NEW MEXICO
PAIN ASSOCIATES

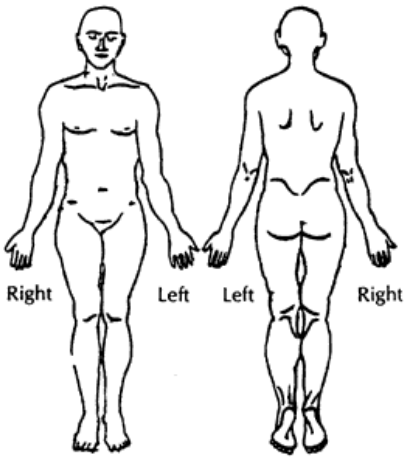
8300 Carmel Ave NE Bldg 5.
Albuquerque, NM 87122
(505) 633-4141

Pain Assessment

Name_____ Date of Birth _____

Address: _____

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: _____ If so, where
_____
_____

Has the Pain ____ Improved ____ Not Changed ____ Worsen

Is your Pain due to an injury? _____
If so, is it a work related injury: _____
Is your pain worse when:
____ Bending ____ Exercising ____ Standing ____ Walking

Is your pain better with:
____ Medication ____ Heat ____ Ice ____ Walking ____ Rest ____ Repositioning
____ Other:

Any Known Allergies:
_____
_____

Family History: _____ No changes since last visit

RELATIVE	MEDICAL CONDITION
Grandfather	
Grandmother	
Father	
Mother	
Sibling	
Child	
Other	

Medical History: _____ No changes since last visit
____ Neuropathic Pain ____FibroMyalgia ____Fractures ____Depression
____HIV/AIDS ____Trigeminal Neuralgia ____Bipolar Disorder ____Cancer
____ Spinal Stenosis ____ Chronic Pain ____Headache/Migraine
____Diabetic Neuropathy ____Hypertension ____Substance Abuse

Surgical History: _____ No changes since last visit
_____
_____

Social History:
Smoking _____ (CURRENT/FORMER)

If yes _____ Packs per day _____ Years of smoking
Alcohol Use: _____
Frequency: DAILY/WEEKLY/MONTHLY
Amount:

Substance Abuse:
_____
_____

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

_____

_____