MISSISSAUGA
Chronic Pain Centre

1224 Dundas St W, #107 Mississauga ON, M9V 1C2
FAX: 647.347.9127 Phone: 905.848.0808
www.mississaugaopain.ca info@mississaugapain.ca

Patient Information:

Patient Name: _____
DOB: ____/____/_____ (dd/mm/yyyy)
HCN#: _____
Address: _____
_____
Contact Phone: _____

Place Patient Label Here

There is NO billing negation for FHO/FHN physicians

Pain Condition(s):

☐ Low Back Pain ☐ Headaches/migraines ☐ Neuropathic pain
☐ Neck pain ☐ Shoulder pain ☐ Complex Regional Pain Syndrome
☐ Fibromyalgia ☐ Other: _____

Pain duration: _____

History of substance/alcohol abuse: ☐Yes ☐ No _____

Current Medications: _____
_____

Treatments and responses to date: _____
_____
_____

Additional information: _____
_____

Please attach copies of imaging reports as well as relevant consultations, treatments, and surgical notes.

Referring Physician: Address: Phone: Fax: Billing #: FHO/FHN Practice: ☐ Yes ☐ No	Family Physician *(if different)*: Address: Phone: Fax: