

Please fill out the enclosed 8 page questionnaire. Use a no. 2 pencil or a black marker and color the circles completely.

There are 3 ways you can get these forms to us:

1. Fax to us (and bring originals to your appointment):

Fax: 508-665-4355

(This will shorten the time you spend in the waiting room before your appointment.)

OR

2. Mail to us:

**Complete Pain Care, LLC
1094 Worcester Rd
Framingham, MA 01702**

OR

3. Bring the forms with you on your appointment date

Patient Registration Form

Patient Information: new change Date:

Name: Birth Date:

Mailing Address:

Home Address (if different):

Home Phone: Mobile Phone:

Emergency Contact: Phone Number: Relationship:

Email Address: @ .

Insurance Information

Insurance #1

Plan Name: Subscriber ID:
 Subscriber: Relationship: self spouse child other
 Subscriber DOB: Effective Date of Insurance:

Insurance #2

Plan Name: Subscriber ID:
 Subscriber: Relationship: self spouse child other
 Subscriber DOB: Effective Date of Insurance:

Referral Information:

Referred by: Address: Phone:

Primary Care Physician: Address: Phone:

I hereby certify that my current pain is / is not a result of a work related injury

.....
Signature

Workers Compensation:

Injury Date:

Claims Processing Agent: Claim #

Employer at Time of Injury: Address where injury took place:

Adjusters Name: Phone: Fax:



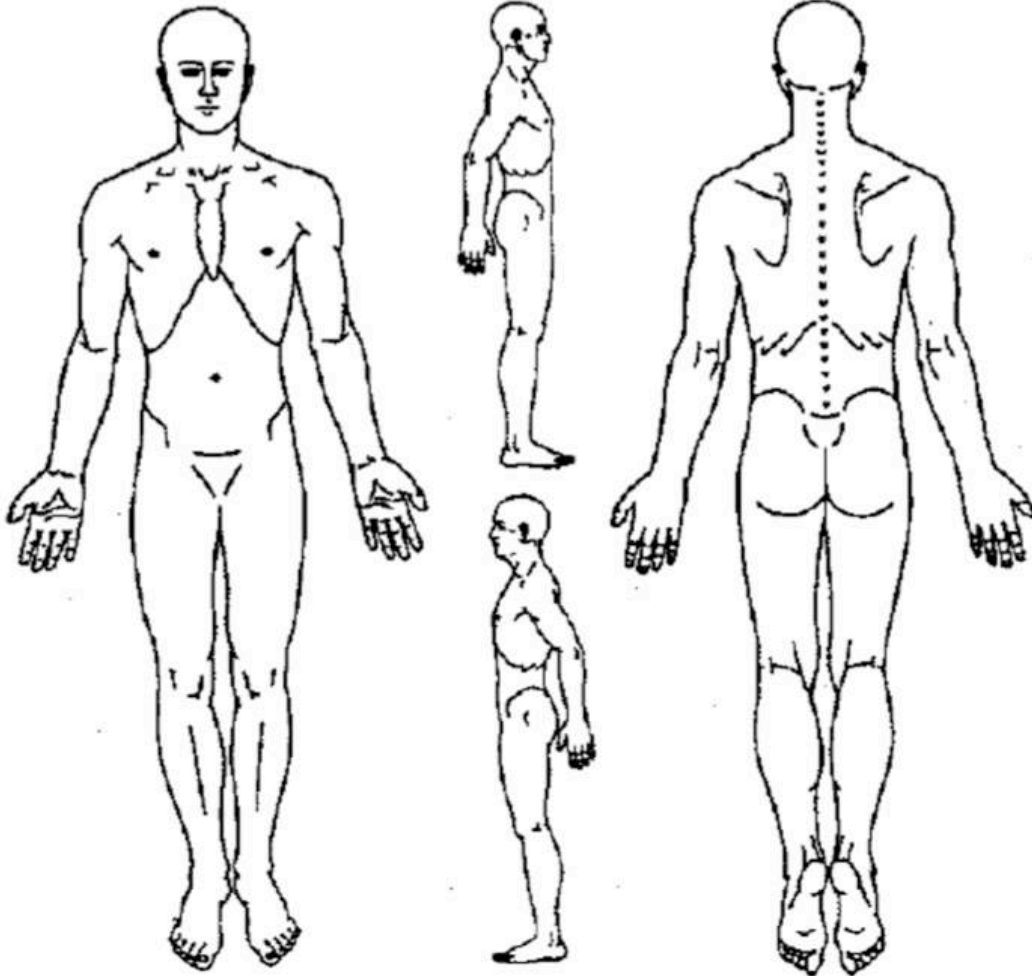
PATIENTS NAME: _____ DATE: _____

Significant Other: _____ Relationship _____ Phone _____

Do you take care of other family members? YES NO

If yes, please describe:

