

# New Patient Intake Paperwork

Your completed intake paperwork helps our providers get to know you and your medical history better. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (480) 563-6400 if you have any questions or are unsure how to complete any section of this form.

Today's Date \_\_\_\_\_

## Patient Information

**Your Name:** \_\_\_\_\_

Gender:  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status:  Married  Single  Divorced  Widowed  Other \_\_\_\_\_

Race:  American Indian or Alaskan Native  Asian or Pacific Islander  Black  White  Refuse to Report

Ethnicity:  Hispanic  Non-Hispanic  Refuse to Report

Primary Language:  English  Spanish  Other \_\_\_\_\_

Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Physical address same as Mailing?  Yes  No If not, \_\_\_\_\_

Preferred Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Home  Mobile  Work

Secondary Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  Home  Mobile  Work

Email: \_\_\_\_\_ Driver's License # /State: \_\_\_\_\_

## Referral and Physician Relationships

Who is your primary care physician? \_\_\_\_\_

Were you referred to Arizona Pain Specialists by another physician?  Yes  No

↳ If so, whom? \_\_\_\_\_

↳ If not, how did you hear about us?  TV  Radio  Insurance Company  Family  Friend  PCP  
 www.ArizonaPain.com  Facebook  Twitter  YouTube  Other Website \_\_\_\_\_

Who is your surgeon? \_\_\_\_\_

## Health Care Coverage

Mark the following sources of medical coverage that apply to you for this current pain complaint(s)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Private Insurance | <input type="checkbox"/> State Medicaid | <input type="checkbox"/> Worker's Compensation |
| <input type="checkbox"/> Medicare          | <input type="checkbox"/> Self-Pay       | <input type="checkbox"/> Automobile Insurance  |

## Preferred Pharmacy

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

## Primary Insurance Plan

Payer (e.g. BC/BS): \_\_\_\_\_ Plan: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy/I.D. Number: \_\_\_\_\_

Insurance policy holder:  Self  Spouse  Child  Other

Complete this box if you are *not* the policy holder for your primary insurance \_\_\_\_\_

**Policy Holder** Name: \_\_\_\_\_ Policy Holder Gender:  Female  Male

Street Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Primary telephone number: \_\_\_\_\_ Employer: \_\_\_\_\_

## Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): \_\_\_\_\_ Plan: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy/I.D. Number: \_\_\_\_\_

Insurance policy holder:  Self  Spouse  Child  Other

Complete this box if you are *not* the policy holder for your secondary insurance \_\_\_\_\_

**Policy Holder** Name: \_\_\_\_\_ Policy Holder Gender:  Female  Male

Street Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Primary telephone number: \_\_\_\_\_ Employer: \_\_\_\_\_

## Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: \_\_\_\_\_ Agent Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Date of initial injury: \_\_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Employment Status

Employed  Retired  Unemployed  Disabled

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

## Medical History

Your Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs

## Pain Location

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

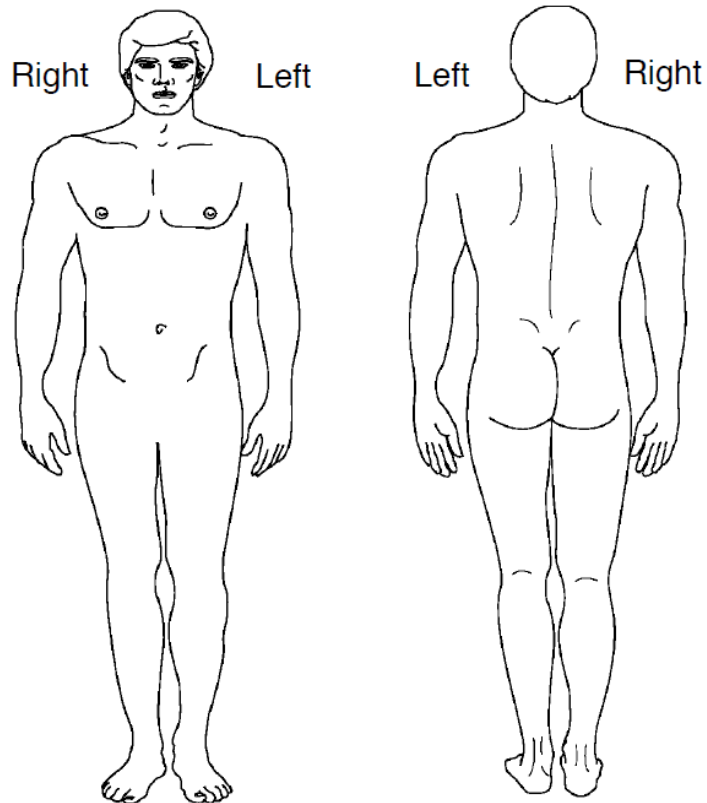
"N" = numbness

"S" = stabbing

"B" = burning

"P" = pins and needles

"A" = aching



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?  Motor Vehicle Accident  Other \_\_\_\_\_

Personal Injury (legal term describing injury sustained to your person by negligence of another)

How did your current pain episode begin?  Gradually  Suddenly

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

## Pain Description

Check all of the following that describe of your pain:

Aching

Hot/Burning

Shooting

Stabbing/Sharp

Cramping

Numbness

Spasming

Throbbing

Dull

Shock-like

Squeezing

Tiring/Exhausting

Tingling/Pins and Needles

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

**Mark the effect of each of the following on your pain**

	Increases my pain	Decreases my pain	No change in my pain
Bending Backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending Forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changes in the Weather	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Your Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on Your Stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from a Sitting Position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other activities: \_\_\_\_\_

**In the past three months have you developed any new:**

- Balance Problems
- Bladder incontinence
- Bowel incontinence
- Chills
- Difficulty Walking
- Fevers
- Nausea
- Vomiting
- Numbness/Tingling – Where? \_\_\_\_\_
- Weakness – Where? \_\_\_\_\_
- I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS.

**Other Doctors Consulted**

Mark the following physicians or specialists you have consulted for treatment of your current pain problem(s).

*(ONLY FOR PAIN RELIEF. NOT FOR OTHER PROBLEMS)*

- Acupuncturist
- ENT Physician
- Neurosurgeon
- Plastic Surgeon
- Anesthesiologist
- General Physician
- Ophthalmologist
- Podiatrist
- Chiropractor
- Hypnotist
- Orthopedic Surgeon
- Psychiatrist/Psychologist
- Dentist
- Internist
- Pain Physician
- Rheumatologist
- Endocrinologist
- Neurologist
- Physical Therapist
- Other \_\_\_\_\_

## Global Pain Scale

**Instructions:** This scale will be used to measure your pain and how it changes (over time and after treatments) on a number of important areas that can affect one's quality of life, so it is important that you answer each question below. For each question, please indicate your level of pain by circling **ONE** number from 0 to 10. Then, add up the totals and divide by two for each section.

	No Pain										Extreme Pain											
<b>Section I - Your Pain</b>																						
My <b>current</b> pain is:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , the <b>best</b> my pain has been is:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , the <b>worst</b> my pain has been is:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , my <b>average</b> pain has been:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past 3 months</i> , my <b>average</b> pain has been:	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
<b>Section I Subtotal</b> _____												<b>÷ 2 =</b> _____										

	Strongly Disagree										Strongly Agree											
<b>Section II - Your Feelings</b>																						
During the <i>past week</i> , I have felt <b>afraid</b> .	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I have felt <b>depressed</b> .	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I have felt <b>tired</b> .	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I have felt <b>anxious</b> .	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I have felt <b>stressed</b> .	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
<b>Section II Subtotal</b> _____												<b>÷ 2 =</b> _____										

	Strongly Disagree										Strongly Agree											
<b>Section III - Your Clinical Outcomes</b>																						
During the <i>past week</i> , I had trouble sleeping.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I had trouble feeling comfortable	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I was less independent.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I was unable to work (or perform normal tasks)	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I needed to take more medication.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
<b>Section III Subtotal</b> _____												<b>÷ 2 =</b> _____										

	Strongly Disagree										Strongly Agree											
<b>Section IV - Your Activities</b>																						
During the <i>past week</i> , I was <b>not</b> able to go to the store.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I was <b>not</b> able to do chores in my home.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I was <b>not</b> able to enjoy my friends & family.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I was <b>not</b> able to exercise (including walking).	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
During the <i>past week</i> , I was <b>not</b> able to participate in my favorite hobbies.	0	1	2	3	4	5	6	7	8	9	10	0	1	2	3	4	5	6	7	8	9	10
<b>Section IV Subtotal</b> _____												<b>÷ 2 =</b> _____										

Add up the scores for each section. The maximum score is 100.

**Total Score:** \_\_\_\_\_

## 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: \_\_\_\_\_
- Other diagnostic testing: \_\_\_\_\_
- I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

## Interventional Pain Treatment History

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

- 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
- Trigger Point Injection – Where \_\_\_\_\_
- Vertebroplasty / Kyphoplasty – Level(s) \_\_\_\_\_
- Other: \_\_\_\_\_
- I HAVE NOT HAD ANY INTERVENTIONAL PROCEDURES PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

## Please mark all of the following treatments you have used for pain relief

	Helped pain	Worsened pain	No change
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brace Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot/Cold Packs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injection Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## 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

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

Local anesthesia  Epidural  General anesthesia  IV Sedation

Please explain: \_\_\_\_\_

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 currently taking any blood-thinners or anticoagulants?  Yes  No

If Yes, which ones?  Plavix  Coumadin  Lovenox  Aggrenox  Other \_\_\_\_\_



## Social History

Are you or can you be pregnant?  Not Applicable  Yes  No

Number of Children: \_\_\_\_\_ Number of Children Living at Home: \_\_\_\_\_

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

Alcohol Use:  Daily Limited Use  History of Alcoholism  Current Alcoholism  
 Never Drinks Alcohol  Drinks Alcohol Socially

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

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

Have you ever abused narcotic or prescription medications?  Yes  No

## Past Medical History

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

### General Medical

- Cancer – Type \_\_\_\_\_
- Diabetes – Type \_\_\_\_\_
- HIV / AIDS

### Head/Eyes/Ears/Nose/Throat

- Headaches
- Migraines
- Head Injury
- Hyperthyroidism
- Hypothyroidism
- Glaucoma

