Interventional Pain Management Center

SNAPA

102 Smithfield Avenue, Pawtucket, RI 02860 401-729-4985 / (fax) 401-475 6021

Your Name: First _____ Last_____ Middle_____

Social Security #_____ DOB_____ Age_____

Address:_____ City_____ State_____ ZIP_____

Best phone to reach you: _____

Alternative phone number to reach you: _____

Referring Physician:_____

Primary Care Physician:_____

Heath Insurance Carrier:_____

If Worker's Compensation; Name of carrier_____ Contact person:_____

Phone number: _____

Do you receive disability benefits? _____ If so, which type?_____

Are you currently employed? yes _____ no _____ occupation_____

If unemployed, for how long? _____ Is this due to your pain? yes _____ no_____

Level of education _____ Marital Status _____ # of children _____

With whom do you live? _____

Weight _____ Height _____

Has your pain interfered with:	**Yes**	**No**	
your appetite?	_____	_____	increased _____ decreased _____
ability to perform self-care activities? (bathing, cooking, dressing)	_____	_____	
Sleeping?	_____	_____	falling asleep ___ staying asleep ____
usual level of activity?	_____	_____	
level of energy to perform normal activity during the day?	_____	_____	
Has pain interfered with your ability to cope with stress?	_____	_____	
Do you drink alcohol?	_____	_____	# drinks per week _____
Do you smoke?	_____	_____	# packs per day_____
Recreational drugs?	_____	_____	What _____

Please, mark an " X" at the point on the line which describes how much stress you are experiencing presently.

(No stress) _____ (most stressful time in my life)

Diagnostic tests you have undergone for this problem (please indicate with "nl" a normal result and "ab" an abnormal result.)

X-ray: yes _____ no _____ CAT Scan: yes _____ no _____

MRI: yes _____ no _____ EMG: yes _____no _____

other _____

Treatments you have undergone for this problem (indicate if good/bad result):

Surgery: yes ____no ____result_____ nerve blocks: yes _____no _____result_____

Steroid injection: yes ____no____ bed rest: yes _____no_____ result_____

Pain history and description:

When did your pain start?_____ What causes it?_____

How often occurs and how long it last? _____

Is it related to any particular activity? Which one(s)? _____

Was it related to a work-related injury? yes_____ no_____

Are you currently on litigation related to your pain? yes_____ no_____

Please, try to score the intensity of your pain, using a scale which goes from 0 (no pain) to 10 (the maximum pain you can imagine).

Pain now : (no pain) 0 _____ 10 (worst pain)

Pain at rest: (no pain) 0 _____ 10 (worst pain)

Pain with activity: (no pain) 0 _____ 10 (worst pain)

Please, list all the medications, including the " over the counter" you currently take:

name:	dose:	frequency	name:	dose:	frequency
_____			_____		
_____			_____		
_____			_____		
_____			_____		
_____			_____		

The services provided to you by the Southern New England Anesthesia and Pain Associates (S.N.A.P.A.) Pain Management Center may or may not be covered by your insurance carrier. We will submit your claim to your carrier on your behalf, but in the event that they deem it a non-covered claim, you are responsible for payment in full to "S.N.A.P.A.", Pain Management Center. Due to our high demand for appointments, it is necessary to call within 24 hours to cancel or reschedule an appointment. If proper notice is not given, you will be charged a $25 fee, which is NOT covered by insurance.

I have completed the above honestly and to the best of my knowledge.

_____ _____

Patient Signature **Date**