Boston Out-Patient Surgical Suites
840 Winter Street
Waltham, MA 02451
Tel: 1-877-651-7246
Fax: 781-407-5892

Appt. Date:

Appt. Time:

Initial Pain Management Patient Questionnaire

Dear New Pain Management Patient,

Welcome to the New England Pain Management Consultants Clinic. Please take a few moments to carefully and completely fill out the following questions regarding your pain history and medical history. Accurate completion of this form is important, so please ask the receptionist or the nurse if you have any questions. When choices are given, circle the answer that is correct.

At New England Pain Management Consultants, your time is important to us. We greatly appreciate your arriving on time and will always do our best to stay on schedule so that you don't have to wait for your appointment. Occasionally, we do get behind schedule because of emergencies or because prior patients have required more time for their appointment than we had anticipated. In the event that this happens, please be assured that you will be seen as soon as possible and always in the order which you were scheduled.

Thank you,

The New England Pain Management Consultants Staff

New England PAIN MANAGEMENT CONSULTANTS

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NAME: _____ DOB: _____

REFERRING MD: _____ PRIMARY MD: _____

ADDRESS _____ ADDRESS: _____

_____ _____

PHONE: _____ PHONE: _____

Chief Complaint:
Please briefly state the main reason you are here today. For example: low back pain, headache, right shoulder pain, etc.

_____

History of Illness:
When did your pain first start? _____

How did your pain start? _____

Was it the result of an accident or injury? ☐ YES ☐ NO

Are you involved in litigation (a lawsuit)? ☐ YES ☐ NO

Is Worker's Compensation involved in injury? ☐ YES ☐ NO

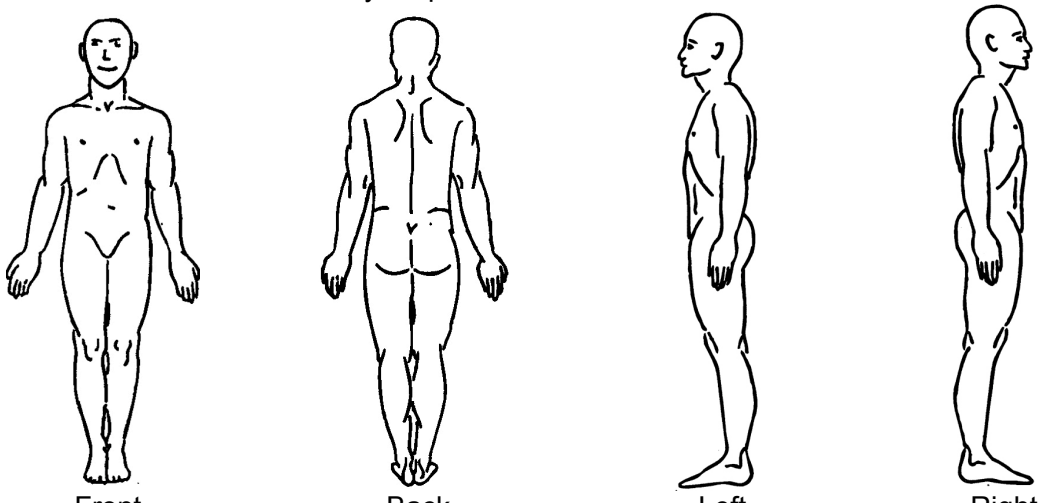
Does the pain radiate from this part of your body to another area? If yes, Where?

