Patient Name:
Date of Birth:
Gender:

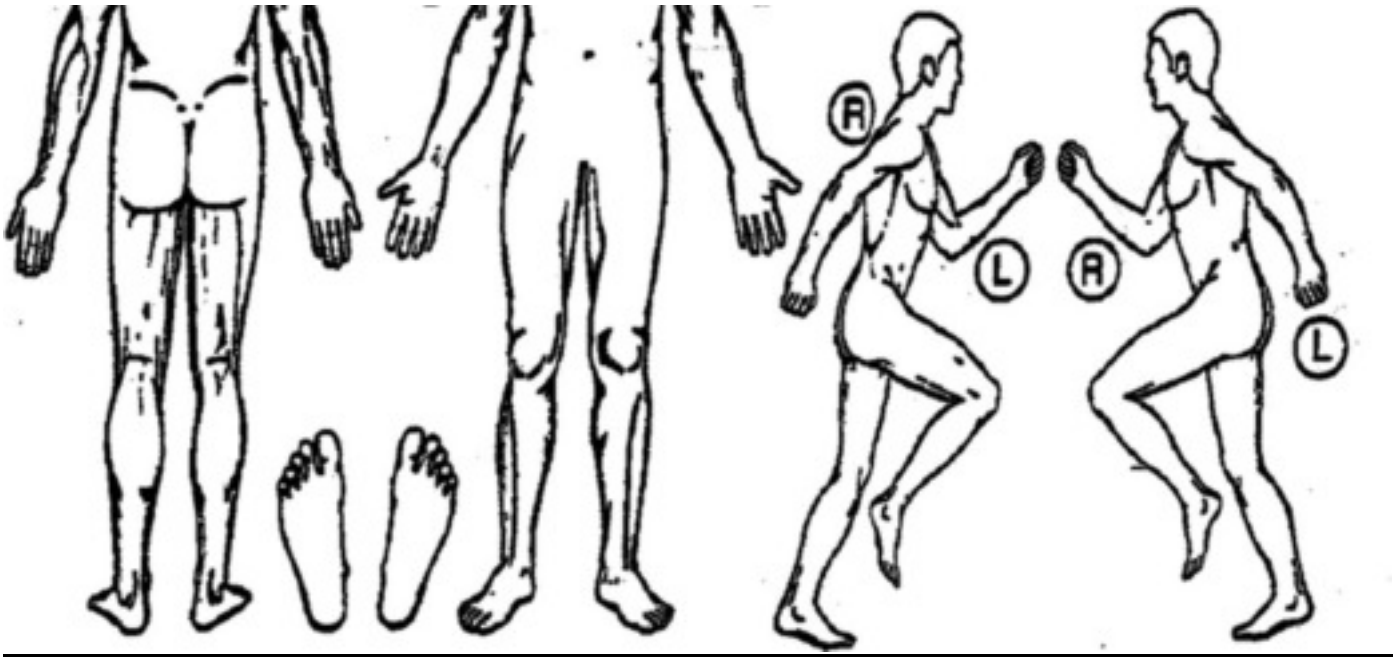
Date: _____

BLOOR PAIN SPECIALISTS

PLEASE EMAIL YOUR COMPLETED FORM TO:
PATIENTS@BLOORPAIN.COM

NEW PATIENTS: BACK AND/OR LEG PAIN

1. Please use the image below to mark WHERE you have pain.



2. Does your pain SHOOT/RADIATE somewhere? _____
_____ (Example: outer right thigh)

3. WHEN did it start? _____ (Example: May, 2016)

4. How did it start? (What Caused It?) _____
_____ (Example: Car Accident)

5. Is Your Pain A Part Of A WSIB Claim? Yes / No. WSIB Claim #: _____

6. How has your pain changed over time? (Check All That Apply):
□ Constant □ Intermittent □ Sporadic □ Improving □ Worsening

7. What does your pain feel like? (Check All That Apply):
□ Aching □ Burning □ Cold □ Dull □ Electric □ Jabbing □ Tingling
□ Numb □ Pins & Needles □ Pressure □ Sharp □ Shooting □ Stabbing □ Stinging

8. What makes your pain worse? (Check All That Apply):
□ Lifting □ Running □ Bending □ Depends On How I Sleep
□ Prolonged Sitting □ Standing □ Prolonged Walking □ Carrying Objects >5lbs
□ Lying Down □ Getting in/out of a Car □ Other: _____

Patient Name:
Date of Birth:
Gender:

9. What makes your pain better? (Check All That Apply):

□ Acupuncture □ Counseling □ Rest □ Home Exercise □ Medications □ Yoga
□ Meditation □ Mindfulness □ Injections / Nerve Blocks □ Physiotherapy
□ TENS units □ Swimming □ Strength Training/Gym □ Aquafit/Aquatherapy
□ Changing Positions □ Other: _____

