NEW ENGLAND CENTER FOR CHRONIC PAIN

MS Chart #: _____

NEW PATIENT EVALUATION

Patient: _____/_____/_____ Date: _____
Last Name *First Name* *Middle Initial*

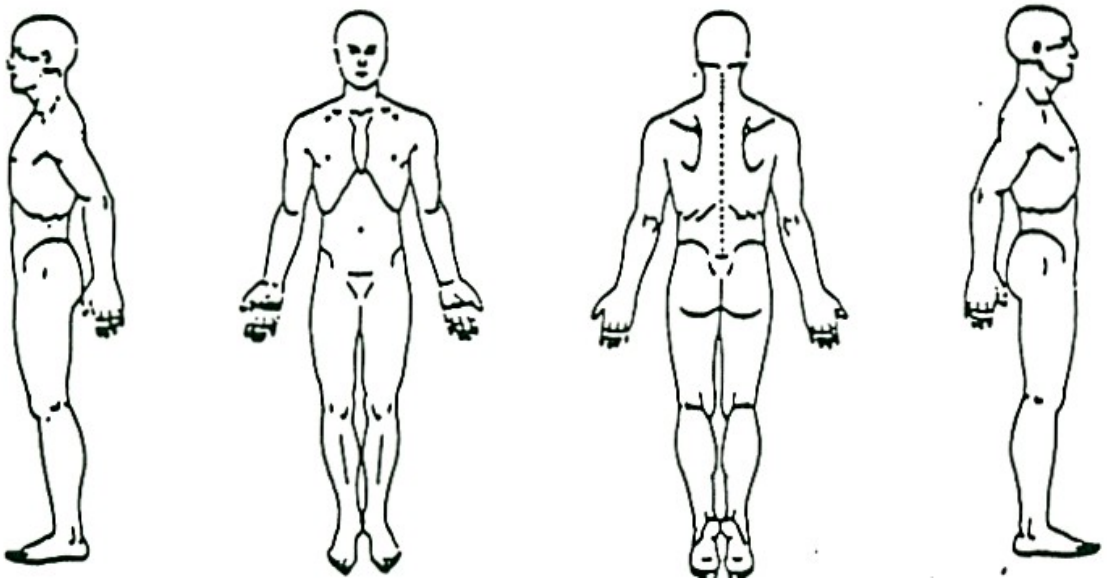
Address: _____/_____/_____/_____
Street *City* *State* *Zip*

Age: _____ Date of Birth: _____ Sex: Select

Home Phone #: _____Cell Phone #: _____ Work Phone #: _____

Email: _____

INSTRUCTIONS: This questionnaire is designed to provide an account of your personal experience that will help us understand your particular pain problem. Please read each question carefully and print your answers clearly. Feel free to add directly to a particular answer or to use additional pages.



Pain Drawing Key
A= Ache
B= Burning
N= Numbness
P= Pins & Needles
S= Stabbing
X= Other

On the body outlines above, please:

- Circle the area(s) of your pain.
- Using the code letters in the Key Box to the right, indicate what sensations you feel in each of the areas you've circled.

Review of Systems: Please indicate symptoms that you currently experience or that were serious in the past *(indicate with a "P" next to the symptom)*. The information you provide concerning past and present symptoms and diseases assists us in obtaining a more comprehensive understanding of your state of health.

N= Never **S**= Sometimes **O**= Often

N S O	Condition
☐☐☐	Headache
☐☐☐	Neck Pain
☐☐☐	Neck Stiffness
☐☐☐	Jaw Pain
☐☐☐	Shoulder Pain
☐☐☐	Hand Pain
☐☐☐	Upper Back Pain
☐☐☐	Lower Back Pain
☐☐☐	Pain in Upper Leg/Hip
☐☐☐	Pain in Lower Leg/Knee
☐☐☐	Pain in Ankle or Foot
☐☐☐	Numbness in Fingers
☐☐☐	Numbness in Toes
☐☐☐	Pins & Needles in Arms
☐☐☐	Pins & Needles in Legs
☐☐☐	Joint Swelling
☐☐☐	Stiffness of Joint(s)
☐☐☐	Fainting
☐☐☐	Loss of Consciousness
☐☐☐	Seizures/Convulsions
☐☐☐	Dizziness
☐☐☐	Nausea
☐☐☐	Vomiting
☐☐☐	Balance Problems
☐☐☐	Coordination Problems
☐☐☐	Ringing in Ears
☐☐☐	Heart Palpitations
☐☐☐	Chest Pains
☐☐☐	Shortness of Breath
☐☐☐	Loss of Appetite
☐☐☐	Night Sweats

