VELAZQUEZ
PAIN RELIEF CENTER

Name:	Date of Birth:	Age:	Sex:
Address: City State Zip Code			
Billing Address:	SSN:	Marital Status	
Primary Phone:	Work Phone:	Secondary Phone:	
Email:	Employment: Full/Part/None	Employer:	
Referring Physician:	Primary Care Physician:		
How did you hear about us? (Referring doctor, friend, family self-referral, internet, magazine, newspaper, advertisement other)			

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	Cell Phone #:
Relationship:	Home Phone #:

INSURANCE INFORMATION

Primary Insurance: Copay:	Secondary Insurance: Copay:
Policy ID:	Policy ID:
Group Number:	Group Number:
Subscriber Name:	Subscriber Name:
Subscriber DOB/Relationship:	Subscriber DOB:

Please circle the best option listed that describes your race and ethnicity:

Race: Asian, Native Hawaiian, Other Pacific Islander, Black/African American, American Indian/Alaska Native, White, More than 1 race	Ethnicity: Hispanic/Latino, Not Hispanic/Latino, unreported/refuse to report	Primary Language:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to my provider when they accept assignment.
Authorization To Release Medical Information: I hereby authorize Dr. Luis Velazquez to release any information necessary for my course of treatment.

I certify that the above information is correct as of the date signed.

_____ _____

Patient Signature Date

New Patient Intake Form

Your Name: _____ **Today's Date** _____

Height: _____ **Weight:** _____ lbs

Referral

Were you referred to our clinic by another physician? If so, whom? _____

↳ If not, how did you hear about us? ❑ Insurance Company ❑ Family ❑ Friend ❑ PCP

❑ www.velazquezpainreliefcenter.com ❑ Facebook ❑ Other Website _____

Pain Description

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out

_____ What number on the pain scale (0-10) best describes your pain **right now**?

_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ What number on the pain scale (0-10) best describes your **least pain**?

_____ What number on the pain scale (0-10) best describes your **average pain over the last month**?

Where is your worst area of pain located? _____

Does this pain radiate? If so, where? _____

Please list any additional areas of pain: _____

Onset of Symptoms

Approximately when did this pain begin? _____

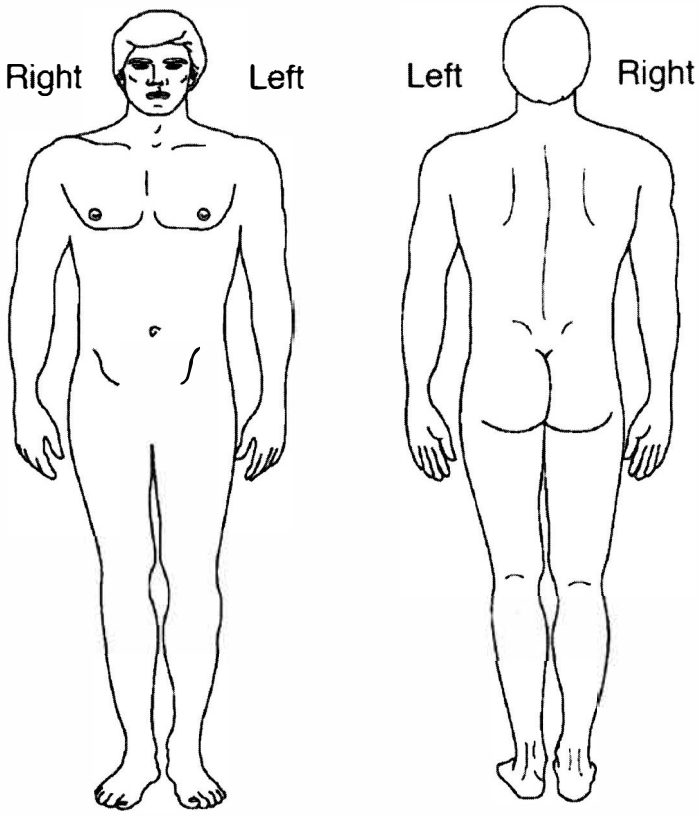
What caused your current pain episode? _____

How did your current pain episode begin? ❑ Gradually ❑ Suddenly

Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:

"N" = numbness
"S" = stabbing
"B" = burning
"P" = pins and needles
"A" = aching



Pain Description - Check all of the following that describe of your pain:

- ❑ Aching
- ❑ Cramping
- ❑ Dull
- ❑ Hot/Burning
- ❑ Numbness
- ❑ Shock-like
- ❑ Shooting
- ❑ Spasming
- ❑ Squeezing
- ❑ Stabbing/Sharp
- ❑ Throbbing
- ❑ Tingling/Pins & Needles
- ❑ Tiring/Exhausting

Pain Frequency

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is your pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

Activities of Daily Living Affected

- ❑ Sleeping
- ❑ Bathing/dressing
- ❑ Eating
- ❑ Toileting
- ❑ Personal hygiene/grooming
- ❑ Shopping
- ❑ Housekeeping
- ❑ Intimacy

In the past three months have you developed any new:

- ❑ Balance Problems
- ❑ Difficulty Walking
- ❑ Numbness/Tingling – Where?_____
- ❑ Bladder incontinence
- ❑ Fevers
- ❑ Bowel incontinence
- ❑ Nausea
- ❑ Weakness – Where? _____
- ❑ Chills
- ❑ Vomiting

❑ **I HAVE <u>NOT</u> RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

❑ MRI of the _____ Date: _____ Facility: _____

❑ X-ray of the _____ Date: _____ Facility: _____

❑ CT scan of the _____ Date: _____ Facility: _____

❑ EMG/NCV study of the _____ Date: _____ Facility: _____

❑ Ultrasound of the _____ Date: _____ Facility: _____

❑ Other diagnostic testing: _____

❑ **I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS**

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑ Chiropractic ❑ Physical Therapy ❑ Psychological Therapy ❑ Podiatrist Treatment

❑ Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Joint Injection – Joint(s) _____

❑ Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Nerve Blocks – Area/Nerve(s) _____

❑ Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑ Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

❑ Spine Surgery

❑ Trigger Point Injection – Where? _____

❑ Vertebroplasty / Kyphoplasty – Level(s) _____

❑ Other: _____

❑ **I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS**

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑No

Which type of anesthesia did you react adversely to? Please check all that apply.

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery

- ❑ Gallbladder removal _____
- ❑ Appendectomy _____
- ❑ Other _____

Female Surgeries

- ❑ Caesarean section _____
- ❑ Hysterectomy _____
- ❑ Laparoscopy _____
- ❑ Ovarian _____
- ❑ Other _____

Heart Surgery

- ❑ Valve replacement _____
- ❑ Aneurysm repair _____
- ❑ Stent placement _____
- ❑ Other _____

Joint Surgery

- ❑ Shoulder _____
- ❑ Hip _____
- ❑ Knee _____

Spine / Back Surgery

- ❑ Discectomy (levels)_____
- ❑ Laminectomy _____
- ❑ Spinal fusion (levels) _____

Other Common Surgeries

- ❑ Hemorrhoid surgery _____
- ❑ Hernia repair _____
- ❑ Thyroidectomy _____
- ❑ Tonsillectomy _____
- ❑ Vascular surgery _____

Please list any other surgeries and dates (attach an additional sheet if necessary):_____

_____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

Current Medications

Are you taking a prescribed **blood-thinner** medication? ❑Yes ❑No If yes, please check which one:

❑ Aggrenox ❑ Coumadin ❑ Effient ❑ Eliquis ❑ Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa

❑ Ticlid ❑ Warfarin ❑ Xarelto ❑ Other _____

Please list **ALL** medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

Do you have any known drug allergies? ❑Yes ❑No

If so, please list all medications you are allergic to:

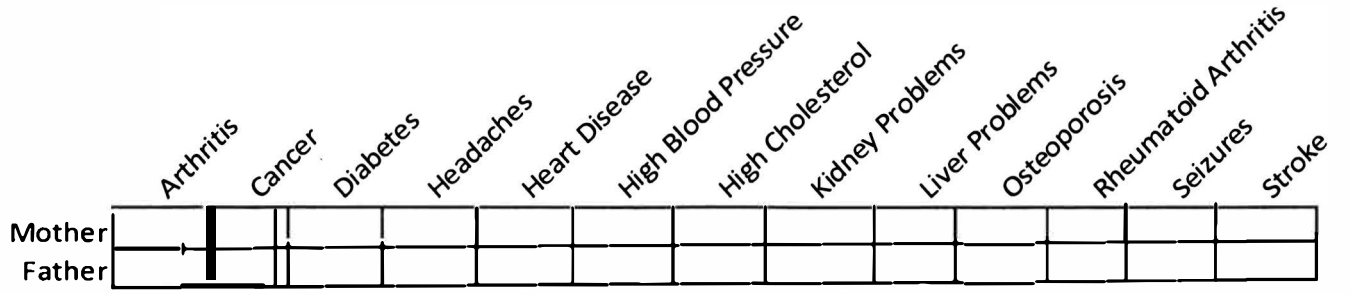
Medication Name **Allergic Reaction Type**

Please check if you are allergic to ❑ Iodine or ❑ Tape Are you allergic to shellfish? ❑ Yes ❑ No

***Are you allergic to latex?** ❑Yes ❑No If yes, you will be asked to complete a separate questionnaire

Family History

Mark all appropriate diagnoses as they pertain to your biological *MOTHER AND FATHER* only.



Other medical problems: _____

❑ **I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY** ❑ **I AM ADOPTED (No Medical History Available)**

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No *If so*, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

Alcohol Use: ❑ Current Alcoholism ❑ Daily Limited Alcohol Use ❑ History of Alcoholism
❑ Never Drinks Alcohol ❑ Social Alcohol Use

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Never Used Tobacco

Drug Use: ❑ Denies Any Illegal Drug Use ❑ Currently Using Illegal Drugs (Which: _____)
❑ Currently Using Someone Else's Prescription Medications
❑ Formerly Used Illegal Drugs (not currently using) (Which: _____)

Have you ever abused narcotic or prescription medications? ❑ Yes ❑No (Which: _____)

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

❑ No Past Medical History

General Medical
❑ Cancer – Type _____ ❑ Diabetes – Type _____ ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
❑ Glaucoma ❑ Headaches ❑ Head Injury ❑ Hyperthyroidism ❑ Hypothyroidism ❑ Migraines

Cardiovascular / Hematologic
❑ Anemia ❑ Bleeding Disorders ❑ Coronary Artery Disease ❑ Heart Attack ❑ High Blood Pressure
❑ High Cholesterol ❑ Mitral Valve Prolapse ❑ Murmur ❑ Pacemaker/Defibrillator ❑ Phlebitis
❑ Poor Circulation ❑ Stroke

Respiratory
❑ Asthma ❑ Bronchitis ❑ Emphysema / COPD ❑ Pneumonia ❑ Tuberculosis ❑ Valley Fever

Gastrointestinal
❑ Bowel Incontinence ❑ Acid Reflux (GERD) ❑ Gastrointestinal Bleeding ❑ Constipation

Musculoskeletal
❑ Amputation ❑ Bursitis ❑ Carpal Tunnel Syndrome ❑ Chronic Low Back Pain ❑ Chronic Neck Pain
❑ Chronic Joint Pain ❑ Fibromyalgia ❑ Joint Injury ❑ Osteoarthritis ❑ Osteoporosis
❑ Phantom Limb Pain ❑ Rheumatoid arthritis ❑ Tennis Elbow ❑ Vertebral Compression Fracture

Genitourinary/Nephrology
❑ Bladder Infection(s) ❑ Dialysis ❑ Kidney Infection(s) ❑ Kidney Stones ❑ Urinary Incontinence

Hepatic
❑ Hepatitis A (active / inactive / unsure)
❑ Hepatitis B (active / inactive / unsure)
❑ Hepatitis C (active / inactive / unsure)

Neuropsychological
❑ Alcohol Abuse ❑ Alzheimer Disease ❑ Bipolar Disorder ❑ Depression ❑ Epilepsy
❑ Prescription Drug Abuse ❑ Multiple Sclerosis ❑ Paralysis ❑ Peripheral Neuropathy
❑ Schizophrenia ❑ Seizures ❑ Reflex Sympathetic Dystrophy/CRPS

❑ Other Diagnosed Conditions

_____

_____

_____

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:
❑ Chills ❑ Difficulty Sleeping ❑ Easy Bruising
❑ Excessive Sweating ❑ Excessive Thirst ❑ Fatigue ❑ Fevers
❑ Insomnia ❑ Low Sex Drive ❑ Night Sweats ❑ Tremors
❑ Unexplained Weight Gain ❑ Unexplained Weight Loss ❑ Weakness

Eyes: ❑ Recent Visual Changes

Ears/Nose/Throat/Neck:
❑ Dental Problems ❑ Earaches ❑ Hearing Problems
❑ Nosebleeds ❑ Recurrent Sore Throats ❑ Ringing in the Ears ❑ Sinus Problems

Cardiovascular:
❑ Bleeding Disorder ❑ Chest Pain ❑ Deep Vein Thrombosis
❑ Fainting ❑ High Blood Pressure ❑ Irregular Heartbeat ❑ Lightheadedness
❑ Shortness of Breath During Sleep ❑ Swelling in the Feet

Respiratory:
❑ Cough ❑ Wheezing ❑ Pulmonary Embolism
❑ Shortness of Breath on Exertion/Effort ❑ Shortness of Breath at Rest

Gastrointestinal:
❑ Abdominal Cramps ❑ Acid Reflux ❑ Constipation
❑ Coffee Ground Appearance in Vomit ❑ Dark and Tarry Stools ❑ Diarrhea
❑ Hernia ❑ Vomiting

Musculoskeletal:
❑ Back Pain ❑ Joint Pain ❑ Joint Stiffness
❑ Joint Swelling ❑ Muscle Spasms ❑ Neck Pain

Genitourinary/Nephrology:
❑ Blood in Urine ❑ Decreased Urine Flow/Frequency/Volume
❑ Erectile Dysfunction ❑ Flank Pain ❑ Painful Urination ❑ Pelvic Pressure

Neurological:
❑ Carpal Tunnel Syndrome ❑ Dizziness ❑ Headaches
❑ Instability When Walking ❑ Numbness/Tingling ❑ Seizures ❑ Tremors

Psychiatric:
❑ Depressed Mood ❑ Feeling Anxious ❑ Stress Problem
❑ Suicidal Thoughts ❑ Suicidal Planning