10. Have you had any of the following imaging investigations regarding your back and leg pain?
□ X-Ray – year: _____ □ Ultrasound – year: _____ □ MRI / CT – year: _____

11. Have you had any of the following associated with your pain:
□ Weakness in your arms or legs □ Numbness in the pelvic floor/area where you sit □ Recent balder or bowel dysfunction □ Changes in the sensation of the bladder or rectum □ Active Cancer □ Recent Infection

REVIEW OF SYSTEMS: GENERAL HEALTH SCREEN

In the past WEEK, have you had ANY of the following? Check All That Apply

Fevers	**□ yes □ no**	**Difficulty Breathing**	**□ yes □ no**
Chills	**□ yes □ no**	**Bleeding Disorder**	**□ yes □ no**
Active Infections	**□ yes □ no**	**Weight loss**	**□ yes □ no**
Taking Antibiotics	**□ yes □ no**	**Cancer**	**□ yes □ no**
Cough	**□ yes □ no**	**Loss of bladder control**	**□ yes □ no**
Flu / Cold	**□ yes □ no**	**Loss of bowel control**	**□ yes □ no**
Chest pain	**□ yes □ no**	**I take a blood thinner**	**□ yes □ no**

IS THERE ANY CHANCE YOU ARE PREGNANT? YES / NO

Over the past two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Allergies (Please List All Allergies): □ NONE

_____

_____

_____

List of Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

How often do you smoke cigarettes/cigars?: □ **never** □ **rarely** □ **weekly** □ **daily**
How often do you consume alcohol? □ **never** □ **rarely** □ **monthly** □ **weekly** □ **daily**
If you drink alcohol, how many drinks do you consume on averagel per day? □ **NA** □ **<1** □ **1-2** □ **3-4** □ **>5**
Do you use recreational/illegal drugs: □ **never** □ **I used to, but not any more** □ **yes. Which one(s):** _____

Patient Name:
Date of Birth:
Gender:

NEW PATIENT MEDICAL HISTORY

Patient: _____ Date of Birth: _____

Medical History:

Check box if you have ever had any of the following:

- ❑ Asthma
- ❑ Angina/Chest Pain
- ❑ Anemia
- ❑ Arthritis
- ❑ Glaucoma
- ❑ Cancer
- ❑ Chronic Bronchitis
- ❑ Cirrhosis
- ❑ Clotting Disorder
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Gallstones
- ❑ Heart Attack
- ❑ Heart Murmur
- ❑ Headaches
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ HIV positive/AIDS
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Migraines
- ❑ Positive TB Test
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Thrombophlebitis
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other – Please List Below

_____
_____
_____
_____
_____
_____
_____

Family History:

- □ Depression
- □ Anxiety
- □ Suicide
- □ Degenerative Disc Disease
- □ Low Back Pain
- □ Neck Pain
- □ Headaches
- □ Fibromyalgia
- □ Other Chronic Pain Syndrome(s):_____
_____
_____

Operations and/or Hospitalizations: List below with approximate date:

Reason	Date	Reason	Date

Psychiatric History:

- □ None
- □ Depression
- □ Anxiety
- □ Suicidal Thoughts / Plans / Attempts
- □ Sleep Disorder
- □ Bipolar Disorder
- □ Schizophrenia
- □ PTSD
- □ Other: _____

_____

_____

I certify that this list is complete to the best of my knowledge.

Patient's Signature: _____ Date: _____
Verified By: _____ Date: _____

Patient Name:
Date of Birth:
Gender:

For the Patient to Fill Out - Date: _____

Please rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

Please rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

Please rate your pain by circling the one number that best describes your pain on the AVERAGE.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

Please rate your pain by circling the one number that best describes your pain on the RIGHT NOW.

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain you can imagine

In the past 24 hours, how much relief have your pain treatments or medications provided? Please circle the one percentage that shows most how much RELIEF you have received.