N S O	Condition
☐☐☐	Epilepsy
☐☐☐	Excessive Thirst
☐☐☐	Abnormal Weight Loss
☐☐☐	Abnormal Weight Gain
☐☐☐	General Fatigue
☐☐☐	Sleep Problems/Insomnia
☐☐☐	Memory Problems
☐☐☐	Eyes Sensitive to Light
☐☐☐	Loss of Smell
☐☐☐	Cold Sweats
☐☐☐	Respiratory Problems
☐☐☐	Asthma
☐☐☐	Anorexia
☐☐☐	Anemia
☐☐☐	Other Blood Disorder: _____
☐☐☐	Nervousness
☐☐☐	Tension
☐☐☐	Anxiety
☐☐☐	Irritability
☐☐☐	Cold Hands or Feet
☐☐☐	Fever
☐☐☐	Chronic Cough
☐☐☐	Chronic Sinusitis
☐☐☐	Upset Stomach
☐☐☐	Constipation
☐☐☐	Diarrhea
☐☐☐	Frequent Urination
☐☐☐	Painful Urination
☐☐☐	Abdominal Pain
☐☐☐	Difficulty Swallowing
☐☐☐	Pain Worse at Night

N S O	Condition
☐☐☐	Heartburn/Indigestion
☐☐☐	Skin Problems/Rash
☐☐☐	Loss of Bladder Control
☐☐☐	Loss of Bowel Control
☐☐☐	Arthritis
☐☐☐	High Blood Pressure
☐☐☐	Low Blood Pressure
☐☐☐	Diabetes
☐☐☐	Lung Problems
☐☐☐	Ulcer
☐☐☐	Kidney Stones
☐☐☐	Bladder Disorder
☐☐☐	Kidney Disorder
☐☐☐	Prostate Problem
☐☐☐	Colitis
☐☐☐	Irritable Colon
☐☐☐	Depression
Y☐ N☐	HIV/AIDS
Y☐ N☐	Cancer: Type:_____
Y☐ N☐	Stroke: Date _____
Y☐ N☐	Heart Attack: Date_____
Y☐ N☐	Coronary Artery Bypass
Y☐ N☐	Pacemaker
Y☐ N☐	Other Metal Implants: _____
	_____
	_____
Y☐ N☐	Other Surgeries: _____
	_____
	_____

Other Conditions:

_____
_____
_____
_____
_____

Social History

☐☐☐	Use Tobacco
☐☐☐	Use Alcohol
☐☐☐	Use Recreational Drugs
☐☐☐	Victim of Physical Abuse

Female Conditions

☐☐☐	Irregular Menses
☐☐☐	Profuse/Scanty Menses
Y☐ N☐	Currently Pregnant
☐☐☐	PMS
☐☐☐	Endometriosis
☐☐☐	Sore Breast(s)/Lumps
☐☐☐	Vaginal Discharge

For each area of pain circled on the first page, please answer the set of questions below starting with the worst ranked pain area.

Worst Area of Pain

1. Location: (e.g., right shoulder, left lower leg): _____
2. Please mark the average level of pain for this area: NONE ☑ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 WORST
3. Is the skin sensitive or painful to touch in this area? Yes ☐ No ☐
4. Date the problem began: _____
5. Describe in detail how this problem began (e.g., after a fall, post surgery, auto accident, etc.):

   _____

   _____
6. Since your problem began the pain generally has:
   ☐ Increased ☐ Decreased ☐ Hasn't Changed
7. How often is this pain present?
   ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)
8. What **positions** (sitting, reclining w/ feet up, lying flat, etc.) **AND activities** (walking, standing, etc.) make this pain **BETTER**?
   Please explain: _____
9. What **positions** (sitting, reclining w/ feet up, lying flat, etc.) **AND activities** (walking, driving, etc.) make this pain **WORSE**?
   Please explain: _____
10. Does this pain interfere with your sleep? Yes ☐ No ☐
    If YES, please describe: _____

