SPINE & PAIN INSTITUTE OF NEW ENGLAND
TOMOYA SAKAI MD
BOARD CERTIFIED PHYSICIAN

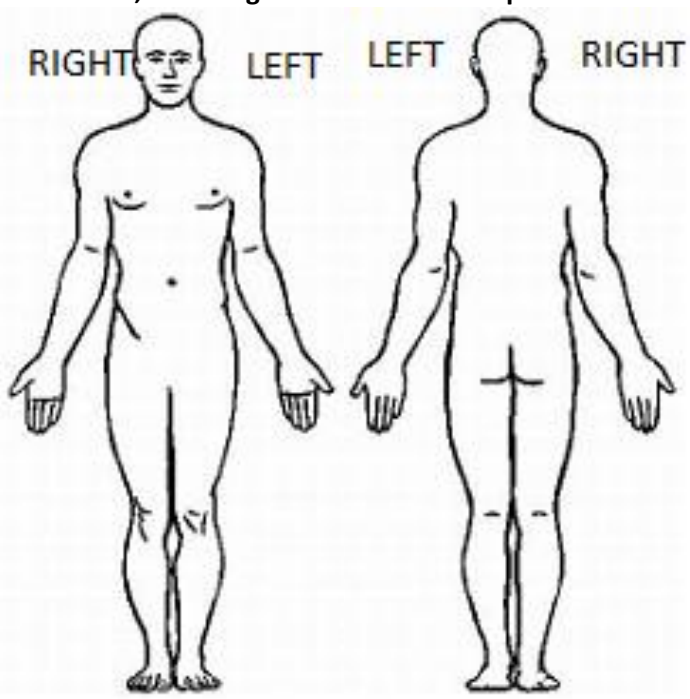
Duxbury, Dedham, Wellesley • (781) 326-8888
West Yarmouth, Mashpee • (508) 790-7000
www.SpinePainDocs.com

Comprehensive Pain Questionnaire

Name: _____ **Today's Date:** _____/_____/_____

- **What is your main pain concern?** _____

- **REQUIRED: Indicate on diagram below where your pain is located, including all areas where the pain radiates:**



- **When did the pain start**? _____
- **If injury, describe:** _____
- **Do you have any associated weakness?** Yes or No
  If yes, where? _____
- **Do you have any associated numbness?** Yes or No
  If yes, where? _____
- **Any worsening of walking balance?** Yes or No
- **Any associated loss of bladder control?** Yes or No
- **Any associated loss of bowel control?** Yes or No
- **Rate the severity of your pain on a 0-10 scale, where 0 is no pain and 10 is the worst possible pain:**
  Current pain: _____/10
  Pain at its worst: _____/10
  Pain at its best: _____/10
- **Since the pain began, severity is:**
  Worse Same Better
- **Pain is (circle one):** Constant Intermittent

- **Quality of pain is (circle as few as possible):**
  Burning Cramping Electric shocks Pins/needles Shooting Stabbing Other: _____

- **What makes your pain worse (circle as few as possible)?**
  Nothing Lying down Sitting Standing Walking Stairs
  Lifting Bending over Exercise Mornings Evenings Weather changes
  Other: _____

- **What makes your pain better (circle as few as possible)**?
  Rest Lying down Sitting Standing Walking Exercise Leaning forward
  Other: _____

- **Has your pain SIGNIFICANTLY affected or limited any of the following (circle as few as possible)?**
  Sleep Job Housework Mood Exercise Other: _____

- **Have you done physical therapy?** Yes-currently or Yes-previously or No
  If yes, indicate dates/year, or number of weeks/sessions? _____
  Did it help improve pain? Yes or No **Did it help improve function?** Yes or No
  Currently doing exercise program prescribed by physical therapy? Yes or No

- **Have you done chiropractic?** Yes-currently or Yes-previously or No
  If yes, indicate name of chiropractor: _____
  Indicate dates/year, or number of weeks/sessions? _____
  Did it help improve pain? Yes or No **Did it help improve function?** Yes or No
  Did chiropractor prescribe exercises? Yes or No **If yes, currently doing prescribed exercises?** Yes or No

