NEW ENGLAND BAPTIST HOSPITAL SM

New England Baptist Hospital
125 Parker Hill Avenue
Boston, MA 02120
Tel.: 617-754-5450

New England Pain Management Consultants
At New England Baptist Hospital

Pain Management Center Health Assessment

Dear New Pain Management Patient,

Welcome to the New England Pain Management Consultants Pain Clinic at New England Baptist Hospital. 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 we 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 appointments 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 in which you were scheduled.

Thank You,

The Pain Clinic Staff of
New England Baptist Hospital

New England
PAIN MANAGEMENT
CONSULTANTS

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NAME: ______________________ DATE OF BIRTH: ____________

REFERRING MD: ______________________ PRIMARY MD: ______________________

ADDRESS: ______________________ ADDRESS: ______________________

____

PHONE: ______________________ PHONE: ______________________

Chief Complaint:

Please briefly state the 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 Side Right Side

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 this condition:

- ☐ 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?

Pain Medications:

Please list any pain medications that you are taking now or have taken in the past to treat your pain.

Pain Medication	Amount	Has it helped?	Prescribed by:
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	

Allergies:

Also list any medications that you are allergic to and the adverse reaction that you have.

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

Allergy / Medication:	Adverse Reaction:

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

Condition			Condition		
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 Problem	☐ 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	HIV	☐ YES	☐ NO
Hepatitis	☐ YES	☐ NO	Are You Pregnant?	☐ YES	☐ NO
Seizures	☐ 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: ______________________________

_______________________________________ MD Signature

____ / ____ / ____ Date