_____

Please check the words that best describe your pain:

☐ ACHING	☐ HOT	☐ SHOOTING
☐ SHARP	☐ COLD	☐ NAGGING
☐ BURNING	☐ NUMB	☐ SEVERE
☐ STABBING	☐ TINGLING	☐ OTHER _____

Please indicate on the chart where your pain is:



Front Back Left Right

Please circle the number on the scale of 0 – 10 that represents your pain:

0 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

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Is your pain constant or intermittent? ☐ Constant ☐ Intermittent

If your pain is intermittent, is there a time of the day when your pain is usually worse or better? Worse _____ AM / PM Better _____ AM / PM

Are there activities that make your pain worse (For example: walking, sitting, stair climbing, etc.)? _____

What makes your pain better? _____

Diagnostics Tests:

Please check any diagnostic tests you have had for this condition:
_____ MRI _____ CAT Scan _____ EMG _____ Other _____

Please check any treatment you have had for pain:
_____ Acupuncture _____ Chiropractor _____ Heat/Cold _____ Massage _____ Medications
_____ Nerve Block or other Steroid Injections _____ Physical/Aqua Therapy
_____ Surgery _____ Tens _____ Other _____

Current Medications: All other medications **not** for pain.

Medication	Amount (Mg)	Frequency	What is it for?

Allergies:
Please list any medications that you are allergic to and the adverse reaction that you have.

☐ **Check if you have no known drug allergies.**

Medication:	Adverse Reaction:

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Past Medical History:
Do you have a history of any of the following?

Chest Pain	☐ YES	☐ NO	Stroke	☐ YES	☐ NO
Heart Attack	☐ YES	☐ NO	Ulcer Disease	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO	Diabetes	☐ YES	☐ NO
Congestive Heart Failure	☐ YES	☐ NO	Thyroid Disease	☐ YES	☐ NO
Abnormal Heart Rhythm	☐ YES	☐ NO	Anemia	☐ YES	☐ NO
Asthma	☐ YES	☐ NO	Bleeding Disorders	☐ YES	☐ NO
Pneumonia	☐ YES	☐ NO	Arthritis	☐ YES	☐ NO
Kidney Failure	☐ YES	☐ NO	Psychiatric Disorders	☐ YES	☐ NO
Prostate Trouble	☐ YES	☐ NO	Cancer	☐ YES	☐ NO
Liver Failure	☐ YES	☐ NO	Seizures	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO	Are You Pregnant?	☐ YES	☐ NO

Past Surgical History:
Please list any surgical procedures that you have had and the date of the surgery.

☐ **Check this box if you have never had surgery.**

Surgery	**Date of Operation**

Family History: Please list any diseases that run in your family.
(for example: diabetes, heart disease, cancer, etc.)

_____

_____

Social History:

Do you smoke? ☐ **YES** ☐ **NO** **If so how much?** _____

Do you drink alcohol? ☐ **YES** ☐ **NO** **If so how much?** _____

Have you ever had a problem with alcoholism? ☐ **YES** ☐ **NO**

Do you have any history of using Marijuana, Cocaine, Heroin, or other illegal drugs? ☐**YES** ☐ **NO**

If yes which drugs? _____

Marital Status: Single Married Divorced Widowed Committed Relationship
Work Status: Working Not working Retired Disabled
Disability: Temporary Permanent
Reason for Disability: _____

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Review Of Symptoms:

Headache	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No
Palpitations	☐ Yes	☐ No	Bladder/Bowel	☐ Yes	☐ No
Chronic Cough	☐ Yes	☐ No	Incontinence	☐ Yes	☐ No
Heartburn	☐ Yes	☐ No	Heat Tolerance	☐ Yes	☐ No
Blood In Urine	☐ Yes	☐ No	Weakness	☐ Yes	☐ No
Thrist/Polyuria	☐ Yes	☐ No	Shortness Of Breath	☐ Yes	☐ No
Visual Problems	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Swelling	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No	Other _____	☐ Yes	☐ No

_____ _____
Signature Date

THIS IS THE END OF THE PATIENT SECTION, THE REST OF THE INFORMATION WILL BE FILLED IN BY YOUR NURSE AND DOCTOR.

Pre-Procedure Evaluation:

History of present illness:

_____

_____

BP: _____ Pulse: _____ Ht: _____ Wt. _____ VNS: _____

Physical Exam:

Airways: _____ Lung: _____ Heart: _____ ASA:

Musculoskeletal: _____

Neurological: _____

Diagnosis: _____

Plan of Procedure: _____

_____ _____
Signature Date