

Chronic Pain Clinical Trial Subject Screening Form

Subject Information

Full Name

Date of Birth

Age

Gender

Phone

Email

Address

Screening Questions

Primary Diagnosis

Pain Duration (months/years)

Pain Location(s)

Current Treatments/Medications

Suspected Cause/Etiology

Is the pain chronic (≥3 months)?

☐

Yes

☐

No

Is the subject willing to participate in the trial?

☐

Yes

☐

No

Eligibility Assessment

Meets Inclusion Criteria?

☐

Yes

☐

No

Meets Exclusion Criteria?

☐

Yes

☐

No

Notes/Comments

Staff Section

Staff Name

Screening Date

Eligible for Enrollment?

☐

Yes

☐

No