HEALTH CARE PROVIDERS fill this out and return to us.

PAIN HISTORY FORM FOR PAIN CLINIC EVALUATION

To the patient

To better understand your prior treatment history, please have your health care provider complete and return this form.

Patient name: _____ Patient birthdate: _____

Provider specialty / address: _____

Provider phone: _____ Today's date: _____

To the provider

Cause and description of patient's chronic pain

_____

_____

_____

_____

_____

Date of diagnosis _____

What treatments were recommended or performed with the patient?

_____

_____

_____

_____

_____

To the best of your knowledge, has the patient been following your recommended treatments for the painful conditions for at least 6 months?

- ❑ Yes
- ❑ No

Provider signature: _____ **Printed name:** _____

We sincerely thank you for your time. Forms may be given to the patient, sent directly to **Maine MMJ Physician Services, PO Box 24, Friendship, ME 04547**, or faxed to us at **(207) 517-0547**. Questions? Call or email our office at (800) 563-1531 or service@maine-mmj.com.