NEW PATIENT INFORMATION & MEDICAL HISTORY - Calmare Therapy Treatment

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Please complete this questionnaire. This confidential history will be part of your permanent record.

Name:____ Date of Birth:__________________ Gender: M __ F __

Address:____

City:____Country:________________________________

Email Address:____

Home Phone:____ Mobile _________________________________

Emergency Contact ____________________________________ Relationship ____________________________

Patient Occupation: ____________________________________ Are you currently employed? Yes No

Name and Address of your primary treating Doctor or Specialist: ______________________________________

____

Primary Diagnosis: ____

Please list any other relevant medical conditions: ____

____

Please indicate your level of Disability? No disability _____Partial _______ Complete_______

Nature & Date of Disability: ____

Are you reliant on any mobility aids (walking stick, wheelchair, etc), please specify:

____

Do you have any allergies? If so, please specify: ____

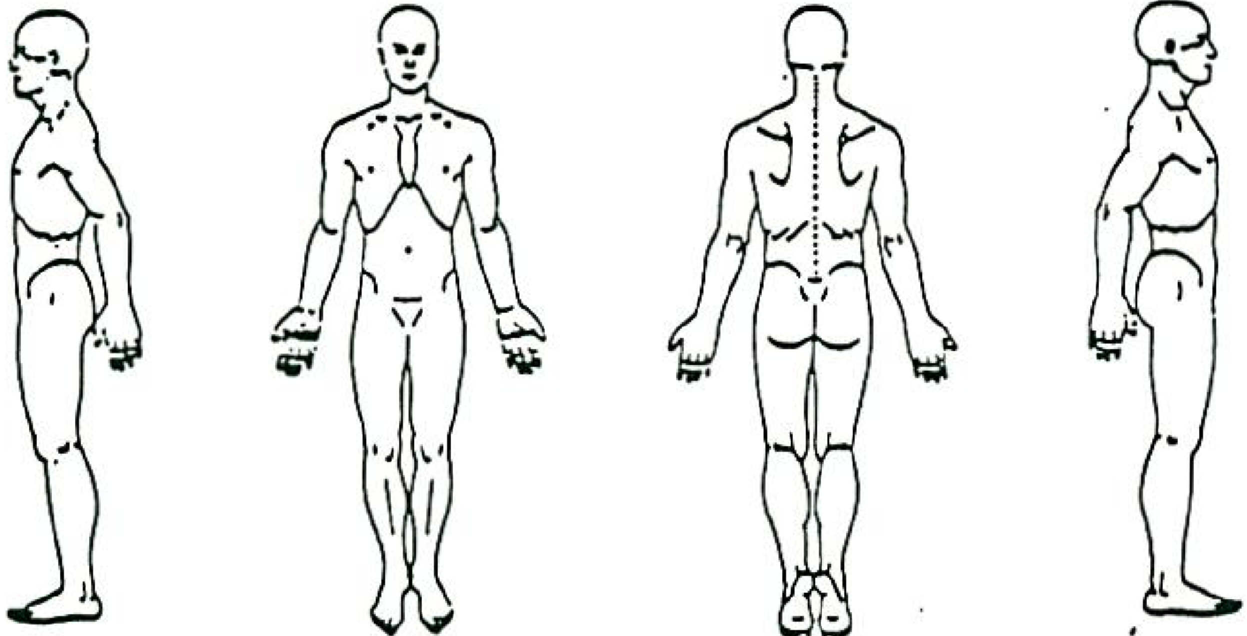
____

NEUROPATHIC HISTORY

Please complete the following information as accurately as possible. All information will be held in strict confidence and will not be divulged to others without your prior authorization (or parent/guardian's authorization in the case of a minor).

Below: Mark the type and location of pain on the body outlines below. Use code letters as indicated:

Pain Drawing Key			
A= Ache	**E=** Electric	**P**= Pins & Needles	**S**= Stabbing
B= Burning	**X**= Other	**N**= Numbness	**T**= Shooting



On the body outlines above, please:

- Circle / Shade the area(s) of your pain.
- Using the code letters in the Key Box, indicate what sensations you feel in each of the areas you've circled / shaded.

Do you experience Allodynia? (hypersensitivity to touch, heat, cold, breeze etc) **YES** **NO**
If yes, describe: ____

CURRENT PAIN SCALE: ***(Mark your overall level or range of pain)***

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

cps Complex Pain Solutions

Are you able to identify cause (diagnosis) of chronic pain: **Please attach separate sheet if necessary**

____

____

____

How did your condition start? Include approximate dates of injury or surgery.

____

____

____

____

What doctors have you seen for this condition?

	Doctor	**Month/Year of Treatment**	**Treatment Prescribed**
1.			
2.			
3.			
4.			
5.			

CURRENT MEDICATIONS AND DAILY PRESCRIBED DOSAGE:

____

____

____

CPS Complex Pain Solutions

Did your chronic pain begin: **Circle**

Immediately after a specific incident*	After multiple incidents*
Gradually over time	No specific reason noted

What makes your pain BETTER: **Circle**

Lying down   Sitting   Standing   Walking   Movement/Exercise

Inactivity   Nothing   Other: ____________________________________

What makes your problem WORSE: **Circle**

Lying down   Sitting   Standing   Walking   Movement/Exercise

Inactivity   Nothing   Other: ____________________________________

How often do you feel pain? **Circle**

Constant (76-100%)	Frequent (51-75%)
Occasional (26-50%)	Intermittent (25% or less)

Since your problem began, the pain has: **Circle**

Increased   Decreased   Spread   **or**   Has not Changed

How would you grade your overall daily stress level? **Circle**

None   Minimal   Moderate   **or**   Great

Does your pain interfere with your interpersonal relationships? **Circle**

0 No	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10 Definitely***

Does your pain interfere with your sleep? **Circle**

0 No	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10 Definitely***

Does your pain interfere with your Activities of Daily living **(showering, toileting, dressing etc)? Circle**

0 No	***1***	***2***	***3***	***4***	***5***	***6***	***7***	***8***	***9***	***10 Definitely***

Complex Pain Solutions

Please list your Sporting / Exercise / Leisure interests

____

____

____

____

Any other information you would like to share that may be helpful in your treatment plan?

____

____

____

____

What are your expectations about undergoing Calmare Therapy? What is your goal?

____

____

____

____

Do you consent to the release of medical information relevant to your care by this clinic? YES NO

Signature: ____ **Date** _______________
(if under 18years of age, guardian to sign please)

Relationship to patient - if applicable: ____