Please fill out the enclosed questionnaire and the accompanying forms.

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

1. Upload:

. **To: www.completepaincare.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

The attached Patient Registration form is for Complete Pain Care since your medical services will be delivered by Complete Pain Care. Don't worry, you are a member of the Center for Morton's and will only be seen by one of our licensed doctors but legally all medical services must be done by Complete Pain Care.

Complete Pain Care
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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:

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PATIENTS NAME:_____ DATE:_____

Where is the worst pain on your foot?
.....

Shoe size ..... Height: ..... Weight:.....

How did your pain begin? .....
.....
.....

Please score your pain **on a scale of 0-10** where **0 is no pain** and **10 is the worse pain** of your life

RIGHT NOW: ___ / 10	At its worse: ___ / 10	At its best: ___ / 10	On Average: ___ / 10

What makes your pain feel:

Worse:
- ☐ Walking
- ☐ Running
- ☐ Lifting
- ☐ Lying
- ☐ Sitting
- ☐ Standing
- ☐ Weather / Temperature change
- ☐ Shoe Types:.....
- ☐ Other:.....

Better:
- ☐ Medication: .....
- ☐ Heat
- ☐ Ice
- ☐ Rest
- ☐ Lying
- ☐ Standing
- ☐ Weather / Temperature change
- ☐ Shoe Types: .....
- ☐ Other: .....

Does your pain radiate (i.e. travel up or down foot or leg)? YES NO
If yes, please describe:.....

Have you had any acute loss of bowel/bladder control? YES NO
If yes, please describe:.....

Do you have numbness? YES NO
If yes, is it constant or occasional? CONSTANT OCCASIONAL
In what part of your body do you feel it? .....
How long ago did it begin? .....

Do you experience any weakness? YES NO
If yes, please describe: .....

Do you have any other symptoms that accompany your pain? YES NO
If yes, please describe: .....

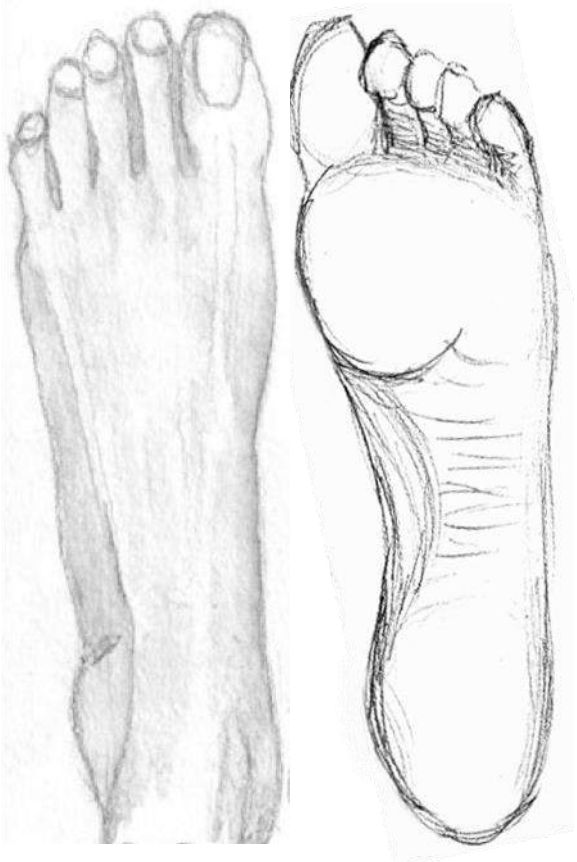
PATIENTS NAME:_____ DATE:_____

Please describe your pain:

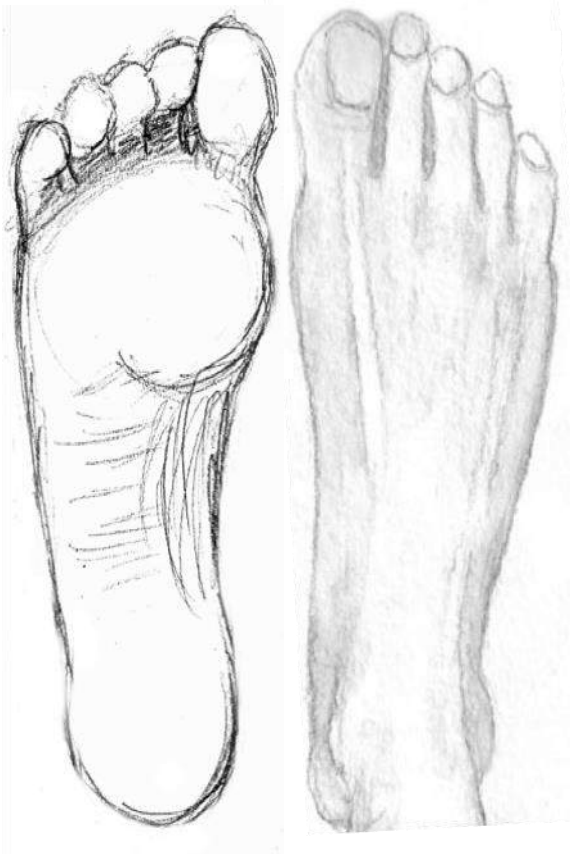
- ☐ Pricking
- ☐ Aching
- ☐ Burning
- ☐ Dull
- ☐ Sharp/Stabbing
- ☐ Shooting
- ☐ Pins and needles
- ☐ Pulling
- ☐ Other .....