Next Worst Area of Pain

1. Location: (e.g., right shoulder, left lower leg): _____
2. Please mark the average level of pain for this area: NONE ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 WORST
3. Is the skin sensitive or painful to touch in this area? Yes ☐ No ☐
4. Date the problem began: _____
5. Describe in detail how this problem began (e.g., after a fall, post surgery, auto accident, etc.):

   _____

   _____
6. Since your problem began the pain generally has:
   ☐ Increased ☐ Decreased ☐ Hasn't Changed
7. How often is this pain present?
   ☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

8. What **positions** (sitting, reclining w/ feet up, lying flat, etc.) **AND activities** (walking, standing, etc.) make this pain **BETTER**?
   Please explain: _____
9. What **positions** (sitting, reclining w/ feet up, lying flat, etc.) **AND activities** (walking, driving, etc.) make this pain **WORSE**?
   Please explain: _____
10. Does this pain interfere with your sleep? Yes☐ No ☐

    If YES, please describe: _____

Next Worst Area of Pain

1. Location: (e.g., right shoulder, left lower leg): _____
2. Please mark the average level of pain for this area: NONE ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 WORST
3. Is the skin sensitive or painful to touch in this area? Yes☐ No ☐
4. Date the problem began: _____
5. Describe in detail how this problem began (e.g., after a fall, post surgery, auto accident, etc.):

   _____

   _____
6. Since your problem began the pain generally has:
   ☐ Increased ☐ Decreased ☐ Hasn't Changed
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8. What **positions** (sitting, reclining w/ feet up, lying flat, etc.) **AND activities** (walking, standing, etc.) make this pain **BETTER**?
   Please explain: _____
9. What **positions** (sitting, reclining w/ feet up, lying flat, etc.) **AND activities** (walking, driving, etc.) make this pain **WORSE**?
   Please explain: _____
10. Does this pain interfere with your sleep? Yes☐ No ☐

    If YES, please describe: _____

Current Daily Pain Patterns

MORNING ROUTINE:

1. Is pain noticed upon awakening? _____ Usual VAS upon waking: _____
2. Behavior of pain sensation (s):_____
3. Meds immediately upon waking? _____
4. Med pattern throughout day_____

AFTERNOON ROUTINE

Time typically notice pain increases: _____ Increase VAS from _____ to _____

1. Behavior of pain sensation (s):_____
2. Routine activities: (e.g., drive x #- hrs to work, walk dog, play tennis): _____

_____

3. Specific activities that typically increases pain in normal day (e.g., sitting at work, driving, doing dishes): _____

_____

4. Activities outside a "normal" day that will increase pain: (e.g., extra driving, extra walking, attending an event):

_____

Frequency of these activities: _____ Increase VAS from _____ to _____

EVENING ROUTINE

1. Time typically notice pain increases: _____ Increase VAS from _____to _____
2. Behavior of pain sensation (s):

_____

3. Routine activities: (e.g., always on couch by 6pm due to pain): _____

_____

CURRENT SLEEP PATTERN:

1. Any trouble getting to sleep:

_____

2. Behavior of pain sensation (s):

_____

3. Sleep through night? _____ Time/frequency of pain throughout night: _____
4. Pain "sensations" felt during night: _____

5. How would you grade your overall stress level due to your pain?

☐ None ☐ Minimal ☐ Moderate ☐ Great

6. How much does your pain interfere with your social life/relations?

☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

No Interference Max Interference

Please describe: _____

7. Does your pain interfere with your ability to work or otherwise be active?

If yes, please explain: _____

Please list all medical evaluations and treatments you have received for any of the pain issues:

NAME	LOCATION	SPECIALITY	DATE	PROCEDURE	SUCCESS
Example: Dr. Jim Smith	*Hosp for Spec Surg*	*Neurosurgeon*	*July 2009*	*Disc removal / injection*	*Yes or No*

Please list **ALL medications (including over-the-counter) you are currently taking** (for any reason or condition):

MEDICATION	DOSEAGE	REASON(S) PRESCIRBED	DATE PRESCRIBED
Example: Tylenol	*200mg 2xday*	*Leg pain / migraines*	*Sept 2009*

Is there any additional information you would like us to be aware of? _____
_____
_____

List your personal goals for when you have less pain: _____
_____
_____

By my signature I attest that the above information is true and accurate:

_____ _____ _____
Patient Signature ***Print Name*** ***Date***

_____ _____ _____
Parent/Guardian Signature (If under 18 or impaired) ***Print Name*** ***Date***

_____
Relationship to Patient