### Cardiovascular / Hematologic

- Anemia
- Heart Attack
- High Blood Pressure
- High Cholesterol
- Mitral Valve Prolapse
- Murmur
- Phlebitis
- Poor Circulation
- Stroke
- Coronary Artery Disease

### Respiratory

- Asthma
- Bronchitis
- Emphysema / COPD

- Pneumonia
- Tuberculosis
- Valley Fever

### Gastrointestinal

- Bowel Incontinence
- GERD (Acid Reflux)
- 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 (page 9).*

### Constitutional:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Chills                  | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Easy Bruising           |
| <input type="checkbox"/> Excessive Sweating      | <input type="checkbox"/> Excessive Thirst    | <input type="checkbox"/> Fatigue                 |
| <input type="checkbox"/> Fevers                  | <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Low Sex Drive           |
| <input type="checkbox"/> Night Sweats            | <input type="checkbox"/> Tremors             | <input type="checkbox"/> Unexplained Weight Gain |
| <input type="checkbox"/> Unexplained Weight Loss |  | <input type="checkbox"/> Weakness                |

### Eyes:

- Recent Visual Changes

### Ears/Nose/Throat/Neck:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Dental Problems     | <input type="checkbox"/> Earaches               | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Nosebleeds          | <input type="checkbox"/> Recurrent Sore Throats |   |
| <input type="checkbox"/> Ringing in the Ears | <input type="checkbox"/> Sinus Problems         |   |

### Cardiovascular:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> Chest Pain                       | <input type="checkbox"/> Deep Vein Thrombosis |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Irregular Heartbeat  |
| <input type="checkbox"/> Lightheadedness      | <input type="checkbox"/> Shortness of Breath During Sleep |   |
| <input type="checkbox"/> Swelling in the Feet |   |   |

### Respiratory:

- |   |                                   |  |
|---|-----------------------------------|--|
| <input type="checkbox"/> Cough                                  | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Pulmonary Embolism          |
| <input type="checkbox"/> Shortness of Breath on Exertion/Effort |                                   | <input type="checkbox"/> Shortness of Breath at Rest |

### Gastrointestinal:

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> Abdominal Cramps                  | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Constipation          |
| <input type="checkbox"/> Coffee Ground Appearance in Vomit |                                      | <input type="checkbox"/> Dark and Tarry Stools |
| <input type="checkbox"/> Diarrhea                          | <input type="checkbox"/> Hernia      | <input type="checkbox"/> Vomiting              |

### Musculoskeletal:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Back Pain      | <input type="checkbox"/> Joint Pain    | <input type="checkbox"/> Joint Stiffness |
| <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Neck Pain       |

### Genitourinary/Nephrology:

- |   |  |
|---|--|
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Decreased Urine Flow/Frequency/Volume |
| <input type="checkbox"/> Flank Pain     | <input type="checkbox"/> Painful Urination                     |

### Neurological:

- |   |  |                                   |
|---|--|-----------------------------------|
| <input type="checkbox"/> Carpal Tunnel Syndrome   | <input type="checkbox"/> Dizziness         |                                   |
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Numbness/Tingling |                                   |
| <input type="checkbox"/> Instability When Walking | <input type="checkbox"/> Tremors           | <input type="checkbox"/> Seizures |

### Psychiatric:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Depressed Mood    | <input type="checkbox"/> Feeling Anxious   | <input type="checkbox"/> Stress Problems |
| <input type="checkbox"/> Suicidal Thoughts | <input type="checkbox"/> Suicidal Planning |  |

## Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Arizona Pain Specialists and any associates, assistants and other health care providers it may deem necessary to treat my condition. I understand that no warrant or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

Initial Here \_\_\_\_\_

## Medication History Consent

A medication history is a list of medicines that Arizona Pain Specialists and other doctors have recently prescribed for a patient. It is collected from a variety of sources, including a patient's pharmacy, health plans, other healthcare providers, and the Arizona State Pharmacy Board.

I give my consent for Arizona Pain Specialists to retrieve and review my medication history. I understand that this will become part of my medical record.

Initial Here \_\_\_\_\_

## Privacy Practices and Consent to Release Protected Health Information

The Notice of Privacy Practices for Arizona Pain Specialists is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records. I acknowledge I have had the opportunity to review the Notice of Privacy Practices.

I authorize the Arizona Pain Specialists to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Arizona Pain Specialists to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that Arizona Pain Specialists will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at the front desk or from [www.arizonapain.com](http://www.arizonapain.com).

Initial Here \_\_\_\_\_

## Authorization

I authorize Arizona Pain Specialists to proceed as indicated in the above Consent sections.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

## Medicare Release

*ALL MEDICARE PATIENTS MUST SIGN THE FOLLOWING STATEMENT:*

I request that payment under the medical insurance program be made on my behalf to Arizona Pain Specialists for any services furnished me by its physician (s) and/or practitioners. I authorize any holder of medical information about me to release it to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_