Please fill out the enclosed questionnaire.

There are 4 ways you can get this form to us:
(This will shorten the time you spend in the waiting room before your appointment.)

1. Upload:

. **To: https://www.bostonstemcell.com/upload/**

. **OR**

2. Fax:

Fax: 508-665-4355

OR

3. Mail:

Complete Pain Care, LLC

600 Worcester Rd, Ste 301

Framingham, MA 01702

OR

4. Bring the forms with you on your appointment date

Patient Registration Form

Patient Information: ☐ new ☐ 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: ☐ self ☐ spouse ☐ child ☐ other

Subscriber DOB: ..... Effective Date of Insurance: .....

Insurance #2

Plan Name: ..... Subscriber ID: .....

Subscriber:..... Relationship: ☐ self ☐ spouse ☐ child ☐ other

Subscriber DOB: ..... Effective Date of Insurance: .....

Insurance #3

Plan Name: ..... Subscriber ID: .....

Subscriber:..... Relationship: ☐ self ☐ spouse ☐ child ☐ other

Subscriber DOB: ..... Effective Date of Insurance: .....

Referral Information:

Referred by: Address: Phone:

Primary Care Physician: Address: Phone:

Workers Compensation:

Injury Date:

Claims Processing Agent: Claim #

Employer at Time of Injury: Address where injury took place:

Adjusters Name: Phone: Fax:

PATIENTS NAME:..... DATE: .....

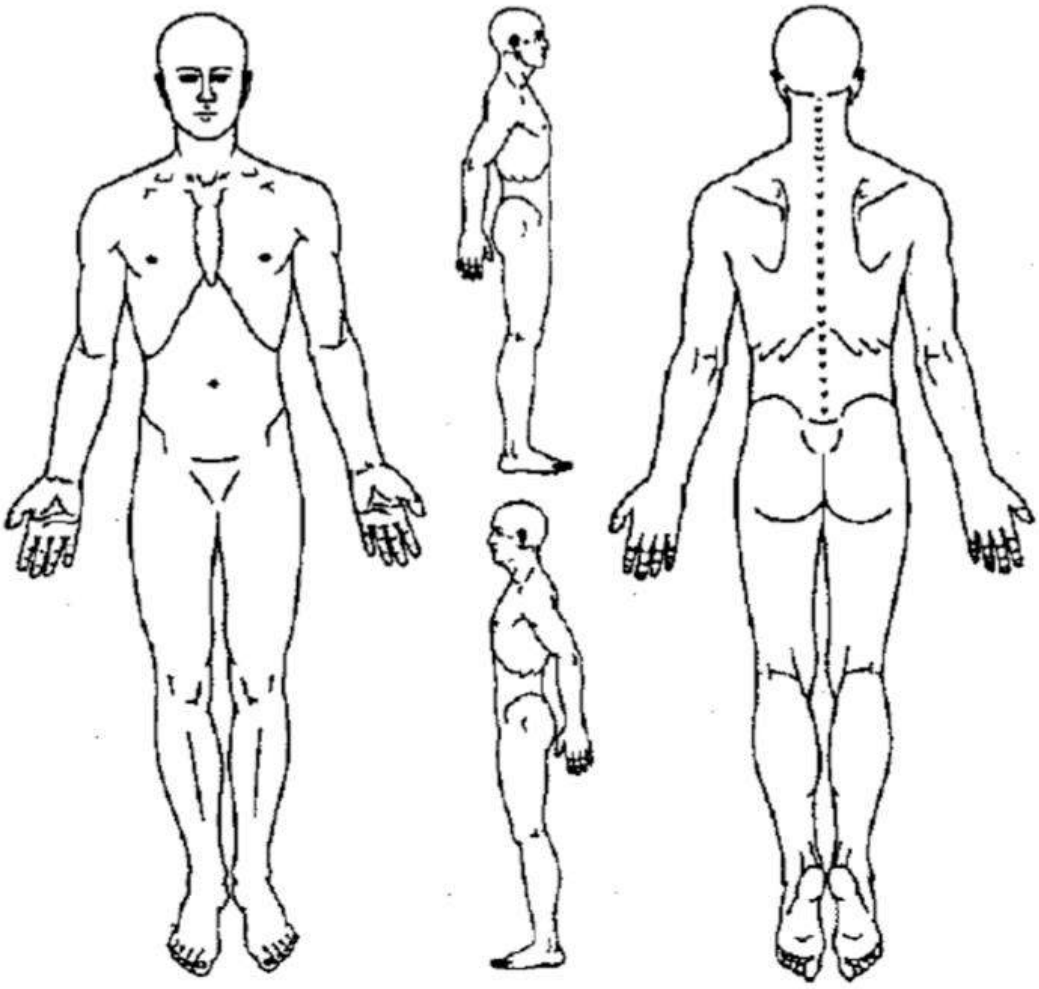
Significant Other: Relationship Phone

....

Do you take care of other family members? O YES O NO

If yes, please describe: .....

Mark the location(s) of pain on the body outlines:				
Numbness ----------	Pins & Needles oooooo	Burning ^^^^^^	Aching xxxxxxx	Sharp or Stabbing ⊗⊗⊗⊗⊗



PLEASE LIST ALL DRUG ALLERGIES/REACTIONS:

ALLERGY	REACTION (RASH, HIVES, SWELLING, ETC.)
.....	.....
.....	.....
.....	.....

PATIENTS NAME:..... DATE: .....

PLEASE LIST ALL THE SURGERIES THAT YOU HAVE HAD:

Surgery (L or R Side?):	Date:	Surgery (L or R Side?):	Date:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

CURRENT MEDICATIONS:

NAME	DOSE	FREQUENCY	SIDE EFFECTS (IF ANY)
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

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

PATIENTS NAME:..... DATE: .....

History of Present Illness

Where is the pain located?

○ Face	○ Neck	○ Headache	
○ Chest	○ Abdomen	○ Pelvis	○ Groin
○ 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?

Right now	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
At its worst	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
At its best	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10
On Average	○ 0	○ 1	○ 2	○ 3	○ 4	○ 5	○ 6	○ 7	○ 8	○ 9	○ 10

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

PATIENTS NAME:..... DATE: .....

Is you pain **not associated with:** (fill in all that apply)

○ Numbness	○ Tingling	○ Weakness
○ Bowel / bladder dysfunction	○ Difficulty sleeping	○ Irritability
○ Difficulty walking	○ Difficulty sitting	○ Other

Have you had the following tests for your pain: (fill in all that apply)

○ Plain X-ray	○ MRI	○ CT Scan
○ Bone Scan	○ EMG / NC Study	

Is your pain **worsened by**: (fill in all that apply)

○ Activity	○ Bending	○ Lifting
○ Sitting	○ Sitting to standing	○ Standing
○ Walking	○ Lying down	○ Other

Is your pain **improved by**: (fill in all that apply)

○ Activity	○ Sitting	○ Standing
○ Walking	○ Lying down	○ Position changes
○ Medications	○ Injections	○ Acupuncture
○ TENS unit	○ Physical therapy	○ Nothing
○ Other		

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

○	○	○	○	○	○	○	○	○	○	○
no relief at all	10-20%	20-30%	30-40%	40-50%	50-60%	60-70%	70-80%	80-90%	>90%	complete relief

Side effects of **your current medication/s:**

○ None	○ Constipation	○ Diarrhea
○ Fatigue	○ Itching	○ Sweating (diaphoresis)
○ Feels like a hangover	○ Headache	○ Stomach upset
○ Nausea	○ Vomiting	○ Rash
○ Vision changes	○ Dry mouth	○ Dizziness
○ Night sweats	○ Palpitations	○ 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)

	Helped	**Did not help**
Botox injection/s	○	○
Epidural Steroid injection/s	○	○
Facet injection/s	○	○
Trigger point injection/s	○	○
Sympathetic block/s	○	○
Bursa injection/s	○	○
Joint injection/s	○	○
Other nerve block/s	○	○
Spinal cord stimulator	○	○
Surgery	○	○
Other Procedure/s	○	○

PATIENTS NAME:..... DATE: .....

Have you tried the following medication/s? If so what happened? (fill in all that apply)

	Helped	Did not help	Caused side effects
Benzodiazepines (Valium, Diazepam, Clonazapam, Alprazolam, Lorazepam, Xanax)	○	○	○
Tylenol / Acetaminophen	○	○	○
NSAIDs (Ibuprofen, Advil, Motrin, Aleve, Naproxen, Relafen, Diclofenac, etc.)	○	○	○
Neurontin / Gabapentin	○	○	○
Lyrica	○	○	○
Topamax / Topiramate	○	○	○
Amitriptyline	○	○	○
Nortriptyline	○	○	○
Baclofen	○	○	○
Zanaflex / Tizanidine	○	○	○
Codeine / Tylenol #3	○	○	○
Vicodin / Vicoprofen / Hydrocodone	○	○	○
Oxycontin / Percocet / Oxycodone	○	○	○
MS Contin / Morphine	○	○	○
Duragesic / Fentanyl Patch	○	○	○
Dilaudid / Hyrdomorphone	○	○	○
Butrans patch	○	○	○
Methadone	○	○	○
Suboxone	○	○	○
Buprenorphine	○	○	○
Soma / Carisoprodol	○	○	○
Flexural / Cyclobenzaprine	○	○	○
Ultram / Tramadol	○	○	○
Cymbalta / Duloxetine	○	○	○
Other medication/s	○	○	○

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

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

During the past 2 weeks:

Have you had little pleasure or interest in activities / hobbies? ○ Yes ○ No

Have you felt down / depressed or hopeless? ○ Yes ○ No

Risk for procedures. Are you **currently taking** any of the following?

○ Coumadin / Warfarin ○ Plavix ○ Aggrenox ○ Ticlid
○ Pradaxa ○ ASA Aspirin ○ Xarelto ○ Eliquis
○ High dose NSAIDS ○ Other blood thinners

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

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

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

Have you fallen in the last 6 months? ○ Yes ○ No

PATIENTS NAME:..... DATE: .....

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	○ Bronchitis	○ Incontinence
○ Heart disease	○ 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 (children) ○ 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

PATIENTS NAME:..... DATE: .....

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