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

Left Foot



Right Foot



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PATIENTS NAME:_____ DATE:_____

During the past 2 weeks:

Have you had little pleasure or interests in activities / hobbies? ..... YES ..... NO
Have you felt down / depressed or hopeless? ..... YES ..... NO
Have you felt tense or anxious? ..... YES ..... NO
Have you had difficulty sleeping? ..... YES ..... NO

PREVIOUS TREATMENTS - Please describe what worked and when?

☐ Surgery: if yes, year ..... type ..... HELPFUL ..... NOT HELPFUL
☐ Previous Injections: year: ..... type: ..... HELPFUL ..... NOT HELPFUL
year: ..... type: ..... HELPFUL ..... NOT HELPFUL
☐ Orthotics: year: ..... type (custom/off the shelf): ..... HELPFUL ..... NOT HELPFUL
☐ Physical Therapy: when? ..... HELPFUL ..... NOT HELPFUL
☐ Chiropractic Care: when? ..... HELPFUL ..... NOT HELPFUL
☐ Psychological Support: when? ..... HELPFUL ..... NOT HELPFUL
☐ Acupuncture: when? ..... HELPFUL ..... NOT HELPFUL
☐ Other: ..... HELPFUL ..... NOT HELPFUL

Tests Done:	**Date**	**Facility**
☐ MRI	.....	.....
☐ CAT SCAN	.....	.....
☐ X RAYS	.....	.....
☐ EMG	.....	.....
☐ OTHER	.....	.....

PAIN MEDICATIONS - Please check/circle all that you have tried in the past or are currently taking:

☐ TYLENOL/ACETAMINOPHEN	HELPFUL	NOT HELPFUL
☐ NSAIDS: Motrin, Advil, Aleve, ibuprofen, naproxen, Celebrex	HELPFUL	NOT HELPFUL
☐ MUSCLE RELAXANTS: Cyclobenzaprine, Zanaflex, Flexeril, tizanidine, Soma, Diazepam, Valium	HELPFUL	NOT HELPFUL
☐ NARCOTICS: Tramadol, Percocet, Vicodin, oxycodone, hydrocodone, orphine, dilaudid, methadone, Duragesic patch, MS Contin, Butran, Oxycontin, Buprenorphine, Other:	HELPFUL	NOT HELPFUL
☐ OTHER PAIN MEDICATIONS: Lyrica, Gabapentin/Neurontin, Amitriptyline, Nortryptyline, Cymbalta	HELPFUL	NOT HELPFUL
☐ Other	HELPFUL	NOT HELPFUL

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PATIENTS NAME:_____ DATE:_____

PAST MEDICAL HISTORY

Are you diabetic? ..... YES.....NO
If yes, what is your average blood sugar? ☐ Less than 150 ☐ 150-200 ☐ Over 200

Are you currently taking blood thinners? ..... YES.....NO
If yes, which one? ☐Warfarin/Coumadin ☐Plavix ☐Aggrenox ☐Ticlid ☐Pradaxa ☐ASA aspirin
☐ Xarelto ☐Eliquis ☐Other: .....

Do you have any medical devices implanted in your body?
(e.g., pacemaker, defibrillator, portacath, pump, rods, artificial knee/hip) ..... YES.....NO
If yes, device type:..... location: .....

Do you have sleep apnea? ..... YES.....NO

Do you have a history of cancer?..... YES.....NO
If yes, please describe what type, when/where/how it was treated: .....
.....

Do you have any allergies to: iodine, betadine, CT Scan dye, IVP dye, contrast dye, or shellfish? YES NO
If yes, please describe reaction:.....