No Relief 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% Complete Relief

Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

	Does not interfere										Compeletely interferes
a) **GENERAL ACTIVITY**	0	1	2	3	4	5	6	7	8	9	10
b) **MOOD**	0	1	2	3	4	5	6	7	8	9	10
c) **WALKING ACTIVITY**	0	1	2	3	4	5	6	7	8	9	10
d) **NORMAL WORK** *(includes both work outside and home housework)*	0	1	2	3	4	5	6	7	8	9	10
e) **RELATIONS WITH OTHER PEOPLE**	0	1	2	3	4	5	6	7	8	9	10
f) **SLEEP**	0	1	2	3	4	5	6	7	8	9	10
g) **ENJOYMENT OF LIFE**	0	1	2	3	4	5	6	7	8	9	10

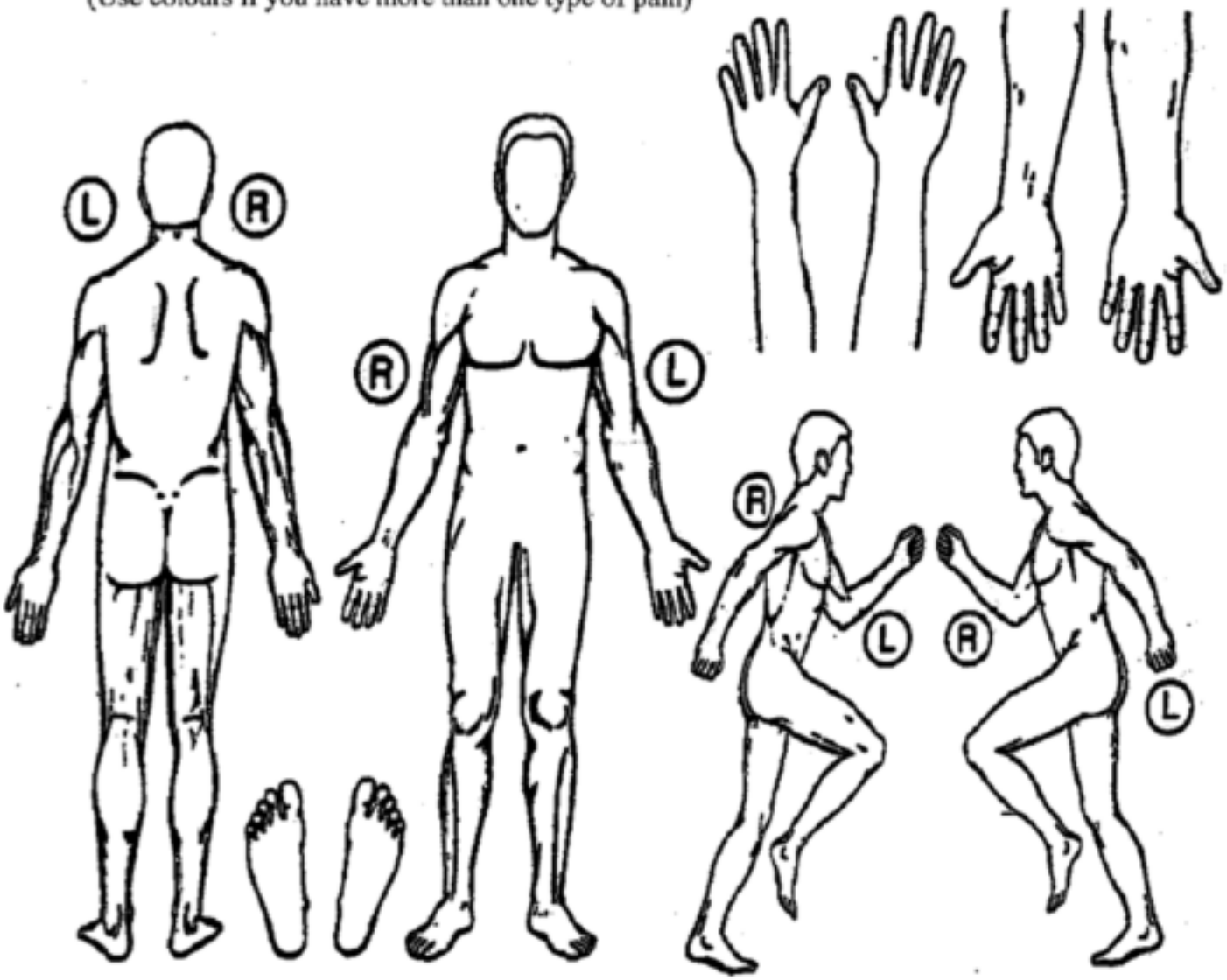
Patient Name:
Date of Birth:
Gender:

OTHER PAINS: NOT YOUR BACK OR LEG PAIN

DO YOU HAVE PAINS ANYWHERE ELSE IN YOUR BODY?

BRIEF PAIN INVENTORY (SHORT FORM) – MODIFIED

On the diagram below, shade in the areas where you feel pain. Put an "X" on the areas where it hurts the most. (S=sharp/stabbing, B=burning, N=numbness, P=pins and needles, A=aching, Arrows=shooting pain.)
(Use colours if you have more than one type of pain)



What things make your pain feel worse?

What things make your pain feel better?

What treatments or medications are you currently receiving for your pain: