PALM TREE
INTERVENTIONAL
PAIN MANAGEMENT
Pain Relief Starts Here

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FORMA DEL PACIENTE NUEVA

Nombre: _____ Fecha:_____/_____/_____

Fecha de Nacimiento:_____/_____/_____ EMAIL: _____

HISTORia:

¿Cuál es su molestia el día de hoy? (queja principal): _____

¿Por cuánto tiempo a tenido este dolor? _____

¿Su dolor empezó después un evento o accidente? SÍ o NO Sí es así, qué? _____

Describe su dolor (círcula todas las que apliquen): un espasmo, ardor, frío, caliente, calambres, presión, adormecimiento, como un shock, punzadas, apretando, apuñalamiento, picor, sensibilidad, estremecimiento (escalofrío)

¿El dolor se refleja en otra parte de su cuerpo? SÍ o NO Si la respuesta es sí, ¿dónde? _____

¿Cuán severo es su dolor? _____ con/ meds _____ sin/ meds

¿En que momento del día tiene más dolor? _____

¿Qué mejora su dolor? _____

¿Qué hace que su dolor empeore? _____

¿Usted a tratado terapia física? SÍ o NO Sí es así, ¿ayudó a su dolor? SÍ o NO

Fechas Atendidas: _____

¿Usted a tratado inyecciónes? SÍ o NO Sí es así, ¿ayudó a su dolor? SÍ o NO ¿Cuándo?_____

¿Usted a tratado cirugías? SÍ o NO Sí es así, ¿ayudó a su dolor? SÍ o NO ¿Cuándo?_____

¿Qué medicamentos para el dolor está tomando? _____

¿Usted a ha tratado y/o ha fallado NSAIDS para controlar el dolor? SÍ o NO

Sí es así, ¿cuáles? (Círcula todas las que apliquen): Ibuprofen Naproxen Aspirin Meloxicam Diclofenac Tylenol

¿Usted se ha realizado radiografías recientemente (en lose últimos dos años)? SÍ o NO

¿Tiene problemas de estreñimiento? SÍ o NO o A VECES

Círculo para lo que se aplica:

Estado de Fumar: NUNCA FUMÓ o EX FUMADOR o FUMADOR CORRIENTE

Estado de Alcohol: BEBEDOR DE ALCOHOL CORRIENTE o NO UN BEBEDOR DE ALCOHOL CORRIENTE

LISTA DE MEDICAMENTOS RCIENTES (or favor añada las dosis):

_____

_____

_____

HISTORIA MÈDICO:

_____

_____

ALERGÌAS:

_____

HISTORIA QUIRÚRGICA:

_____

_____

HISTORIA FAMILIA:

_____

_____

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. ow often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pills to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended an AA or NA meeting?	o	o	o	o	o
20. How often have you been in an argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

Please include any additional information you wish about the above answers. Thank you.