4901 Lang Ave NE, Suite 202
Albuquerque, NM 87109
(505) 633-4141

Name_________________________________ Date:______________

Date of Birth ______________________ Age________________

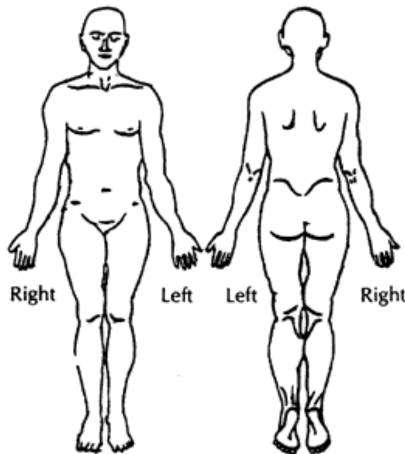
Address: ____

Referring Physician:______________________Primary Care Physician________________

Occupation: ____________________________

Allergies:____
____
____

Mark with an X the affected area:



Rate your pain: ________ Pain Goal: _______

Describe your pain:

____Aching
____Burning
____Cramping
____Dull
____Headache

____Numbness
____Pins & Needles
____Pound
____Pressure

____Sharp
____Shooting
____Sore Spasm
____Squeezing
____Tender

____Throbbing
____Tight
____Tingling

Is the Pain ____ Constant or ____ Intermittent. Does the pain radiate from another location?:

____

____

When did the pain begin?

____

What caused the pain?

____

What other factors worsen or affect your pain?

____

What other factors relieve your pain?

____

Are there any associated symptoms? (eg: numbness/tingling/weakness/incontinence, etc)

____

What are the goals you wish to achieve with Pain Management?

____

Have you had any test related with your current pain:

- MRI of the: ____________________________________ Date: ____________
- X-Ray of the: __________________________________ Date: ____________
- CT Scan of the: _________________________________ Date: ____________
- EMG/NCV study of the: ___________________________ Date: ____________
- Other Diagnostic Testing: _________________________ Date: ____________
- I have not had ANY diagnostic tests for my current pain complaint

Have you received any of the following treatments? if so, what was the result on your pain relief

	No Change	**Helped the Pain**	**Worsen the Pain**
Spine Surgery			
Physical Therapy			
Chiropractic Care			
Psychological Therapy			
Brace support			
Acupuncture			
Hot/Cold Packs			
Massage Therapy			
TENS Units			

Have you received any of the following Pain treatment Interventions?

- ☐ Epidural Steroid Injections: ____________________
- ☐ Joint Injection:____________________
- ☐ Medial Branch Blocks/Facet Injections ____________________
- ☐ Nerve Blocks____________________
- ☐ Radiofrequency Nerve Ablation____________________
- ☐ Spinal Cord Stimulator: Trial/ Permanent?____________________
- ☐ Trigger Point Injections: ____________________
- ☐ Vertebroplasty/Kyphoplasty: Levels: ____________________
- ☐ Other? ____________________

What other Physicians or specialists have you consulted for your current pain issues:

- ☐ Acupuncturists
- ☐ Chiropractor
- ☐ Internist
- ☐ Neurosurgeon
- ☐ Orthopedic Surgeon
- ☐ Physical Therapy
- ☐ Psychiatrist/Psychologist
- ☐ Rheumatologist
- ☐ Neurologist
- ☐ Other:

Medical History:

- ☐ Cancer: Type: ____________________
- ☐ Anemia
- ☐ Heart Attack
- ☐ Coronary Artery Disease
- ☐ High Blood Pressure
- ☐ Peripheral Vascular Disease
- ☐ Stroke/TIA
- ☐ Heart Valve Disorder
- ☐ Presence of stent/pacemaker/ defibrillator
- ☐ GERD (Acid reflux)
- ☐ Gastrointestinal Bleeding
- ☐ Stomach Ulcers

