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:  O new  O 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:  O self  O spouse  O child  O other
Subscriber DOB:  
Effective Date of Insurance:  

Insurance #2
Plan Name:  
Subscriber ID:  
Subscriber:  
Relationship:  O self  O spouse  O child  O 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  O is  /  O 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:  

Complete Pain Care, LLC Patient Intake: Page 1 of 3  
Rev. 32_12_15
PATIENT'S 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:

<table>
<thead>
<tr>
<th>Numbness</th>
<th>Pins &amp; Needles</th>
<th>Burning</th>
<th>Aching</th>
<th>Sharp or Stabbing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>000000</td>
<td>。。。。</td>
<td>。。。。</td>
<td>。。。。。。。。。</td>
</tr>
</tbody>
</table>

PLEASE LIST ALL DRUG ALLERGIES/REACTIONS:

<table>
<thead>
<tr>
<th>ALLERGY</th>
<th>REACTION (RASH, HIVES, SWELLING, ETC.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>____________________________</td>
<td>______________________________________</td>
</tr>
<tr>
<td>____________________________</td>
<td>______________________________________</td>
</tr>
<tr>
<td>____________________________</td>
<td>______________________________________</td>
</tr>
</tbody>
</table>
PATIENTS NAME: ______________________________ DATE: __________

PLEASE LIST ALL THE SURGERIES THAT YOU HAVE HAD:

<table>
<thead>
<tr>
<th>Surgery (L or R Side?):</th>
<th>Date:</th>
<th>Surgery (L or R Side?):</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>.................................................................</td>
<td></td>
<td>.................................................................</td>
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<td>.................................................................</td>
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<tr>
<td>.................................................................</td>
<td></td>
<td>.................................................................</td>
<td></td>
</tr>
</tbody>
</table>

CURRENT MEDICATIONS:

<table>
<thead>
<tr>
<th>NAME</th>
<th>DOSE</th>
<th>FREQUENCY</th>
<th>SIDE EFFECTS (IF ANY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>.................................................................</td>
<td></td>
<td>.................................................................</td>
<td></td>
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<tr>
<td>.................................................................</td>
<td></td>
<td>.................................................................</td>
<td></td>
</tr>
<tr>
<td>.................................................................</td>
<td></td>
<td>.................................................................</td>
<td></td>
</tr>
</tbody>
</table>

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

RACE:
- American Indian or Alaskan Native
- Asian
- Native Hawaiian or Other Pacific Islander
- Black or African American
- White
- Hispanic
- Other Race
- Other Pacific Islander
- Unreported/Refused to Report

ETHNICITY:
- Hispanic or Latino
- Not Hispanic or Latino
- Refused to Report

LANGUAGE:
- English
- Spanish
- Indian (includes Hindi & Tamil)
- Russian
- Other
History of Present Illness

Where is the pain located?
- Face
- Neck
- Headache
- Chest
- Abdomen
- Pelvis
- 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?

<table>
<thead>
<tr>
<th></th>
<th>Right now</th>
<th>At its worst</th>
<th>At its best</th>
<th>On Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>9</td>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

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
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
- CT Scan
- MRI
- EMG / NC Study

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
- Injections
- TENS unit
- Physical therapy
- Other

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

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>10-</th>
<th>20-</th>
<th>30-</th>
<th>40-</th>
<th>50-</th>
<th>60-</th>
<th>70-</th>
<th>80-</th>
<th>&gt;90%</th>
<th>complete relief</th>
</tr>
</thead>
<tbody>
<tr>
<td>no relief at all</td>
<td></td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td>50%</td>
<td>60%</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
- Chiropractic Care
- Psychological support
- Massage
- TENS Unit
- Other conservative treatment/s

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

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Helped</th>
<th>Did not help</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botox injection/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidural Steroid injection/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facet injection/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trigger point injection/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sympathetic block/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bursa injection/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint injection/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other nerve block/s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal cord stimulator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Procedure/s</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Have you tried the following medication/s? If so what happened? (fill in all that apply)

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

Is there ongoing litigation regarding your pain .......... O Yes ....... O No

Recently your pain has been: O Worsening O Improving O Unchanged

During the past 2 weeks:

- Have you had little pleasure or interest in activities / hobbies? O Yes O No
- Have you felt down / depressed or hopeless? O Yes O No

Risk for procedures. Are you currently taking any of the following?
- Coumadin / Warfarin O Plavix O Aggrenox O Ticlid
- Pradaxa O ASA Aspirin O Xarelto O Eliquis
- High dose NSAIDs O Other blood thinners

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

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

Do you have a fear of needles? O Yes O No

Have you fallen in the last 6 months? O Yes O No
Past Medical History

Have you ever been diagnosed with:

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