Comprehensive Pain Center
Anna Jaques Hospital

978-463-1045

Patient Information

Patient Label

Primary Care Physician: _____ **Referring Physician**: _____

How did you find out about our pain clinic? ❑ Friend ❑ MD ❑ Newspaper ❑ Web

Where is your pain? _____

_____

When did your pain start?_____ ❑ Gradually ❑ Suddenly
Month/Year

How did it begin? (car accident, fall, job related injury, etc)?_____

_____

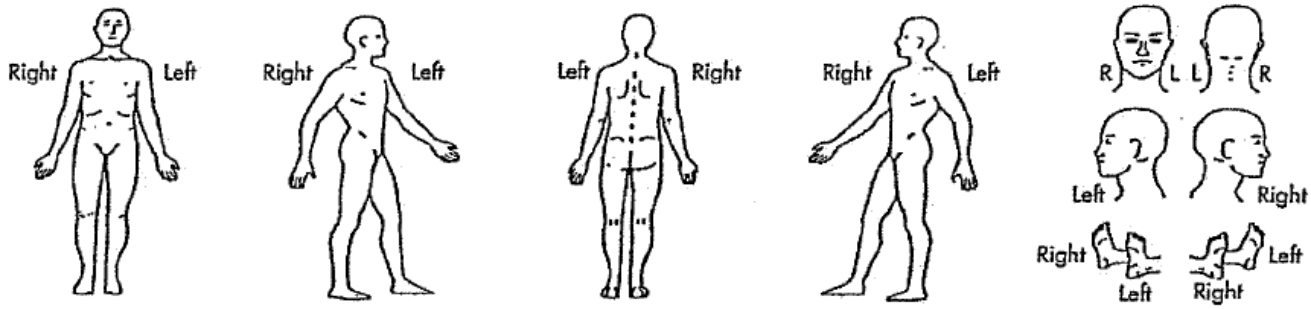
What do you believe is causing the pain?_____

_____

What best describes your pain:

❑ Ache	❑ Crushing	❑ Intense	❑ Numb	❑ Stabbing	❑ Tender
❑ Burn	❑ Bull	❑ Itchy	❑ Pinching	❑ Steady	❑ Unbearable
❑ Cold	❑ Heavy	❑ Miserable	❑ Sharp	❑ Tear	❑ Weak
❑ Constant	❑ Hot	❑ Nagging	❑ Spasm	❑ Throbbing	

Please indicate on the diagram below, where your pain is located:



Please circle the appropriate number	NONE	MILD			MODERATE			SEVERE			
Pain level now:	0	1	2	3	4	5	6	7	8	9	10

Does the pain affect?

Sleep: ..... ❑ Trouble falling asleep ❑ Trouble staying asleep

Appetite: ..... ❑ Weight loss ❑ Weight gain ❑ Stayed the same

Physical Activity: ..... ❑ Decreased ❑ Increased ❑ Stayed the same

Relationships with others (irritability): _____

Emotions (i.e. anger, sadness): _____

Concentration: _____

Pain is worse: ..... ❑ On Awakening ❑ End of Day ❑ During Night

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We want to know what affects your pain:

Which of these activities improve your pain?

- ❒ Bending Backward
- ❒ Bending Forward
- ❒ Cold
- ❒ Coughing
- ❒ Eating
- ❒ Exercise
- ❒ Getting out of bed
- ❒ Heat
- ❒ Ice
- ❒ Laying down
- ❒ Noise
- ❒ Relaxation
- ❒ Sexual Activity
- ❒ Sitting
- ❒ Standing
- ❒ Touch
- ❒ Walking
- ❒ Weather Changes

Other:_____

Which of these activities make your pain worse?

- ❒ Bending Backward
- ❒ Bending Forward
- ❒ Bowel Movement
- ❒ Changing Positions
- ❒ Cold
- ❒ Coughing
- ❒ Driving
- ❒ Heat
- ❒ Lifting
- ❒ Lying down
- ❒ Sexual Activity
- ❒ Sitting
- ❒ Stairs
- ❒ Standing
- ❒ Stress
- ❒ Touch
- ❒ Walking
- ❒ Weather Changes

Other:_____

Therapies Tried:

- ❒ Acupuncture
- ❒ Chiropractor
- ❒ Hypnosis
- ❒ Massage
- ❒ Other Pain Clinics
- ❒ Swimming
- ❒ Tens Unit
- ❒ Traction

Other:_____

Medication Treatment History

Medication for Pain (name)	Dosage and Frequency	Start Date	Stop Date	Why Stopped	How much helped {%}	Side effects?

Have you undergone Nerve Blocks/Pain Procedures?

