ☐ 3- Pain prevents me walking more than ¼ mile
- ☐ 4- I can only walk using a cane or crutches
- ☐ 5- I am in bed most of the time and have to crawl to the toilet

5. SITTING
- ☐ 0- I can sit in any chair as long as I like
- ☐ 1- I can only sit in my favorite chair as long as I like
- ☐ 2- Pain prevents me from sitting more than one hour
- ☐ 3-Pain prevents me from sitting more than ½ hour
- ☐ 4-Pain prevents me from sitting more than 10 minutes
- ☐ 5-Pain prevents me from sitting at all

6. STANDING
- ☐ 0- I can stand as long as I want without extra pain
- ☐ 1- I can stand as long as I want but it gives me extra pain
- ☐ 2- Pain prevents me from standing for more than one hour
- ☐ 3- Pain prevents me from standing for more than 30 minutes
- ☐ 4- Pain prevents me from standing for more than 10 minutes
- ☐ 5- Pain prevents me from standing at all

7. SLEEPING
- ☐ 0- Pain does not prevent me from sleeping well
- ☐ 1- I can sleep well only by using medication
- ☐ 2- Even when I take medication, I have less than 6 hours sleep
- ☐ 3- Even when I take medication, I have less than 4 hours sleep
- ☐ 4- Even when I take medication, I have less than 2 hours sleep
- ☐ 5- Pain prevents me from sleeping at all

8. SOCIAL LIFE
- ☐ 0- My social life is normal and gives me no extra pain
- ☐ 1- My social life is normal but increases the degree of pain
- ☐ 2- Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e., dancing, etc.
- ☐ 3- Pain has restricted my social life and I do not go out as often
- ☐ 4- Pain has restricted my social life to my home
- ☐ 5- I have no social life because of pain

9. TRAVELING
- ☐ 0- I can travel anywhere without extra pain
- ☐ 1- I can travel anywhere but it gives me extra pain
- ☐ 2- Pain is bad, but I manage journeys over 2 hours
- ☐ 3- Pain restricts me to journeys of less than 1 hour
- ☐ 4- Pain restricts me to short necessary journeys under 30 minutes
- ☐ 5- Pain prevents me from traveling except to the doctor or hospital

10. EMPLOYMENT/ HOMEMAKING
- ☐ 0- My normal homemaking/ job activities do not cause pain.
- ☐ 1- My normal homemaking/ job activities increase my pain, but I can still perform all that is required of me.
- ☐ 2- I can perform most of my homemaking/ job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)
- ☐ 3- Pain prevents me from doing anything but light duties.
- ☐ 4- Pain prevents me from doing even light duties.
- ☐ 5- Pain prevents me from performing any job or homemaking chores.

Patient Name	**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.