



BPC

We don't treat pain, we treat people with pain.

Complete this form and Fax order to 781-290-0720

Pain Evaluation Sleep Evaluation / Study Headache

New Patient Information

Patient Name: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Email: _____
 Home Phone: (____) _____
 Work Phone: (____) _____
 Sex: (circle) ___M___F
 Date of Birth: _____
 Social Security: _____
 Diagnosis: _____
 Date of Injury: _____

Patient's Chief Complaints (circle all that apply)

Pain location (PL)	Pain type (PT)	Sleep
1) Head/neck/back	1) Soreness	1) Excessive daytime sleepiness
2) Shoulders/arms/hands	2) Tingling	2) Fatigue
3) Hips/legs/feet	3) Numbness	3) Insomnia
4) Other	4) Dull	4) Chronic snoring
	5) Sharp	5) Witnessed apneas
	6) Tender	6) Restless legs
	7) Burning	7) Frequent awakenings
	8) Stabbing	
	9) Cramping	
	10) Shooting	
	11) Throbbing Pressure	

Pain Intensity (PI)

1) Nonexistent
 2) Limited
 3) Mild
 4) Above mild
 5) Moderate
 6) Above moderate
 7) Severe
 8) Very severe
 9) Unbearable
 10) Worst possible

We Must Receive The Following Prior to the Initial Visit:

- Any Radiology Reports
- Name of any past Pain Management/ Rehabilitation physician
- Previous sleep studies or consultations

Physician Information

Primary Care Physician: _____ Phone: (____) _____
 Primary Care Address: _____
 City: _____ State: _____ Zip: _____
 Referring Physician: _____
 Referring Address: _____
 City: _____ State: _____ Zip: _____

Patients Insurance

Name of Insurance: _____
 Policy #: _____ Group: _____
 Does patient have secondary insurance? _____

Workers Compensation

WC Carrier: _____ Address: _____
 Claim #: _____ Date of injury: _____ Body Part Covered: _____
 Case Manager: _____ Phone Number: _____ Ext: _____
 Utilization Reviewer: _____ Phone Number: _____ Ext: _____
 Employer at time of injury: _____ Contact Name/Phone _____
 Attorney Name: _____ Phone: _____