FAULKNER HOSPITAL

Faulkner Hospital
1153 Centre Street
Boston, MA 02130
Telephone: (617) 983-7080
Fax: (617) 983-7658

Pain Clinic 7th FL
617-983-7080
Initial Evaluation
Date _______________
Time _______________

New England Pain Management Consultants
At Faulkner Hospital

INITIAL PAIN MANAGEMENT PATIENT QUESTIONNAIRE

Dear New Pain Management Patient,

Welcome to the New England Pain Management Consultants Pain Clinic at Faulkner 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 Faulkner Hospital

Brigham and Women's Healthcare

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Please list the following:

Patient Name: ______________________ DOB: __________ Telephone: ____________

Referring Physician: ______________________________ Telephone: ____________

Address: ____
Street Address City State / Zip

Primary Care Physician: ___________________________ Telephone: ____________

Address: ____
Street Address City State / Zip

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

____

____

____

HISTORY OR PRESENT ILLNESS:
When did your pain first start? ______________________________________

How did your pain start? ____

Was it the result of an accident or injury? ☐ YES ☐ NO
Were you injured at work? ☐ YES ☐ NO
Are you involved in litigation (Lawsuit)? ☐ YES ☐ NO
Is Worker's Compensation involved in injury? ☐ YES ☐ NO

What part of your body hurts the most? ______________________________

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

____

Describe the quality of the pain; circle all of the words that apply. Sharp Burning Dull Aching

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? ____

Are you unsteady on your feet? ______________ Any history of falls? ______________

What assistive device do you use to help you walk? ________________________

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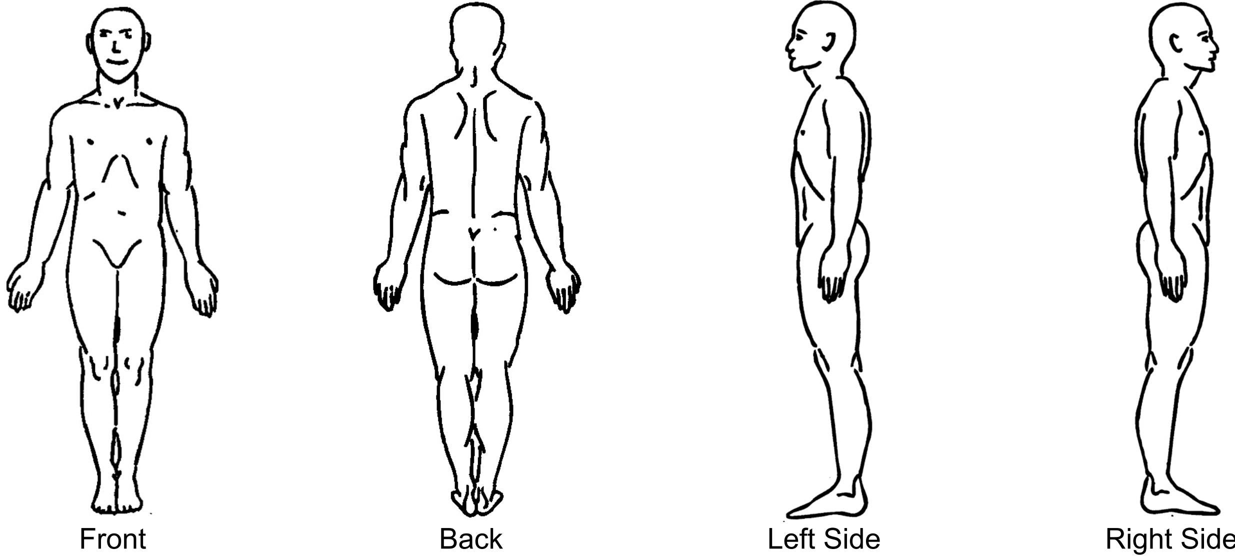
Please check any diagnostic test you have had for this condition.

- ☐ MRI ______________________
- ☐ CAT Scan ______________________
- ☐ Xrays ______________________
- ☐ EMG ______________________
- ☐ Myelogram ______________________
- ☐ Other ______________________

Please check any treatments you have had for your pain:

- ☐ Acupuncture
- ☐ Chiropractor
- ☐ Heat / Cold
- ☐ Hypnosis
- ☐ Massage
- ☐ Medications
- ☐ Nerve Blocks
- ☐ Physical / Aqua Therapy
- ☐ Steroid Injections
- ☐ Surgery
- ☐ Tens
- ☐ Ultrasound
- ☐ Other: ______________________

Please indicate on the chart where your pain is:



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

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. ☐ **Shellfish** ☐ **Contrast Dye** ☐ **Latex**

Allergy / Medication:	Adverse Reaction:

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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	
		☐ YES ☐ NO	

CURRENT MEDICATIONS: (Don't list pain medications here. Pain medications should be listed above.)
Include over-the-counter and herbals.

Medication	Amount (Mg)	Frequency	What is it for?

Do you take any of these medications? ☐Lovenox ☐Ticlid ☐Trental ☐Persantine ☐Heparin

☐Aspirin ☐Baby Aspirin ☐ Coumadin ☐Plavix ☐Vitamin E ☐Fish Oil ☐Aggrenox

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

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PAST MEDICAL HISTORY: Do you have a history of any of the following?

Chest Pain (Angina)	☐ 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	AIDS / HIV	☐ YES	☐ NO
Hepatitis A B C	☐ YES	☐ NO		☐ YES	☐ NO
Seizures	☐ YES	☐ NO	Are You Pregnant?	☐ YES	☐ NO

SOCIAL HISTORY:

Marital Status: Single Married Divorced Widowed Committed Relationship

Work Status: Working Not working Retired Disabled

Occupation: ____________________

Disability: Temporary Permanent

Reason for Disability: ____________________

If you are not currently working, do you plan to return to work? ☐ YES ☐ NO

Have you ever felt unsafe or been aftaid of anyone (e.g. your partner, a relative, or anyone else?)

If yes, give domestic abuse brochure for safety ☐ YES ☐ NO

Referred to Social Work: ☐ YES ☐ NO

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

____

REVIEW OF SYSTEMS:

Have you ever been a ☐ YES ☐ NO

If yes, do you still smoke? ☐ YES ☐ NO

How many packs a day do you smoke? ____________

If no, what year did you quit? ____________

Do you drink alcohol? ☐ YES ☐ NO

If yes, how many drinks / day? ____________

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

Do you have a history of using marijuana, cocaine, heroin or other illegal drugs? ☐ YES ☐ NO

If yes, which drugs? ____________________

Height: ________ Ft. ________ In.

Weight: ________ Lbs.

____
Patient Signature

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

☐ Procedure instruction sheet reviewed with patient

☐ Medication and steroid side effects reviewed with patient

VITAL SIGNS: Blood Pressure: ____ / ____

Pulse: ________

____________________ RN

Reviewed by: Date: