THE UNIVERSITY OF NEW MEXICO ◆ HEALTH SCIENCES CENTER
UNM HOSPITAL

CNC Pain Consultation & Treatment Center
2211 Lomas Blvd. NE
Albuquerque, NM 87106
505-925-4431

Centers Excellence AMERICAN PAIN SOCIETY Award Recipient 2011

New Patient Form

Please complete this form. It is part of your first visit at the Pain Center. Please answer **every question** the best you can. Bring this form with you when you come to the Pain Center. **If this form is *not* filled out, your visit may take much more time.**

Some questions may not seem important to you. They are important to our doctors. The more the doctors know, the better they can understand your pain. Thank you for helping us to help you.

Make sure to bring all your prior medical records with you. Bring any CDs or DVDs of imaging studies you have had. Imaging studies are things like x-rays, MRIs, and CT scans. This is very important.

Important Things to Know

- **We do *not* write prescriptions.** We may make suggestions to your primary care doctor about what to prescribe.
- Please be sure you understand what we tell you about your prescriptions. If you are not sure what we said, *please ask.* Don't leave until you understand.
- Make sure we answer your questions before you leave on the day of your visit.

I: General Information

Name: _____ Today's Date: _____Appt. Date: _____

Address:_____

Home Phone:_____ Cell Phone: _____ Work Phone:_____

Date of Birth:_____ Age: _____ Sex: M F

Referring Doctor: _____ Phone:_____

Address: _____ City _____ State _____ Zip Code _____

Primary Care Doctor: _____Phone:_____

Address: _____ City _____ State _____ Zip Code _____

II. Pain History:

1. Please describe how your pain started: _____

_____

_____

2. Please circle the word(s) which describe your pain best (skip the words that don't apply):

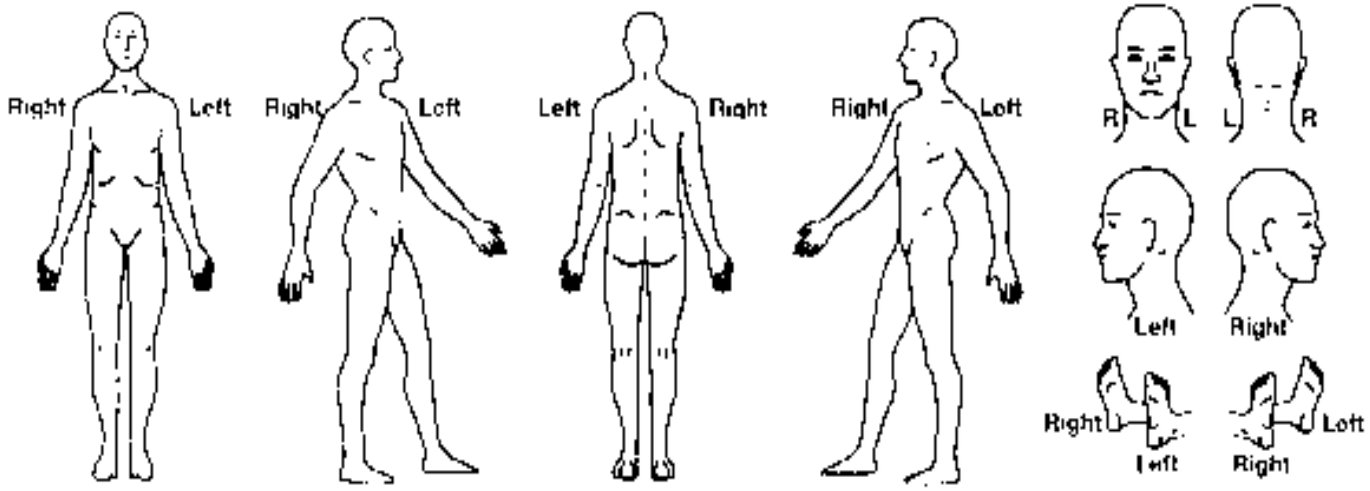
Penetrating	Radiating	Unbearable	Achy	Burning	Hot
Deep	Throbbing	Miserable	Nagging	Shock-like	_____
Tiring	Gnawing	Shooting	Stabbing	Numb	_____
Exhausting	Sharp	Dull	Stinging	Tender	_____

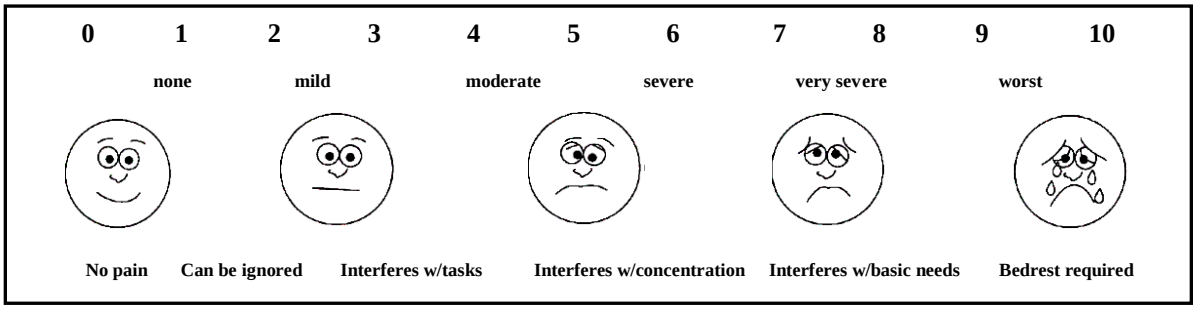
3. Is the pain: ☐ constant ☐ intermittent

4. When is the pain worst? ☐ morning ☐ afternoon ☐ evening ☐ night

5. Do you have other symptoms with the pain? ☐ numbness ☐ tingling ☐ weakness ☐ muscle spasms

6. Please fill in the areas of the pain on the diagram below:





Please rate your pain (0 if no pain; 10 if the worst imaginable pain, just can't be worse!)

7.	As of right NOW?	1	2	3	4	5	6	7	8	9	10
8.	Please rate your pain at its easiest:	1	2	3	4	5	6	7	8	9	10
9.	Please rate your pain at its worst:	1	2	3	4	5	6	7	8	9	10
10.	At what realistic rate would you be comfortable?	1	2	3	4	5	6	7	8	9	10

With current treatment, how much has your pain interfered with your (0-10):

11.	General activity:	1	2	3	4	5	6	7	8	9	10
12.	Work:	1	2	3	4	5	6	7	8	9	10
13.	Mood:	1	2	3	4	5	6	7	8	9	10
14.	Enjoyment of life:	1	2	3	4	5	6	7	8	9	10
15.	Relationships:	1	2	3	4	5	6	7	8	9	10

16. Please list some of your usual activities over the past 30 days. Put an X by those activities you can no longer participate in because of pain.

17.	Please rate your average daily activity level 1-10 (1= none; 10 = extremely active)	1	2	3	4	5	6	7	8	9	10

18. How long have you had this pain? _____

_____

19. What do you believe is the cause of your pain? _____

_____

20. Is your pain from an ☐ accident-related or ☐ work-related injury? □ Yes □ No If yes, please describe:

_____

_____

_____

21. What makes the pain better? _____

_____

22. What makes the pain worse? _____

_____

_____

23. Have you had any Surgeries for your pain problem? □ Yes □ No If yes, what kind?

_____

_____

_____

24. Have you had any INJECTIONS for your pain problem? □ Yes □ No If yes, what kind?

_____

_____

_____

25. Please list **ALL the medications and supplements** you are currently taking:

	Medication	Dose	How Often Taken	For What Condition/Problem
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				

The relevant medications were re-conciliated with PowerChart

26. Please list other medications for pain relief that you have tried and why discontinued:

_____

_____

_____

27. Have you tried any of alternative therapies for your pain problem (circle appropriate)?

Modality	Tried?	Did it help?	Comments
• Physical therapy	Yes No	Yes No	
• Occupational therapy	Yes No	Yes No	
• Chiropractic treatments	Yes No	Yes No	
• Acupuncture	Yes No	Yes No	
• Massage	Yes No	Yes No	
• Pool therapy	Yes No	Yes No	
• TENS unit	Yes No	Yes No	
• Heating pads	Yes No	Yes No	
• Relaxation/imagery	Yes No	Yes No	
• Biofeedback	Yes No	Yes No	
• Psychotherapy	Yes No	Yes No	
• Homeopathic treatments	Yes No	Yes No	

28. What, if anything, has helped your pain the most

_____

_____

_____

29. Any loss of bowel or bladder control? ☐ Yes ☐ No

_____

30. Constipation? ☐ Yes ☐ No

Is it managed? ☐ Yes ☐ No

_____

_____

31. What do you take to prevent/ treat constipation?

_____

32. Other Issues?

☐ weight loss	
☐ weight gain	
☐ fever	
☐ daytime sedation	
☐ confusion	
☐ memory problems	
☐ balance problems	
☐ coordination problems	
☐	
☐	

33. If you have any of these symptoms, do you think that they are due to your medication? ☐ Yes ☐ No
34. Sleep pattern: You get _____ hours of sleep per night, including _____ hours of uninterrupted sleep.
35. Number of times waking due to pain: _____
36. Do you feel rested in the morning? ☐ Yes ☐ No
37. Have you ever done a sleep study? ☐ Yes ☐ No
38. Were you diagnosed with sleep apnea? ☐ Yes ☐ No
39. If yes, is it treated? ☐ Yes ☐ No If yes, with what? _____

_____

Do you take any over the counter or prescription medications for sleep? ☐ Yes ☐ No If yes what?

_____

III. Past Medical History: (mark all that apply)

- ☐ Heart problems
- ☐ High blood pressure
- ☐ Liver problems
- ☐ Lung problems
- ☐ Asthma
- ☐ Circulation problems
- ☐ Diabetes (type I or type II)
- ☐ Frequent infections
- ☐ Bleeding problems
- ☐ HIV/AIDS
- ☐ Kidney/urine problems
- ☐ Seizure
- ☐ Stroke
- ☐ Psychological/ psychiatric problems
- ☐ Thyroid problems
- ☐ Tuberculosis

Other health problems:

_____

_____

_____

_____

_____

_____

_____

IV. Past Surgeries: (mark right or left, if applicable)

Date	Type of Surgery	R	L

Past Hospitalizations without Surgical treatments:

Date	Reason for Hospitalization	# days

V. Family History:

Please describe the health of your relatives the best you can:

1. Mother:

_____

_____

2. Father:

_____

_____

3. Grandparents:

_____

_____

VI. Allergies: Did you have to go to Emergency Room with Allergic reaction? □ Yes □ No

Allergen (<u>what</u> caused it?)	What was YOUR Reaction
•	□ Hives, □ Rash, □ Problems breathing, □ Swelling of
•	□ Hives, □ Rash, □ Problems breathing, □ Swelling of
•	□ Hives, □ Rash, □ Problems breathing, □ Swelling of
•	□ Hives, □ Rash, □ Problems breathing, □ Swelling of
•	

VII. Review of Systems (mark all that apply)

General
- ☐ None
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Change in sleep habits
- ☐ Fatigue
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:_____

Neurological
- ☐ Memory changes
- ☐ Numbness/tingling
- ☐ Dizziness/fainting
- ☐ Weakness
- ☐ Unbalanced walking
- ☐ Headache
- ☐ Seizures
- ☐ Speech problems
- ☐ Hearing problems
- ☐ Blurred vision
- ☐ Other vision problems
- ☐ Other:_____

Head & Neck:
- ☐ None
- ☐ Hoarseness
- ☐ Neck spasms
- ☐ Neck swelling
- ☐ Other:_____

Respiratory
- ☐ None
- ☐ Wheezing
- ☐ Cough
- ☐ Short of breath
- ☐ Other:_____

Cardiovascular
- ☐ None
- ☐ Leg swelling
- ☐ Chest pain
- ☐ Fast heart beat
- ☐ Irregular heart beat
- ☐ Other:_____

Gastrointestinal
- ☐ None
- ☐ Yellow skin or eyes
- ☐ Nausea/vomiting
- ☐ Problems swallowing
- ☐ Cramping/stomach pain
- ☐ Change in appetite/diet
- ☐ Indigestion
- ☐ Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black stools
- ☐ Blood in stools
- ☐ Other:_____

Hematology/Lymph
- ☐ None
- ☐ Abnormal bleeding
- ☐ Prior transfusion
- ☐ Easy bruising
- ☐ Swelling in groin/armpit/neck
- ☐ Other:_____

Skin
- ☐ None
- ☐ Open sore(s)
- ☐ Abnormal color
- ☐ Rashes
- ☐ Other:_____

Genitourinary
- ☐ None
- ☐ Burning with urination
- ☐ Frequency
- ☐ Blood in urine
- ☐ Dribbling
- ☐ Inability to control bladder
- ☐ Other:_____

Musculoskeletal
- ☐ None
- ☐ Joint swelling
- ☐ Joint Pain
- ☐ Upper back pain
- ☐ Low back Pain
- ☐ Stiffness
- ☐ Trauma
- ☐ Falls
- ☐ Other:_____

Endocrine
- ☐ None
- ☐ Cold intolerance
- ☐ Hot flashes
- ☐ Increased thirst
- ☐ Increased appetite
- ☐ Increased urination
- ☐ Other:_____

Psychological
- ☐ None
- ☐ Worried/anxious
- ☐ Sad
- ☐ Depressed
- ☐ Other:_____

_____

_____

_____

Are you on a blood thinner? ☐ Yes ☐ No _____

_____

Is there anything else you feel is important for us to know?

_____

_____

_____

_____

VIII. Social History:

1. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other
2. Do you have children: ☐ Yes ☐ No If yes, how many: _____ Ages?_____
3. Who lives in the household with you? _____
4. How do your family members react to your pain? _____

_____

_____

5. What is the effect of your pain on your family? _____

_____

_____

6. Is there a spiritual dimension to your life? ☐ Yes ☐ No If yes, please describe _____

_____

7. Do you consume **caffeine** products: ☐ Yes ☐ No If yes: _____ drinks per day
8. Did you have drug/alcohol problems: ☐ Yes ☐ No If yes…
9. **Alcohol History:** Do you drink alcoholic beverages regularly (at least 1 drink per month)?

☐ **Yes, currently** ☐ **Yes, but Occasionally/rarely** ☐ **No, I quit** ☐ **Never did!**

Beverage	Number of drinks per				Number of years
	Day	Week	Month	Year	
Beer (12 oz cans/bottles)					
Wine (4 oz glass)					
Liquor (1 shot)					

10. **Tobacco History (smoking):** ☐ **Yes, currently** ☐ **Yes, but quit** ☐ **Occasionally/rarely** ☐ **Never**
    Do you use: ☐ Cigarettes ☐ Snuff or Dip ☐ Pipes ☐ Cigars ☐ Chewing Tobacco
    How old were you when you started smoking regularly? _____ years old.
    How many cigarettes do/did you smoke per day? _____ cig/day.
    How long have you smoked? _____years
    If you have quit, how old were you when you quit? _____ years old.
11. **Do you use recreational drugs/substances of any kind? If yes** are you using these items presently?

_____

_____

_____

12. Does any member of your family have current or prior drug or alcohol problem? ☐ Yes ☐ No

If yes, (who, when, what)_____

_____

_____

13. Do you feel safe in your home? ☐ Yes ☐ No

14. Please list significant sources of stress in your life **other than the pain**:

_____

_____

15. Sources of income: Do you work outside the home? ☐ Yes ☐ No

16. If yes, what is the nature of your work? _____

17. If no, when was the last time you worked? _____

18. Are you receiving or applying for any of the following:

Medicaid	☐ Yes ☐ No	Date applied
Medicare	☐ Yes ☐ No	Date applied
SSI Disability	☐ Yes ☐ No	Date applied
Other Disability	☐ Yes ☐ No	Date applied
Workmen's compensation	☐ Yes ☐ No	Date applied
General assistance	☐ Yes ☐ No	Date applied
Food stamps	☐ Yes ☐ No	Date applied

19. Are you involved with or considering legal action? ☐ Yes ☐ No

20. If yes, what type? _____

_____

_____

_____

21. Are you considering any of the following:

    a. Returning to work? ☐ Yes ☐ No
    b. Returning to school? □ Yes □ No
    c. Retraining for work? □ Yes □ No
    d. Continuing with your current work/occupation? □ Yes □ No □ Non applicable

COMMENTS:

_____

_____

_____

_____

_____

_____

What are your expectations in coming to the Pain Consultation & Treatment Center at UNM?

_____

_____

_____

_____

I certify that the answers in this document are complete and accurate to the best of my knowledge.

Sign: _____ Date: _____