Appt. Date:

Appt Time:

Morton Hospital
88 Washington St, Taunton, MA 02780
Phone: 508-828-7186

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?

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

Symptom			Symptom		
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 ______________