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- **List medications you *CURRENTLY TAKE FOR PAIN*, including dose, and specify whether or not it is helping:**

_____

_____

- **List meds *PREVIOUSLY TRIED FOR PAIN*, including dose. Specify whether or not it helped, and why it was stopped:**

_____

_____

- **Have you seen any other pain management physicians before?** Yes-currently or Yes-previously or No
  If yes, name of physician, location, when: _____
  Did you have injections? Yes or No
  If yes, specify type of injections and whether or not they helped: _____

- **Have you seen a surgeon for your current pain condition?**
  Neurosurgeon Orthopedic spine surgeon Orthopedic surgeon (non-spine) Other: _____

- **Have you seen any non-surgical specialists for your current pain condition?**
  Neurologist Rheumatologist Physiatrist (rehab doctor) Psychiatrist Psychologist Other: _____

- **List other treatments you tried (other than medications) and indicate whether or not it helped (e.g. acupuncture):**

For women 65+ - **Have you been screened for Osteoporosis via diagnostic imaging?** (Bone scan/density) Yes or No

If yes to above question, please list the date study was performed _____ and the findings _____

- **What diagnostic studies have you had for your current pain?**

MRI:

a. Cervical spine (neck)	Date: _____ _____	Where: _____
b. Lumbar spine (low back)	Date: _____ _____	Where: _____
c. Other: _____	Date: _____ _____	Where: _____

CT scan:

a. Cervical spine (neck)	Date: _____ _____	Where: _____
b. Lumbar spine (low back)	Date: _____ _____	Where: _____
c. Other: _____	Date: _____ _____	Where: _____

X-Rays:

a. Cervical spine (neck)	Date: _____ _____	Where: _____
b. Lumbar spine (low back)	Date: _____ _____	Where: _____
c. Hips/Pelvis	Date: _____ _____	Where: _____
d. Other: _____	Date: _____ _____	Where: _____

EMG:

a. Neck and/or arm(s)	Date: _____ _____	Where: _____
b. Low back and/or leg(s)	Date: _____ _____	Where: _____
Other studies: _____ ____	Date: _____ _____	Where: _____

- **Is there any reason you cannot have an MRI?** Yes or No
  If yes, please specify why: Claustrophobia Pacemaker Spinal cord stimulator Metal in body

- **Medical (non-surgical) history (circle all that apply and specify type if indicated)**:
  None Osteoporosis COPD (lung disease) Fibromyalgia Infection (e.g. hepatitis, HIV)
  Diabetes Heart disease Cancer (specify) Depression Other: _____

- **Surgical history (circle all that apply and describe type of surgery if possible)**:
  None Cervical spine (neck) Lumbar spine (low back) Shoulder Knee Hip Cardiac stent Pacemaker
  Other: _____

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- **Allergies (circle all that apply):**
  None Latex Betadine Local anesthetic (e.g. lidocaine) IV contrast dye Steroid Adhesives/tape
  Other: _____
  If contrast allergy, describe type of contrast (e.g. for CT or MRI) and reaction: _____

- **List all OTHER CURRENT prescription and non-prescription medications and doses (or provide separate list):**

_____

_____

_____

_____

If taking blood thinner, list here: _____

- **Pharmacy name and address (street and city):** _____

- **Social history:**

  Activities of daily living: Independent Need assistance Unable

  Currently working: Yes or No
  If temporarily not working due to injury, list date you last worked: _____
  Retired: Yes or No
  Disability benefits: Yes or No
  Occupation: _____

  Tobacco: Yes or No or Quit **If yes, how much?** _____

  Alcohol: Yes or No or Quit **If yes, how much?** _____
  Alcoholism: Yes or No **If yes, attending AA meetings?** Yes or No

  Marijuana: Yes or No or Quit **Certified and registered with state of MA for medical marijuana:** Yes or No

  Prescription drug abuse: Yes or No or Quit **If yes, specify which drug(s):**_____

  Other drug abuse: Yes or No or Quit **If yes, specify which drug(s):**_____

  Drug abuse treatment program: Yes-currently or Yes-previously or No
  If yes, specify type (e.g. Suboxone, methadone, inpatient): _____

- **Family history of medical problems:**
  None Bleeding disorder Cancer (specify) Chronic pain Fibromyalgia Severe arthritis Depression
  Other: _____

- **Review of symptoms (circle all that apply if not already indicated above):**
  1) General: Weight gain Unintentional weight loss Fatigue Fever Chills Night sweats Cancer
  2) Eyes: Visual change Double vision
  3) Ears/Nose/Throat: Ringing in ears Difficulty swallowing
  4) Pulmonary: Cough Difficulty breathing
  5) Cardiovascular: Chest pain Irregular/skipped beats Swelling
  6) Gastrointestinal: Diarrhea Constipation Bowel incontinence
  7) Hematological: Abnormal bleeding Abnormal bruising
  8) OB/GYN: Pregnant –currently Pregnant–planning soon
  9) Genitourinary: Urinary frequency Urinary urgency Urinary incontinence Difficulty urinating
  10) Skin: Rash Infection
  11) Neurological: Headache Light-headed Vertigo
  12) Psychological: Depression Suicidal thoughts Suicide attempts Anxiety Panic attacks Hallucinations
  Verbally abused Physically abused Sexually abused History of rape
  13) Other: _____

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APPOINTMENT CANCELLATION/ NO SHOW POLICY

SPINE is privileged to provide diagnoses and treatment of patients with pain. We work diligently to maintain our high level of personalized service and strive to accommodate our patients' needs for office visits in a timely manner. This requires careful planning and coordination among many individuals in our office.

We understand that emergencies arise from time to time for our patients, just as they do for us. However, when a patient cancels an appointment without adequate notice, or simply fails to keep an appointment, we cannot use that time to serve the needs of our other patients. Therefore, we have developed this policy regarding failure to keep appointments or cancelling appointments without adequate notice. We respectfully request your understanding and agreement to our policy as it is stated below.

NEW PATIENTS

We will give you a reminder call 48 hours in advance of your scheduled appointment. Any new patient who fails to keep an appointment or who cancels or reschedules an appointment less than 24 hours prior to their appointment will be required to pay a fee of $40.00 in order to schedule a new consultation visit. For Monday appointments, cancellations must be made by noon on the preceding Friday. This fee will have to be paid prior to your next appointment.

ESTABLISHED PATIENTS (*Patients who have previously seen a physician in our practice*)

Any established patient who fails to keep an appointment or who cancels or reschedules an appointment less than 48 hours in advance of their appointment will be charged a fee of $35.00 per occurrence. For Monday appointments, cancellations must be made by noon on the preceding Friday.

If a new or established patient fails to give adequate notice on two consecutive occasions, the practice will have the right to dismiss that patient.

FEES

All fees charged by Spine & Pain Institute of New England pursuant to this No Show/Cancellation policy are not payable by your insurance company.

All fees are payable on or before your next office visit with your Spine & Pain Institute of New England physician or within 30 days of receipt of a billing statement from New England Accounts Receivable Management for that fee, whichever is earlier.

Your physician may waive your "no-show" fee for good cause shown. To request that this fee be waived, you must email a written request and explanation to the following address: info@spinepaindocs.com. If you do not have access to a computer, you may write a letter to Spine & Pain Institute of New England, 104 Tremont Street Unit 1, Duxbury MA 02332. Attention: Office Manager

Please remember that it is your responsibility to make certain that we have updated, accurate phone numbers so that we may contact you.

Thank you for your consideration and understanding of our policy.

Patient Name_____

Patient Signature:_____Date: _____

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Policies and Procedures

The mission of the Spine & Pain Institute of New England is to provide high quality, safe, and accessible care. The aim is to decrease pain and increase function through consultation, coordination of care, and diagnostic and therapeutic interventions.

