



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: www.bostonstemcell.com/upload/

(If you email this back to us, it will not be secure.)

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:

Primary Care and Referral Physician:

Primary Care Physician:

Address:

Phone:

Referred by:

Address:

Phone:

Significant Other:

Relationship

Phone

.....

.....

.....

Do you take care of other family members? YES NO

If yes, please describe:

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

CURRENT MEDICATIONS:

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

Past Medical History

Have you ever been diagnosed with:

- | | | | |
|--|--|--|---------------------------------------|
| <input type="radio"/> Anemia | <input type="radio"/> Gout | <input type="radio"/> Hepatitis B | <input type="radio"/> Stroke |
| <input type="radio"/> Congestive heart failure | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Hepatitis C | <input type="radio"/> Glaucoma |
| <input type="radio"/> Chest pain | <input type="radio"/> Neck pain | <input type="radio"/> Bronchitis | <input type="radio"/> Incontinence |
| <input type="radio"/> Heart disease | <input type="radio"/> Back pain | <input type="radio"/> Asthma | <input type="radio"/> Hyperthyroidism |
| <input type="radio"/> High blood pressure | <input type="radio"/> Cellulitis | <input type="radio"/> COPD | <input type="radio"/> Hypothyroidism |
| <input type="radio"/> High Cholesterol | <input type="radio"/> Psoriasis | <input type="radio"/> Anxiety disorder | <input type="radio"/> Ulcers |
| <input type="radio"/> Heart murmur | <input type="radio"/> Skin Cancer | <input type="radio"/> Depression | <input type="radio"/> Sleep apnea |
| <input type="radio"/> Mitral valve prolapse | <input type="radio"/> Tuberculosis | <input type="radio"/> Cancer | <input type="radio"/> Diabetes |
| <input type="radio"/> Osteoarthritis | <input type="radio"/> Kidney disease | <input type="radio"/> Seizures | <input type="radio"/> Other _____ |

Implants

Do you have any of these device implants:

- Pacemaker Defibrillator Portacath Pump Rods Artificial knee/hip Other implants

PLEASE LIST ALL DRUG ALLERGIES/REACTIONS:

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

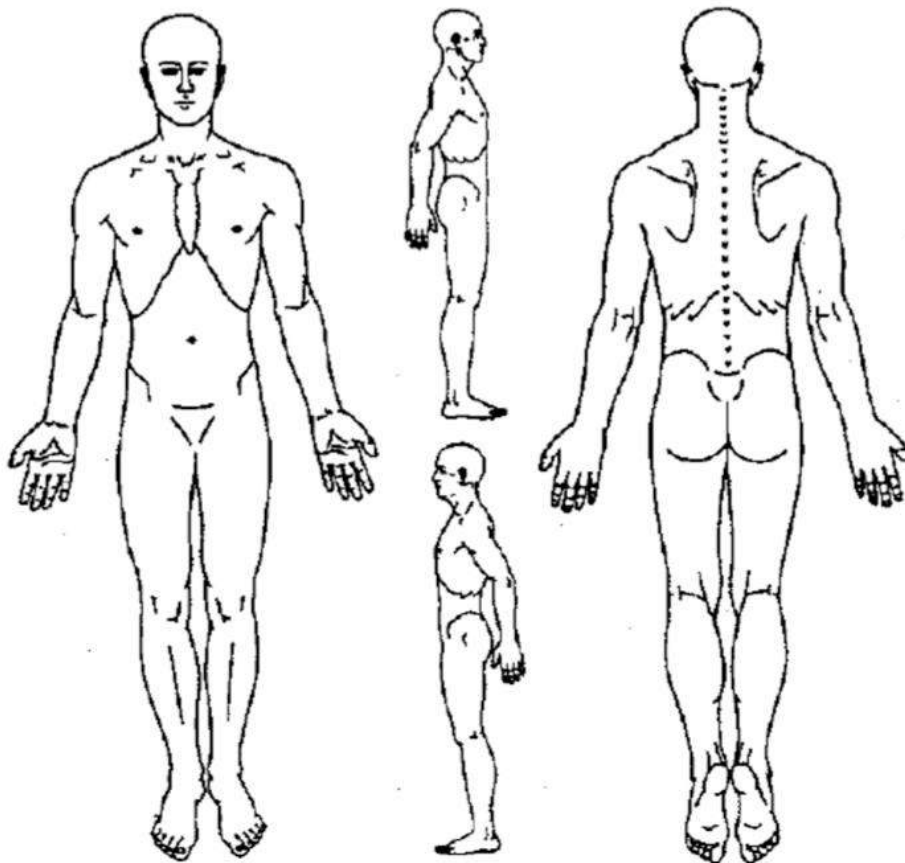
FAMILY HISTORY OF OSTEOARTHRITIS:

Mother Father Siblings Children

PLEASE LIST ALL THE SURGERIES THAT YOU HAVE HAD:

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

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



History of Present Illness

Where is the pain located?

- | | | | |
|-------------------------------------|--------------------------------------|--------------------------------------|---------------------------------------|
| <input type="radio"/> Face | <input type="radio"/> Neck | <input type="radio"/> Headache | |
| <input type="radio"/> Chest | <input type="radio"/> Abdomen | <input type="radio"/> Pelvis | <input type="radio"/> Groin |
| <input type="radio"/> Upper back | <input type="radio"/> Mid Back | <input type="radio"/> Lower back | <input type="radio"/> Multiple Joints |
| <input type="radio"/> Left Shoulder | <input type="radio"/> Right Shoulder | <input type="radio"/> Both Shoulders | <input type="radio"/> Total Body |
| <input type="radio"/> Left Elbow | <input type="radio"/> Right Elbow | <input type="radio"/> Both Elbows | <input type="radio"/> Other: _____ |
| <input type="radio"/> Left Hand | <input type="radio"/> Right Hand | <input type="radio"/> Both hands | |
| <input type="radio"/> Left Arm | <input type="radio"/> Right Arm | <input type="radio"/> Both Arms | |
| <input type="radio"/> Left Buttock | <input type="radio"/> Right Buttock | <input type="radio"/> Both Buttocks | |
| <input type="radio"/> Left Thigh | <input type="radio"/> Right Thigh | <input type="radio"/> Both Thighs | |
| <input type="radio"/> Left Hip | <input type="radio"/> Right Hip | <input type="radio"/> Both Hips | |
| <input type="radio"/> Left Knee | <input type="radio"/> Right Knee | <input type="radio"/> Both Knees | |
| <input type="radio"/> Left Calf | <input type="radio"/> Right Hip | <input type="radio"/> Both Hips | |
| <input type="radio"/> Left Foot | <input type="radio"/> Right Foot | <input type="radio"/> Both Feet | |
| <input type="radio"/> Left Ankle | <input type="radio"/> Right Ankle | <input type="radio"/> Both Ankles | |

How did your pain begin?

- | | | | |
|--|---|--|------------------------------------|
| <input type="radio"/> Spontaneous | <input type="radio"/> Accident at Work | <input type="radio"/> Accident at home | <input type="radio"/> Other: _____ |
| <input type="radio"/> Motor Vehicle Accident | <input type="radio"/> Following surgery | <input type="radio"/> Gradually | |

Describe the pain:

- | | | | |
|---------------------------------|--------------------------------------|--------------------------------|------------------------------------|
| <input type="radio"/> Burning | <input type="radio"/> Sharp | <input type="radio"/> Shooting | <input type="radio"/> Dull |
| <input type="radio"/> Throbbing | <input type="radio"/> Knife/stabbing | <input type="radio"/> Aching | <input type="radio"/> Other: _____ |

If your pain travels, does it radiate to the:

- | | | | |
|--------------------------------|---------------------------------|---------------------------------|------------------------------------|
| <input type="radio"/> Left arm | <input type="radio"/> Right arm | <input type="radio"/> Both arms | <input type="radio"/> Other: _____ |
| <input type="radio"/> Left leg | <input type="radio"/> Right leg | <input type="radio"/> Both legs | |

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	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
At its worst	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
At its best	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10
On Average	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 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

Is your pain **associated with**: (fill in all that apply)

