cnpm
CANADIAN NEUROMODULATION PAIN MANAGEMENT CENTRE

NEW PATIENT INFORMATION FORM

Today's Date *(mm/dd/yyyy)*: _____

Patient Information

Your Name *(First and Last)*: _____

Date of Birth: *year* _____ *month* _____ *day*_____ Weight: _____ Height: _____

Referring Physician: _____

Primary Care Physician: _____

Coverage: ☐ WSIB ☐ Disability Insurance ☐ Third Party Insurance ☐ Not applicable

Your Contact Info: Tel _____ Email _____

Pain History

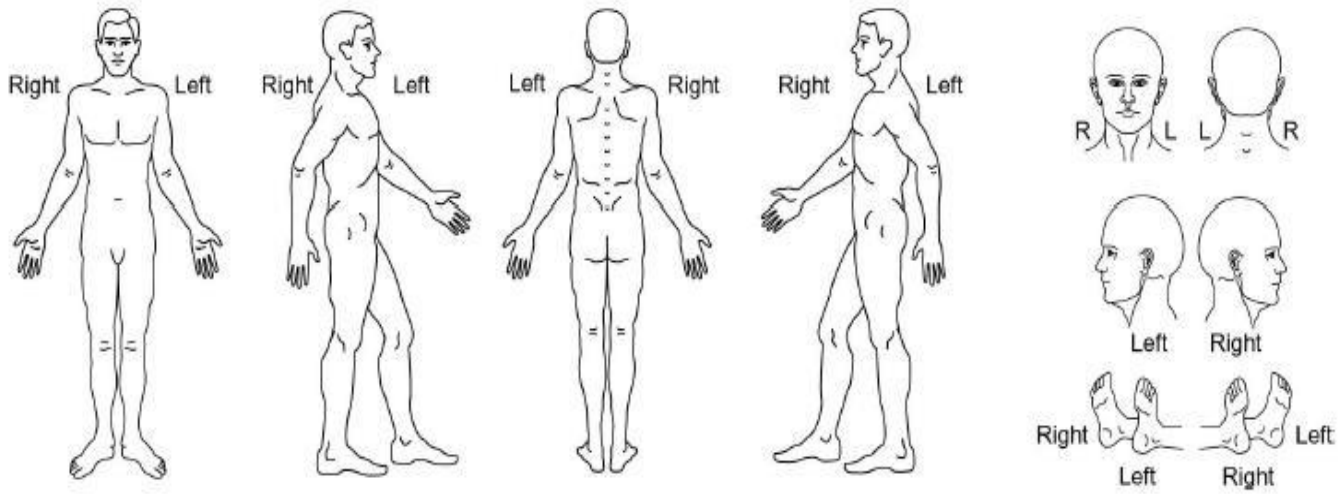
Chief Complaint (Reason for your visit)? _____

_____

Does this pain radiate? If so where? _____

Please list any other areas of pain: _____

Put an "**X**" on this diagram to indicate the **areas of your pain**:



Symptom Onset

Approximately, when did this pain start? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Change since pain began? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

What best describes the **character of your pain**:
☐ Dull ☐ Tender ☐ Stabbing ☐ Tingling ☐ Burning
When is your **pain at its worst**? ☐ Morning ☐ Afternoon ☐ Night
How often is the pain? ☐ Constant ☐ Intermittent ☐ Changes in severity but always present

Please rate your pain if no pain is "0" and the worst pain imaginable "10": *(Circle number)*
Right Now the pain is: *(None)* 0 1 2 3 4 5 6 7 8 9 10 *(Worst)*
The **Best** the pain gets is: *(None)* 0 1 2 3 4 5 6 7 8 9 10 *(Worst)*
The **Worst** the pain gets is: *(None)* 0 1 2 3 4 5 6 7 8 9 10 *(Worst)*

What factors **worsen** or affect your pain? _____
_____

What factors **relieve** your pain? _____
_____

Are there any **associated symptoms**? *(eg: numbness/ tingling/ weakness/ incontinence, etc)*
_____

What are the **goals** you wish to achieve in managing your pain?
_____

Diagnostic Tests and Imaging

Mark all of the following tests that you have had related to your current pain complaints:

☐ MRI of the: _____ Date:_____
☐ CT of the: _____ Date:_____
☐ X-Ray of the: _____ Date:_____
☐ EMG/NCV study of the: _____ Date:_____
☐ Other Diagnostic Testing: _____ Date: _____
☐ I have not had ANY diagnostic tests for my current pain complaint

Interventional Pain Treatment History ☑

☐ Epidural Steroid Injection: ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Joint Injection – which joint(s)? _____
☐ Medial Branch Blocks/ Facet Injections: ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Nerve Blocks – Area/ Nerve(s): _____
☐ Radiofrequency Nerve Ablation: ☐ Cervical ☐ Thoracic ☐ Lumbar
☐ Trigger Point Injections: Where? _____
☐ Other: _____

Mark the following physicians or specialists you have consulted for your current pain problem(s): ☑

☐ Acupuncturist ☐ Chiropractor ☐ Internist ☐ Physical Therapist
☐ Psychiatrist/ Psychologist ☐ Neurologist ☐ Orthopedic Surgeon ☐ Neurosurgeon
☐ Rheumatologist ☐ Other _____

Past Medical History

Please list any other **medical conditions**:

_____
_____
_____
_____
_____

Past Surgical History

Please list any **surgical procedures** you have had done in the past including date:

1) _____ Date _____
2) _____ Date _____
3) _____ Date _____
4) _____ Date _____
5) _____ Date _____

☐ I have **NEVER** had any surgical procedures performed

Social History

Occupation: _____ OR

☐ Temporary Disability ☐ Permanent Disability ☐ Retired ☐ Unemployed

When was the last time you worked? (Month/ year) _____

Are you currently under **worker's compensation**? ☐ Yes ☐ No

How many stairs in your current home? ☐ 0 ☐ 1 flight ☐ >2 flights

Alcohol Use: ☐ Social Use ☐ Daily use of alcohol ☐ Never
☐ History alcoholism ☐ Current alcoholism

Tobacco Use: ☐ Current user Packs per day? _____ How many years? _____
☐ Former user Quit Date: _____
☐ Never used

Cannabis Use: ☐ Current user ☐ Former user ☐ Never used

Illegal Drug Use: ☐ Deny any illegal drug use ☐ Currently using illegal drugs
☐ Formerly used illegal drugs (not currently used)

Have you ever abused narcotic or prescription medications? ☐ Yes ☐ No

Current Medications

Are you currently taking any **blood thinners**/ anti-coagulants? ☐ No ☐ YES

If yes, please mark which ones: ☑ ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Ticlid ☐ Lovenox

☐ Pradaxa ☐ Xarelto ☐ Eliquis ☐ Other(s)_____

Please list **all medications** you are currently taking including **vitamins**. Attach additional sheet if required:

Medication Name/ Dose/ Frequency

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____
11) _____
12) _____

Please list all **past pain medications** that you have been on at any point **for your current pain** complaints?

Pain Medication Name/ Dose/ Frequency

1) _____
2) _____
3) _____
4) _____
5) _____

Allergies

Do you have any drug/ medication allergies? ☐ No ☐ YES If so, please list all medications you are allergic to:

1) _____ Type of reaction: _____
2) _____ Type of reaction: _____
3) _____ Type of reaction: _____
4) _____ Type of reaction: _____

Topical Allergies: ☑ ☐ Latex ☐ Iodine ☐ Tape ☐ IV/ X-ray Contrast ☐ None