The purpose of this form is to give patients information to assist in the success of their treatment and outline expectations:

1. Please set up appointments for visits in advance. Due to the physician's full schedule, he/she is not able to see walk-ins.
2. Please call at least 48 hours in advance if you cannot keep your scheduled appointment.
3. **If you miss 2 consecutive appointments, we will consider you discharged from the practice. If you are late for your appointment (15 minutes or more), you may be asked to reschedule. The physician will evaluate your individual case prior to making the decision to end treatment due to missed appointments and tardiness.**
4. **ALL medication refill requests will be handled by the end of the next business day.** It is the patient's responsibility to contact the office to request refills in a timely manner.
5. Please understand that chronic pain is different from acute pain. There is not always "immediate" relief from chronic pain. It may require several treatments to provide adequate pain relief.
6. **This clinic does not write prescriptions for opioids (narcotics). If opioid pain medication is clearly indicated, the physician will make appropriate recommendations to your referring physician.**
7. Please comply with all treatment plans set up for you by your physician. Pain management is multidisciplinary and pain relief is often due to a combination of treatments.
8. Arrangement for payment of services must be made prior to your appointment.
9. Emergency—please go to the emergency room if you are unable to contact your doctor here or your primary care physician.

I have read and understand the above policies.

Please sign: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Spine & Pain Institute of New England reserves the right to modify the privacy practices outline in the notice.

I have been made aware of and have been given the opportunity to review the Notice of Privacy Practices for Spine & Pain Institute of New England.

Name of Patient (please print) _____

Signature of Patient_____ Date: _____

Patient refused to sign acknowledgment ☐

Staff Member: Date

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Patient Registration

Last Name_____First Name_____Middle _____
Address_____City_____State_____Zip _____
Telephone (primary)_____(secondary)_____Date of Birth _____
Sex_____Age____Social Security #_____Marital Status_____
E-mail Address: _____

Your email address will remain confidential and will only be used if we cannot reach you at the contact information given above. You will also receive our patient focused newsletter which includes educational information about pain conditions and treatment alternatives

Next of kin (for emergency use ONLY):

Name: _____
Relationship: _____
Phone #:_____

Primary Care MD: _____
Telephone (office): _____ (fax) _____
Address: _____

Referring MD: _____
Telephone (office): _____ (fax) _____
Address: _____

Insurance Type (check one):

- Private
- Workers' Comp
- Motor Vehicle Accident

Primary Insurance:

Insurance Company:_____Cardholder's Name _____
Policy #_____Group # _____
Subscriber Date of Birth if different from the patient: _____

Secondary Insurance:

Insurance Company:_____Cardholder's Name_____
Policy #_____Group #_____

If Workers' Comp or Motor Vehicle Accident

Insurance Company:_____phone _____
Claim #_____Date of Injury: _____
Adjuster Name:_____phone_____fax_____
Attorney Name: _____phone_____fax _____

Employer: _____
Address_____City_____State_____Zip_____
Telephone: _____

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Name: _____ **Date of Birth:**_____

1. Assignment of health insurance benefits

I authorize Spine & Pain Institute of New England, PC to release medical information about me to my insurance carrier and its agents any information needed to determine benefits or the benefits payable for related services. I request that the payment under my current health insurance be made on my behalf to Spine & Pain Institute of New England, PC on any bill for services furnished me by the provider.

_____ _____

Signature of Patient Date

2. Other Party Liability

Is this condition/injury/illness the result of a motor vehicle accident, Workers' Compensation or Personal Injury Claim? ☐ No ☐ Yes

If the answer is "yes", is the claim still open? ☐ No ☐ Yes
Is the claim in litigation? ☐ No ☐ Yes
If yes, please supply the name and address of your attorney:

_____

_____

_____ _____

Signature of Patient Date

3. Release of Medical Records

At the time of your first visit to Spine & Pain Institute of New England, you will be asked to sign an acknowledgment of receipt of our notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act of 1996.

Copies of your medical notes are sent to your referring physician, primary care physician and insurance carrier. Any and all other requests for medical records need to be requested in writing.

I consent to the disclosure of my medical records. I also hereby release Spine & Pain Institute of New England and their personnel from any liability concerning such disclosure. This consent is subject to revocation at any time, except to the extent that action has been taken by Spine & Pain Institute of New England, PC and their personnel in good faith.

_____ _____

Signature of Patient Date