PLEASE LIST ALL DRUG ALLERGIES/REACTIONS:

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

PLEASE LIST ALL THE SURGERIES THAT YOU HAVE HAD:

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

PATIENTS NAME:_____ DATE:_____

REVIEW OF SYSTEMS: INDICATE WHICH OF THE FOLLOWING YOU HAD OR HAVE AT PRESENT:

Abdominal Pain	YES	NO	Communicable Disease	YES	NO
Blood in Stools	YES	NO	Tuberculosis	YES	NO
Constipation	YES	NO	Kidney Disease / Dialysis	YES	NO
Stomach Problems /Reflux /Heartburn	YES	NO	Liver disease / Hepatitis	YES	NO
Anemia	YES	NO	Weight Gain or Loss	YES	NO
Bleeding disorders / blood clots / phlebitis	YES	NO	Diabetes	YES	NO
Ankle Swelling	YES	NO	Fatigue	YES	NO
Deep Vein Thrombosis	YES	NO	Persistent Fever	YES	NO
Arrhythmia / Palpitations	YES	NO	Asthma	YES	NO
Congestive Hearth Failure	YES	NO	Breathing disorder / lung disease	YES	NO
Chest Pain	YES	NO	Bronchitis	YES	NO
Heart (Surgery, disease, problems)	YES	NO	COPD / Emphysema	YES	NO
High Blood Pressure	YES	NO	Anxiety	YES	NO
High Cholesterol	YES	NO	Brain Tumor	YES	NO
Mitral value prolapse/ heart murmur	YES	NO	Depression	YES	NO
Antibiotics for dental work	YES	NO	Poor Sleep	YES	NO
Peripheral Vascular Disease / Poor Circulation	YES	NO	Psychiatric / Psychological care	YES	NO
Arthritis/ Joint Pain or Swelling:	YES	NO	Neurological disorder	YES	NO
Autoimmune disease	YES	NO	Seizure Disorder	YES	NO
Artificial Joints (hip knee etc.)	YES	NO	Stroke / TIA	YES	NO
Osteoporosis	YES	NO	Hearing Loss	YES	NO
Gout	YES	NO	Incontinence (Urine? Stool?)	YES	NO
Rheumatoid Arthritis	YES	NO	Glaucoma	YES	NO
Sciatica / Back problems	YES	NO	Thyroid Problems	YES	NO
Neck Stiffness / Neck Pain	YES	NO	Ulcers	YES	NO
Cellulitis	YES	NO	Varicose Veins	YES	NO
Psoriasis	YES	NO	Plantar Warts	YES	NO
Skin Cancer	YES	NO			
Fracture History please specify:					

What activities would you like to perform if your pain were under better control?

1. .....

2. .....

3. .....

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PATIENTS NAME:_____ DATE:_____

SOCIAL HISTORY: PLEASE ANSWER TO THE BEST OF YOUR ABILITY (If you are uncomfortable answering a question you may leave it blank)

Do you use smoke tobacco? CURRENTLY PREVIOUSLY NEVER

If ***CURRENTLY*** smoking tobacco: Per day: _____ Number of years: _____

How many minutes after waking up before your first cigarette? _____ minutes

Check one: ☐THINKING ABOUT QUITING ☐READY TO QUIT ☐NOT READY TO QUIT

If ***PREVIOUSLY*** smoked tobacco how long has it been since your last cigarette: _____

How much Beer/ Wine / Liquor do you have per week? .....

Did you ever in your life abuse alcohol, prescription drugs or any illegal drugs? YES NO

If ***YES*** please describe: .....

Do you have a family history of alcoholism? YES NO

Do you use recreational substances? (Illegal or prescription drugs for recreational purposes) CURRENTLY PREVIOUSLY NEVER

Do you have a family history of substance abuse? YES NO

Do you have a family history of prescription drug abuse? YES NO

Do you think you feel down or suffer from depression? YES NO

Do you use caffeine products? YES NO

Do you have any of the following diagnosis? ADD OCD Bipolar Schizophrenia None

Were you a victim of sexual abuse prior to the age of 13? YES NO

Significant Other: Relationship Phone

....

Do you take care of other family members? YES NO

If yes, please describe: .....

Previous / Current Occupation: ..... Are you currently working? YES NO

If no, why?: .....

Are you currently receiving compensation or disability payments now? YES NO

Are you in litigation because of your pain or injury? YES NO

Do you live alone YES NO

Residence: ☐House ☐Apartment Steps to climb (#).....

Do you have difficult with:

Speaking ..... YES.....NO

Vision ..... YES.....NO

Hearing ..... YES.....NO

Do you learn best by:

Verbal instruction ..... YES.....NO

Visual demonstration ..... YES.....NO

Hands on (if possible) ..... YES.....NO

Any of the above ..... YES.....NO

Assisted devices:	Date Started Using:	Frequency of use:	Assisted devices:	Date Started Using:	Frequency of use:
☐ Glasses	.....	.....	☐ Wheelchair	.....	.....
☐ Contact Lenses	.....	.....	☐ Cane	.....	.....
☐ Hearing Aid	.....	.....	☐ Walker	.....	.....
☐ Dentures	.....	.....	☐ Crutches	.....	.....
☐ Prosthesis	.....	.....	☐ Other	.....	.....

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PATIENTS NAME:_____ 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