Date	Procedure Type	Where	Outcome

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Past Medical History - Personal: (Please provide and explanation below for any checked items)

- ❒ Anemia
- ❒ Angina
- ❒ Anxiety
- ❒ Asthma
- ❒ Back Problems
- ❒ Bleeding Disorder
- ❒ Blood Clots
- ❒ Bowel Problems i.e. colitis/ constipation
- ❒ Cancer
- ❒ COPD/Emphysema
- ❒ Muscle / Skeletal Problems
- ❒ Depression
- ❒ Diabetes
- ❒ Fibromyalgia
- ❒ GERD / Heartburn
- ❒ Heart Attack
- ❒ Heart Problems
- ❒ Hepatitis/Jaundice
- ❒ High Blood Pressure
- ❒ HIV
- ❒ Lung Problems
- ❒ Migraines
- ❒ Mitral Valve Prolapse
- ❒ Neurological Pain
- ❒ Pacemaker
- ❒ Seizure / Epilepsy
- ❒ Sleep Apnea
- ❒ Stroke /TIA
- ❒ Thyroid
- ❒ Tuberculosis (TB)
- ❒ Ulcers
- ❒ Venereal Disease

Other _____

_____

_____

Past Surgeries/Illnesses/Hospitalizations (describe):

_____

_____

_____

Allergies:

_____

_____

_____

Review of Systems (check all that apply) As relates to your health

- ❒ Abnormal Heartbeat
- ❒ Blackouts
- ❒ Burning on Urination
- ❒ Calf Cramps w/walking
- ❒ Change of Vision
- ❒ Difficulty Starting Urination
- ❒ Difficulty Swallowing
- ❒ Ear Pain
- ❒ Fever or Chills
- ❒ Frequent Belching
- ❒ Frequent Constipation
- ❒ Frequent diarrhea
- ❒ Frequent Headaches
- ❒ Frequent Rash
- ❒ Frequent Urination
- ❒ Get up more than once every night to urinate
- ❒ Gum Trouble
- ❒ Heart or Chest Pain
- ❒ Hemorrhoids
- ❒ Hoarseness
- ❒ Hot or cold spells
- ❒ Loss of Hearing
- ❒ Morning Cough
- ❒ Nausea or Vomiting
- ❒ Nervous Exhaustion
- ❒ Nosebleeds
- ❒ Poor appetite
- ❒ Reading Glasses
- ❒ Recent Weight change
- ❒ Seizures
- ❒ Shortness of Breath
- ❒ Stomach Pain
- ❒ Swollen Ankles
- ❒ Toothache
- ❒ Ulcers
- ❒ Other _____

Women only:

- ❒ Irregular Periods
- ❒ Menopause
- ❒ Pregnant

Family History (check all that apply) ❑ None Apply

- ❒ Addiction Disorders
- ❒ Alcoholism
- ❒ Arthritis
- ❒ Bleeding Disorders
- ❒ Cancer
- ❒ Chronic Pain
- ❒ Diabetes
- ❒ Gout
- ❒ Heart Trouble
- ❒ High Blood Pressure
- ❒ Kidney Trouble or Stones
- ❒ Mental Illness
- ❒ Respiratory Problems
- ❒ Seizures
- ❒ Spine Problems
- ❒ Stroke
- ❒ Other _____

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Social History:

Are you currently: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

With whom do you live? _____

How has pain affected your life? _____

Education, last grade completed: _____

Are you presently working? ❑ No ❑ Yes/Occupation: _____

Any legal actions related to pain condition? ❑ No ❑ Yes _____

Are you disabled? ❑ No ❑ Yes/Reason _____

Are you able to take care of yourself? ❑ Yes ❑ No _____

What activities help you relax? _____

What are your hobbies? _____

Do you exercise? ❑ No ❑ Yes _____

Do you have any animals? ❑ No ❑ Yes

Religious/Culture/Spiritual practices affecting hospital treatment: ❑ No ❑ Yes _____

Due to the increase in domestic violence, we ask all adult patients the following:

Do you feel unsafe or afraid of anyone (i.e. your partner, a relative or anyone else)? ☐ Yes ☐ No

Is anyone trying to control or hurt you (i.e. control who you see and talk to, where you go, what your wear, how you spend your money etc)? ☐ Yes ☐ No

Are you interested in support from a social worker? ☐ Yes ☐ No

Substance Use:

Use of tobacco products: ❑ Never smoked ❑ Quit Smoking ❑ Still smoking ❑ Chew Tobacco ❑ Pipe

How much do/did you smoke? _____/day How many years do/did you smoke? _____

Do you wish to quit? ❑ Now ❑ Soon ❑ Eventually ❑ Never

How much caffeine do you drink daily (include coffee, tea, colas): _____

Use of Alcohol: ❑ No ❑ Yes-Amount/Frequency: _____

Which of the following drugs or substances, if any, have you used in the **past** (check all that apply)?

❑ Cocaine
❑ Heroin
❑ Marijuana
❑ Other Illicit Drugs (*specify*) _____ _____

Are you using any of the drugs or substances below (check all that apply) and when last used?

❑ Cocaine-*when*: _____
❑ Heroin-*when:* _____
❑ Marijuana-*when:* _____
❑ Other Illicit Drugs (*specify*) and when: _____ _____

Form Filled out by (please print): _____

Signature: **Date/Time:**