- | | | |
|---|---|------------------------------------|
| <input type="radio"/> Numbness | <input type="radio"/> Tingling | <input type="radio"/> Weakness |
| <input type="radio"/> Bowel / bladder dysfunction | <input type="radio"/> Difficulty sleeping | <input type="radio"/> Irritability |
| <input type="radio"/> Difficulty walking | <input type="radio"/> Difficulty sitting | <input type="radio"/> Other: _____ |

Is your pain **NOT associated with**: (fill in all that apply)

- | | | |
|---|---|------------------------------------|
| <input type="radio"/> Numbness | <input type="radio"/> Tingling | <input type="radio"/> Weakness |
| <input type="radio"/> Bowel / bladder dysfunction | <input type="radio"/> Difficulty sleeping | <input type="radio"/> Irritability |

- Difficulty walking Difficulty sitting 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

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

- Activity Bending Lifting
 Sitting Sitting to standing Standing
 Walking Lying down 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

Where did you have your imaging done? _____

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

Is there ongoing litigation regarding your pain Yes No

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

	Helped	Did not help	Caused side effects
Tylenol / Acetaminophen	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NSAIDs (Ibuprofen, Advil, Motrin, Aleve, Naproxen, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Codeine / Tylenol #3	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vicodin / Vicoprofen / Hydrocodone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oxycontin / Percocet / Oxycodone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ultram / Tramadol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cymbalta / Duloxetine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other medication/s	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	Helped	Did not help
Joint injection/s	<input type="radio"/>	<input type="radio"/>
Surgery	<input type="radio"/>	<input type="radio"/>
Other Procedure/s	<input type="radio"/>	<input type="radio"/>

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 _____

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

- | | | | | | | | | | | |
|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| no relief
at all | 10-
20% | 20-
30% | 30-
40% | 40-
50% | 50-
60% | 60-
70% | 70-
80% | 80-
90% | >90% | complete
relief |

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

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

Social History

Occupation: Working Retired Homemaker Unemployed Student Disabled

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

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

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 _____

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

Personal history of prescription drugs. Yes No

Family History of Depression Yes No

Family history of Psychological disease ADD OCD Bipolar Schizophrenia

Review of Systems - These refer to problems other than your main pain problem above:

Do you have any (check all that apply):

<input type="radio"/> Chest Pain	<input type="radio"/> Palpitations	<input type="radio"/> Difficulty swallowing	<input type="radio"/> Heartburn
<input type="radio"/> Weight Gain	<input type="radio"/> Weight Loss	<input type="radio"/> Fever	<input type="radio"/> Fatigue
<input type="radio"/> Skin changes	<input type="radio"/> Dry skin	<input type="radio"/> Hives/rashes	<input type="radio"/> Non-healing lesions
<input type="radio"/> Recurrent Infections	<input type="radio"/> Urinary incontinence	<input type="radio"/> Excessive urination	<input type="radio"/> Difficulty urinating
<input type="radio"/> Change in Energy level	<input type="radio"/> Change in mood/behavior	<input type="radio"/> High stress level	<input type="radio"/> Irritability
<input type="radio"/> Abdominal Pain	<input type="radio"/> Blood in stool	<input type="radio"/> Constipation	<input type="radio"/> Leg swelling
<input type="radio"/> Easy bruising	<input type="radio"/> Abnormal bleeding	<input type="radio"/> Large lymph nodes	<input type="radio"/> Poor Sleep
<input type="radio"/> Arthritis / Joint Pain	<input type="radio"/> Joint Swelling	<input type="radio"/> Joint stiffness	<input type="radio"/> Muscle pain
<input type="radio"/> Seizures	<input type="radio"/> Numbness/tingling	<input type="radio"/> Weakness in a limb	<input type="radio"/> Cold intolerance
<input type="radio"/> Change in vision	<input type="radio"/> Wear corrective lenses	<input type="radio"/> Changes in hearing	<input type="radio"/> Changes in memory
<input type="radio"/> Wheezing	<input type="radio"/> Coughing up blood	<input type="radio"/> Cough	<input type="radio"/> Shortness of breath
	<input type="radio"/> Sexual dysfunction	<input type="radio"/> Allergies (non-medication)	