- ☐ IBS/Chrohns Disease
- ☐ Chronic Kidney Disease
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☐ Dialysis
- ☐ Multiple Sclerosis
- ☐ Peripheral Neuropathy
- ☐ Seizures
- ☐ Balance Disorder
- ☐ Head Injury
- ☐ Headache
- ☐ Migraines
- ☐ Glaucoma
- ☐ Vertigo
- ☐ Hearing Problems
- ☐ Nosebleeds
- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Chronic Join Pains
- ☐ Depression
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Bipolar Disorder
- ☐ ADD?ADHD
- ☐ PTSD
- ☐ Diabetes, Type:______________
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other: _____________________

Past Surgical Procedures and dates:

____

____

____

Family History:

Mark any diagnoses that your parents or siblings have had:

- ☐ Arthritis
- ☐ Headaches/Migraines
- ☐ Liver Problems
- ☐ Seizures
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Rhematoid Arthritis
- ☐ Other:

Social History:

Number of people in your household: ___________________________

Are there stairs in your current home: ___________________________

Are you under worker's compensation: ___________________________

Is there an ongoing lawsuit related to your visit today: ___________________________

Alcohol Use:

_____Social _____ Daily _____Never _____ History of alcoholism _____Current Alcoholism

Tobacco Use:

_____ Current User: Packs a day: _____

_____Non Smoker

Illegal Drug Use:

_____ No Use _____ Currently uses Illegal Use _____ Formerly used illegal drugs

Have you ever abused narcotic or prescription medications: _____ Yes _____ No

Medications:

Are you taken any blood thinners or anti-coagulants: _____ Yes _____ No

If yes, Which one: _____ Aspirin _____Plavix _____Coumadin _____Lovenox _____ Other

Please list all Medications and supplements you are currently taking:

Medication Name	Dose	Frequency

Have you ever taken any pain medications for your current pain:

____

____

____

If your pain has caused constipation, please answer the next question

On average, how often do you have a bowel movement?

- ☐ More than 3 times a day
- ☐ Once per day
- ☐ 2 to 3 times per day
- ☐ Less than once per week
- ☐ 2 to 3 times per week

Are these changes new with the use of the pain medication? ____________________

Review of Systems:

Constitutional:

_____ Activity Change
_____Chills
_____Fatigue
_____ Unexpected Weight Change
_____Appetite Change
_____Diaphoresis (Sweating)
_____Fever

Hent:

_____Congestion
_____Facial Swelling
_____Nosebleed
_____ Sneezing
_____Tinnitus (ringing in ear)
_____Drooling
_____Hearing Loss
_____Running Nose
_____Sore Throat
_____Throat Swallowing

Eyes:

_____Sensitivity To light
_____Redness
_____Eye Pain
_____Visual Disturbance

Respiratory:

_____Difficulty Breathing
_____Choking
_____Shortness of Breath
_____Cough
_____Chest Tightness
_____Wheezing

Cardiovascular:

_____Chest Pain
_____Leg Swelling
_____Palpitations

Gastrointestinal:

_____Abdominal Distention
_____Abdominal Pain
_____Constipation

_____Rectal Pain
_____Blood in the Stool
_____Diarrhea
_____Nausea
_____Vomiting

Endocrine:
_____Cold/Heat Intolerance

Musculoskeletal:
_____Back Pain
_____Joint Swelling
_____Neck Pain
_____Excessive Thirst
_____Gait Problem
_____Myalgias
_____Neck Stiffness
_____Excessive Hunger

Genitourinary:
_____Decreased Urine
_____Difficulty Urine
_____Blood in Urine
_____Menstrual Cramps
_____Vaginal Bleeding
_____Vaginal Pain
_____Painful Urination
_____Genital Sores
_____Pain with intercourse
_____Pelvic Pain
_____Vaginal Discharge

Hematological:
_____Swollen Glands
_____Bleeding
_____Bruising

Neurological:
_____Dizziness
_____Seizures
_____Difficultly with Speech
_____Lightheadedness
_____Headache
_____Tremors
_____Facial Droop
_____Weakness
_____Numbness

Psychiatric:
_____Agitation
_____Hallucinations
_____Sleep Disturbance
_____Nervous/Anxious
_____Confusion
_____Self Injury
_____Suicidal Ideas
_____Hyperactive

Allergies:
_____Environmental
_____Food
_____Weakened Immune System

Skin:
_____Color Change
_____Rash
_____Pallor
_____Wound

Notes