Pain Management Centers of New England
Patient Intake Questionnaire

Name: _____ ***DOB:*** _____

Primary Care Physician:_____

Date of Initial Visit:_____

What is the problem that brings you to the Pain Management Center?

_____

_____

Is your condition due to: ☐Auto accident ☐ Fall ☐Work injury ☐Other_____
Date of onset: _____

Have you seen anyone else for your current problem? Check all that apply.

☐Physical Therapist ☐Occupational Therapist ☐Massage Therapist
☐Speech Therapist ☐Chiropractor ☐Acupuncturist
☐Spine Center ☐ER/Urgent Care Physician ☐ Primary Care Physician
☐ Other _____

Please check all diagnostic tests that you have had for your current problem.

☐EEG ☐EMG ☐CT scan ☐Myleogram
☐MRI ☐X-ray ☐Bone scan ☐Other_____

PLEASE BRING COPIES OF ALL TEST RESULTS TO YOUR APPOINTMENT

Do you have any condition that would make learning difficult for you? ☐Yes ☐No
(i.e. hard of hearing, memory problems, reading difficulties, difficulty understanding English, vision problems)
If yes, please
specify_____

How do you learn the best? (i.e. verbal, visual, demonstration)
_____

ALLERGIES

Known Allergies: _____
Adverse reaction/sensitivity to Medications: _____
Latex Allergy Screening: (Yes/No)
Do you have any reaction from handling rubber products? _____
Do you have any allergies to bananas, avocados, kiwi, or chestnuts? _____
Do you have regular exposure to latex in your work setting? _____
Comments: _____

CURRENT MEDICATIONS Include over the counter medications / herbal remedies/ vitamins & minerals

Drug	Dosage/Frequency	Drug	Dosage/Frequency

MEDICAL/SURGICAL HISTORY

	Yes	No	Comments		Yes	No	Comments
Tuberculosis				Diabetes			
Respiratory				Cancer			
Asthma				Kidney/Urinary			
High Blood Pressure				Epilepsy/Seizures			
Low Blood Pressure				Stomach/GI			
Dizziness				Heart Attack			
Heart Disease				Stroke			
Circulation/Vascular				Skin Problems			
Arthritis				Pacemaker/ Implantable Devices			
Thyroid				Bleeding Disorders			
Osteoporosis				Intestinal Trauma			
Joint Replacement				Psychiatric History			
Pregnancy				Other			

Have you had a spine or neck surgical procedure within the last 60 days? ☐ No ☐Yes
If yes, please
list_____

List prior hospitalizations or surgeries that you have had

Date	Facility	Procedure/Purpose

SYMPTOMS

Do you have problems with	Yes	No	Comments	Do you have problems with	Yes	No	Comments
Bowel control				Depression/Anxiety			
Bladder control				Sleeping			
Headaches				Fatigue			
Blurry/Double vision				Weight loss or gain			
Dizziness				Skin			
Shortness of Breath				Nausea or vomiting			
Cough				Swelling or edema			
Chest Pain				Joint pain			
Comments:							
Is there anything we need to know that is not covered on this form? If so, please explain.							

SOCIAL HISTORY

What is your occupation?

_____

Working Status: ____ Working ____On light Duty ____Disabled ____ Retired
Smoking History: ____ Never ____Quit (when _____) ____Smoking (how much _____)

Alcohol Intake: ____Never ____Socially ____Moderately ____Daily
Exercise: ____Yes ____No If yes, please list what you are doing and how frequently _____

RATING YOUR PAIN

At the Pain Management Center, assessing your pain is very important to us. You will be asked to rate your pain prior to and at the first visit, during the course of treatment on subsequent visits, as well as during post-treatment follow up phone calls. Choose a scale that you can relate to. This will give us an idea of how much pain you are experiencing prior to treatment, as well as letting us know how well your treatment is working. We may also ask you to set a pain goal for yourself, such as having no pain that is worse than a particular number you choose on the scale.

Numerical Scale

With this type of scale, you can quantify your pain intensity using numbers. Generally, the scale ranges from 0-10, with 0 being equivalent to no pain, and a description of 10 on the scale equaling the worst pain you have ever experienced.

0	1	2	3	4	5	6	7	8	9	10
No Pain					Moderate Pain					Worst Pain

Verbal Scale

A verbal pain scale allows you to express your degree of discomfort by choosing the level of pain described on the scale which best corresponds to how you feel. This may include descriptions of no pain, mild pain, moderate pain, severe pain, or the worst pain you have ever had. This is especially valuable to the physician or healthcare provider who is assessing the progression and effectiveness of your treatment.

This is an example of how you may use a verbal pain scale to describe in words the relationship between the way you are feeling and the number you choose to describe it:

0 No Pain

Mild Pain

1-2 Pain is present, but you have to stop and think about it to tell if it is really there. You are fairly comfortable.

3-4 You notice your pain at rest and/or during your daily routine. It may interfere with your usual routine.

Moderate Pain

5-7 Your pain is distracting you, but you may be able to focus on something else rather than your pain for a short period of time. You may find it difficult to carry out your usual routine.

Severe Pain

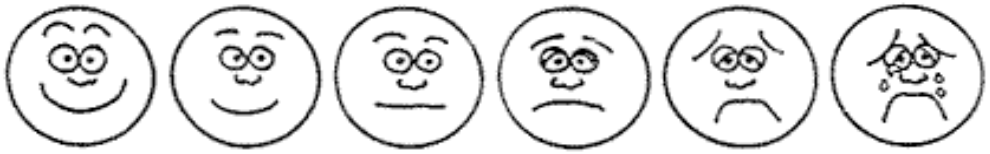
8-9 Your pain is severe enough that it makes you stop in the middle of an activity.

You may have pain even during rest or quiet times. It is difficult to think of anything else but your pain at this level.

10 Your pain is now the WORST possible pain that you can imagine.

Visual Scale

Visual scales display parts of human anatomy to help you describe the location and/or the intensity of your pain. A widely used visual scale is the Wong-Baker Faces Pain Rating Scale, which utilizes facial expressions as a means for you to show your physician or healthcare provider how the pain is making you feel. This is often used with children, cognitively impaired elderly or disabled people who are unable to verbalize their pain. It is used by pointing to the face that best describes your level of discomfort.



	0	1	2	3	4	5
	NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST
Alternate coding	0	2	4	6	8	10

Face 0 Very happy- does not hurt at all.
Face 1 Hurts a little bit.
Face 2 Hurts a little more**.**
Face 3 Hurts even more.
Face 4 Hurts a whole lot.
Face 5 Hurts as much as you can imagine, although you don't have to be crying to feel this bad.

Please record your current pain rating:

SCALE USED (Circle all that apply)**: NUMERICAL VISUAL VERBAL**

CURRENT PAIN RATING: _____

_____

Name of person completing form:_____
Date_____

Clinician Signature _____
Date_____