Mark the location(s) of pain on the body outlines:				
Numbness	Pins & Needles	Burning	Aching	Sharp or Stabbing
-----	OOOOOO	^^^	XXXXXX	⊗⊗⊗⊗⊗



PLEASE LIST ALL DRUG ALLERGIES/REACTIONS:

ALLERGY	REACTION (RASH, HIVES, SWELLING, ETC.)
.....
.....
.....

PATIENTS NAME: _____ **DATE:** _____

PLEASE LIST ALL THE SURGERIES THAT YOU HAVE HAD:

Surgery (L or R Side?):	Date:	Surgery (L or R Side?):	Date:
.....
.....
.....
.....

CURRENT MEDICATIONS:

NAME	DOSE	FREQUENCY	SIDE EFFECTS (IF ANY)
.....
.....
.....
.....

THE BELOW INFORMATION IS BEING USED FOR CENSUS PURPOSES ONLY. PLEASE CHECK THE APPROPRIATE RESPONSE

<p>RACE:</p> <p><input type="radio"/> American Indian or Alaskan Native</p> <p><input type="radio"/> Asian</p> <p><input type="radio"/> Native Hawaiian or Other Pacific Islander</p> <p><input type="radio"/> Black or African American</p> <p><input type="radio"/> White</p> <p><input type="radio"/> Hispanic</p> <p><input type="radio"/> Other Race</p> <p><input type="radio"/> Other Pacific Islander</p> <p><input type="radio"/> Unreported/Refused to Report</p>	<p>ETHNICITY:</p> <p><input type="radio"/> Hispanic or Latino</p> <p><input type="radio"/> Not Hispanic or Latino</p> <p><input type="radio"/> Refused to Report</p> <p>LANGUAGE:</p> <p><input type="radio"/> English</p> <p><input type="radio"/> Spanish</p> <p><input type="radio"/> Indian (includes Hindi & Tamil)</p> <p><input type="radio"/> Russian</p> <p><input type="radio"/> Other</p>
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PATIENTS NAME:..... DATE:



History of Present Illness

Where is the pain located?

- Face
- Neck
- Headache
- Chest
- Abdomen
- Pelvis
- Groin
- Upper back
- Mid Back
- Lower back
- Left Shoulder
- Right Shoulder
- Both Shoulders
- Left Elbow
- Right Elbow
- Both Elbows
- Left Hand
- Right Hand
- Both hands
- Left Arm
- Right Arm
- Both Arms
- Left Buttock
- Right Buttock
- Both Buttocks
- Left Thigh
- Right Thigh
- Both Thighs
- Left Hip
- Right Hip
- Both Hips
- Left Knee
- Right Knee
- Both Knees
- Left Calf
- Right Hip
- Both Hips
- Left Foot
- Right Foot
- Both Feet
- Left Ankle
- Right Ankle
- Both Ankles
- Multiple joints
- Generalized, total body
- Other

Describe the pain:

- Burning
- Sharp
- Shooting
- Throbbing
- Knife/stabbing
- Aching
- Dull
- Other

How did your pain begin?

- Spontaneous
- Accident at Work
- Accident at home
- Motor Vehicle Accident
- Following surgery
- Gradually
- Other

Please score your pain on a scale of 1-10, where 0 is no pain and 10 is the worst pain of your life, how would you describe your pain?

Right now	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
At its worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
At its best	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
On Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10

Timing of your pain:

- Continuous
- Recurrent (more than ½ the day)
- Intermittent (less than ½ the day)
- Worse in the morning
- Worse in the evening

If your pain travels, does it radiate to the:

- Left arm
- Right arm
- Both arms
- Left leg
- Right leg
- Both legs
- Other

Is your pain **associated with:** (fill in all that apply)

- Numbness
- Tingling
- Weakness
- Bowel / bladder dysfunction
- Difficulty sleeping
- Irritability
- Difficulty walking
- Difficulty sitting
- Other

PATIENTS NAME:..... DATE:



Is your pain **not associated with:** (fill in all that apply)

- Numbness
- Bowel / bladder dysfunction
- Difficulty walking
- Tingling
- Difficulty sleeping
- Difficulty sitting
- Weakness
- Irritability
- Other

Have you had the following tests for your pain: (fill in all that apply)

- Plain XRay
- Bone Scan
- MRI
- EMG / NC Study
- CT Scan

Is your pain **worsened by:** (fill in all that apply)

- Activity
- Sitting
- Walking
- Bending
- Sitting to standing
- Lying down
- Lifting
- Standing
- Other

Is your pain **improved by:** (fill in all that apply)

- Activity
- Walking
- Medications
- TENS unit
- Other
- Sitting
- Lying down
- Injections
- Physical therapy
- Standing
- Position changes
- Acupuncture
- Nothing

The relief that **your current medication provides is:**

- no relief at all
- 10-20%
- 20-30%
- 30-40%
- 40-50%
- 50-60%
- 60-70%
- 70-80%
- 80-90%
- >90%
- complete relief

Side effects of **your current medication/s:**

- None
- Fatigue
- Feels like a hangover
- Nausea
- Vision changes
- Night sweats
- Constipation
- Itching
- Headache
- Vomiting
- Dry mouth
- Palpitations
- Diarrhea
- Sweating (diaphoresis)
- Stomach upset
- Rash
- Dizziness
- Other

Have you tried the following conservative treatment/s: (fill in all that apply)

- Physical Therapy /pool therapy
- Massage
- Chiropractic Care
- TENS Unit
- Psychological support
- Other conservative treatment/s

Have you tried the following treatments for your pain? If so what happened? (fill in all that apply)

	Helped	Did not help
Botox injection/s	<input type="radio"/>	<input type="radio"/>
Epidural Steroid injection/s	<input type="radio"/>	<input type="radio"/>
Facet injection/s	<input type="radio"/>	<input type="radio"/>
Trigger point injection/s	<input type="radio"/>	<input type="radio"/>
Sympathetic block/s	<input type="radio"/>	<input type="radio"/>
Bursa injection/s	<input type="radio"/>	<input type="radio"/>
Joint injection/s	<input type="radio"/>	<input type="radio"/>
Other nerve block/s	<input type="radio"/>	<input type="radio"/>
Spinal cord stimulator	<input type="radio"/>	<input type="radio"/>
Surgery	<input type="radio"/>	<input type="radio"/>
Other Procedure/s	<input type="radio"/>	<input type="radio"/>

PATIENTS NAME:..... DATE:



Have you tried the following medication/s? If so what happened? (fill in all that apply)

	Helped	Did not help	Caused side effects
Benzodiazepines (Valium, Diazepam, Clonazepam, Alprazolam, Lorazepam, Xanax)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Tylenol / Acetaminophen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NSAIDs (Ibuprofen, Advil, Motrin, Aleve, Naproxen, Relafen, Diclofenac, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Neurontin / Gabapentin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lyrica	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Topamax / Topiramate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amitriptyline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nortriptyline	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Baclofen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Zanaflex / Tizanidine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Codeine / Tylenol #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vicodin / Vicoprofen / Hydrocodone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxycontin / Percocet / Oxycodone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MS Contin / Morphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Duragesic / Fentanyl Patch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dilaudid / Hydromorphone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Butrans patch	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Methadone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Suboxone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Buprenorphine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Soma / Carisoprodol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flexural / Cyclobenzaprine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ultram / Tramadol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cymbalta / Duloxetine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other medication/s	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Is there ongoing litigation regarding your pain Yes No

Recently your pain has been: Worsening Improving Unchanged

During the past 2 weeks:

Have you had little pleasure or interest in activities / hobbies? Yes No

Have you felt down / depressed or hopeless? Yes No

Risk for procedures. Are you **currently taking** any of the following?

- Coumadin / Warfarin
- Plavix
- Aggrenox
- Ticlid
- Pradaxa
- ASA Aspirin
- Xarelto
- Eliquis
- High dose NSAIDS
- Other blood thinners

Do you have any allergies to iodine, betadine, CT Scan dye, IVP dye or contrast dye? Yes No

Do you faint or feel like fainting or have fainted around needles? Yes No

Do you have a fear of needles? Yes No

Have you fallen in the last 6 months? Yes No

PATIENTS NAME:..... DATE:



Past Medical History

Have you ever been diagnosed with:

- | | | | |
|--|--|--|---------------------------------------|
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Hepatitis B | <input type="radio"/> Stroke |
| <input type="radio"/> Congestive heart failure | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Hepatitis C | <input type="radio"/> Glaucoma |
| <input type="radio"/> Chest pain | <input type="radio"/> Neck pain | <input type="radio"/> Bronchitis | <input type="radio"/> Incontinence |
| <input type="radio"/> Heart disease | <input type="radio"/> Back pain | <input type="radio"/> Asthma | <input type="radio"/> Hyperthyroidism |
| <input type="radio"/> High blood pressure | <input type="radio"/> Cellulitis | <input type="radio"/> COPD | <input type="radio"/> Hypothyroidism |
| <input type="radio"/> Cholesterol | <input type="radio"/> Psoriasis | <input type="radio"/> Anxiety disorder | <input type="radio"/> Ulcers |
| <input type="radio"/> Heart murmur | <input type="radio"/> Skin Cancer | <input type="radio"/> Depression | <input type="radio"/> Sleep apnea |
| <input type="radio"/> Mitral valve prolapse | <input type="radio"/> Tuberculosis | <input type="radio"/> Other psychiatric disorder | <input type="radio"/> Diabetes |
| <input type="radio"/> Osteoarthritis | <input type="radio"/> Kidney disease | <input type="radio"/> Seizures | <input type="radio"/> Cancer |

Implants

Do you have any of these device implants:

- Pacemaker Defibrillator Portacath Pump Rods artificial knee/hip
 Other implants

Social History

Occupation: Working Retired Homemaker Unemployed
 Student Disabled Other

Type of work: Desk job Manual Laborer Other

Persons in the home:

- Spouse Significant other Child (dren) Parent(s) Alone

What is your marital status?

- Single Married Divorced Widowed Engaged Separated Other

Exercise

Do you Exercise? Yes No

If Yes:

How often? Once a week Twice a week Three times a week Daily

What Type of exercise do you do? Stretching Strengthening Aerobics Other

Drugs:

Have you ever in your life used a recreational drug? Yes No

Do you use caffeine products? Minimal Moderate None Daily

Are you a: Current smoker Former smoker Never smoked

If you are a current smoker:

How soon after you wake up do you smoke your first cigarette?

- within 5 min 6-30 min 31-60 min after 60 min

How many cigarettes a day do you smoke?

- 5 or less 6-10 11-20 21-30 31 or more

How often do you smoke cigarettes? Every day Some days but not everyday

Are you interested in quitting?

- Ready to quit Thinking about quitting Not ready to quit

If you are a former smoker, how long has it been since you last smoked:

- < 1 month 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years > 10 years

PATIENTS NAME:..... DATE:



Alcohol

Did you have a drink containing alcohol in the past year? Yes No

If you answered YES to the above question, please answer the next 3 questions:

1. If so, how often did you have a drink containing alcohol?

- Never
- Monthly or less
- 2 to 4 times a month
- 2 to 3 times a week
- 4 or more times a week

2. How many drinks did you have a typical day when you had a drink?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 to 9
- 10 or more

3. How often did you have six or more drinks on one occasion in the past year?

- Never
- Less than monthly
- Monthly
- Weekly
- Daily

Family history of alcoholism Yes No

Family history of illegal drugs Yes No

Family history of prescription drugs Yes No

Personal history alcoholism Yes No

Personal history of illegal drugs Yes No

History of preadolescent abuse Yes No

Psychological disease ADD OCD Bipolar Schizophrenia

Depression Yes No

Review of Systems - These refer to problems other than your main pain problem above:

Do you have any (check all that apply):

- Allergies (other than medication allergies)
- Recurrent infections
- Chest Pain
- Palpitations
- Leg swelling
- Weight Gain
- Weight Loss
- Fever
- Fatigue
- Skin changes
- Dry skin
- Hives/rashes
- Non-healing lesions
- Change in Energy level
- Cold intolerance
- Excessive urination
- Hearing changes
- Difficulty swallowing
- Abdominal Pain
- Blood in stool
- Heartburn
- Constipation
- Easy bruising
- Abnormal bleeding
- Large lymph nodes
- Arthritis / Joint Pain
- Joint Swelling
- Joint stiffness
- Muscle pain
- Seizures
- Numbness/tingling
- Weakness in a limb
- Changes in memory
- Change in vision
- Wear corrective lenses
- Difficulty urinating
- Get up more than once/night to urinate
- Urinary incontinence
- Sexual dysfunction
- Cough
- Coughing up blood
- Wheezing
- Shortness of breath
- Poor Sleep
- Change in mood or behavior
- High stress level
- Irritability