BRAINCARE
PERFORMANCE CENTER | Rancho Mirage

Please click the link or copy and paste the email address below to attach and send your completed form:
rmclinic@braintreatmentcenter.com

mPNS Pain Therapy Questionnaire

Personal Information

Patient Name: ______________________ Date of Birth: ______________

Contact Number: ______________________ May we text you? Yes ☐ No ☐

Emergency Contact Name /Number: ______________________

Please Indicate Your Primary Reason for seeking mPNS Treatment

☐ Pain Management
☐ Mobility Improvement
☐ Spasticity
☐ Other (please specify):

Please describe the primary condition(s) for which you are seeking treatment: ______________________

____

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How long have you been experiencing this pain/condition?

☐ Less than 3 months (acute)
☐ 3-6 months
☐ Over 6 months (chronic)

Have you been diagnosed with any of the following? (Check all that apply)

☐ Diabetic neurophathy
☐ Neck pain
☐ Shoulder pain
☐ Foot pain
☐ Spasticity
☐ Carpal tunnel syndrome or other peripheral neuropathy
☐ Back pain
☐ Other (please specify) ______________________

Is your pain/condition the result of an injury? Yes ☐ No ☐

If yes, was the injury:

☐ Recent (within the last 3 months)
☐ Older than 3 months

Treatment History (check all that apply):

Have you previously or currently received any of the following treatments for your condition?

☐ Physical Therapy Past ☐ Currently ☐
☐ Surgery Past ☐ Currently ☐
☐ Pain Medications Past ☐ Currently ☐
☐ Other (please specify): ______________________

____

General Health History (check all that apply)

- ☐ Diabetes
- ☐ Heart Disease
- ☐ Pacemaker or Other Electronic Implanted Device
- ☐ Other Metal Implants/Other (Orthopedic, Cochlear, Shrapnel)
- ☐ Epilepsy
- ☐ Cancer Past ☐ Current ☐
- ☐ Skin Conditions (e.g. psoriasis, eczema in treatment areas)
- ☐ Pregnancy (current)

Other Medical Conditions (please specify): ______________________________

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Medication Use

Are you currently taking any medications for the condition you are seeking treatment? Yes ☐ No ☐

If yes, please list them below including dosage(s):

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

Your Other Health Care Providers

Please list any other doctors or healthcare professionals currently involved in your care for this condition (primary care, pain specialist, physical therapists, etc):

Name ____________________ Specialty ____________ Contact ____________

Name ____________________ Specialty ____________ Contact ____________

Name ____________________ Specialty ____________ Contact ____________

Consent and Acknowledgments

I acknowledge that I have been informed of the potential benefits and contraindications of mPNS therapy. ____________ initials

I understand that mPNS therapy is intended as a treatment for chronic conditions and that I may require ongoing treatment sessions to manage my condition. ____________ initials

By typing my name below, I am electronically signing this document.

Signature: ______________________________ ***Date:*** ____________

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Pain Indicator

Name: ______________________ Date: ______________

1. Mark Your Pain Spots:
   - On the provided human outline, locate the area(s) where you feel pain.
2. Indicate Your Pain Level:
   - In the box pointing to the area where you feel pain, write a number from 0 to 10 to indicate the pain intensity (1 indicates mild pain and 10 indicates severe pain).
   - If your pain areas are not indicated, draw or write on the outlines including a pain score of 0-10.
   - After treatment if you have locations that previously scored a 1-10 and become pain free, please put a zero next to those locations.