

New Patient Intake Paperwork



Your completed intake paperwork helps our providers get to know you and your medical history. 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: _____ **Social Security Number:** _____

Street Address: _____ **Date of Birth:** _____ **Age:** _____

City/State/Zip: _____ **Height:** _____ **Weight:** _____ lbs

Email: _____ **Gender:** Male Female

Physical Address Same as Mailing? Yes No **If not,** _____

Preferred Phone: _____ Home Mobile Work

Secondary Phone: _____ Home Mobile Work

Email: _____ **Driver's License # / State:** _____

Emergency Contact Name: _____ **Phone:** _____ **Relationship:** _____

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

Referral

Were you referred to our clinic by another physician? 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 _____

Preferred Pharmacy

Pharmacy Name: _____ **Phone Number:** _____

Street Address: _____ **City/State/Zip:** _____

Primary Insurance Plan

Payer (e.g. BC/BS): _____ **Plan:** _____

Policy/I.D. Number: _____ **Group Number:** _____

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

Insurance policy holder: Self Spouse Child Other: _____

Policy Holder Name: _____ **Policy Holder Gender:** Female Male

Date of Birth: _____ **Social Security Number:** _____

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): _____ Plan: _____
Policy/I.D. Number: _____ Group Number: _____

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

Insurance policy holder: Self Spouse Child Other: _____
Policy Holder Name: _____ Policy Holder Gender: Female Male
Date of Birth: _____ Social Security Number: _____

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: _____

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

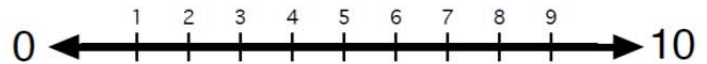
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities

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**?

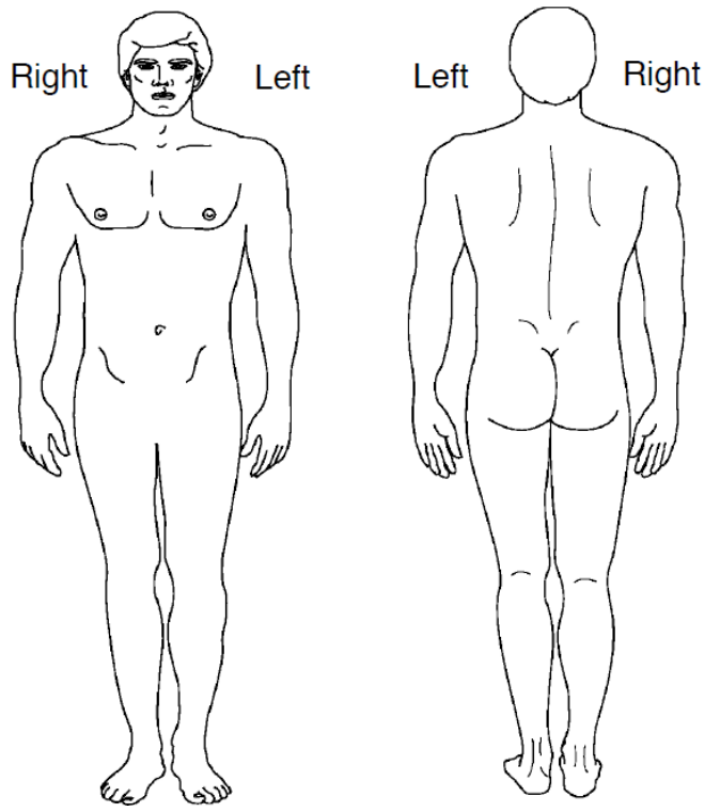
_____ What number on the pain scale (0-10) best describes your **worst pain**?

_____ 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**?

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? _____

Is your pain the result of a Motor Vehicle Accident or Personal Injury (legal term describing injury sustained to your person by negligence of another) Yes No

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:

- | | | | |
|--|--------------------------------------|------------------------------------|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Hot/Burning | <input type="checkbox"/> Shooting | <input type="checkbox"/> Stabbing/Sharp |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Numbness | <input type="checkbox"/> Spasming | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tiring/Exhausting |
| <input type="checkbox"/> 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

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.

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.

Pain Treatment History

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

- Chiropractic Physical Therapy Spine Surgery 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
- 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

Please indicate which (if any) of the following blood-thinners you are taking:

- Aggrenox Coumadin / Warfarin Effient Lovenox Plavix Pletal Pradaxa Prasugrel
 Ticlid Other _____

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

<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>	<u>Medication Name</u>	<u>Dose</u>	<u>Frequency</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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

Topical Allergies:

Iodine

Latex

Tape

Are you allergic to shellfish?

Yes

No

Family History

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

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

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:

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 (Which: _____)

Currently Uses Marijuana

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:

General Medical

- Cancer – Type _____
- Diabetes – Type _____
- HIV / AIDS

Head/Eyes/Ears/Nose/Throat

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

Cardiovascular / Hematologic

- Anemia
- Bleeding Disorders
- 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, above.*

Constitutional:

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

Eyes:

- Recent Visual Changes

Ears/Nose/Throat/Neck:

- Nosebleeds
- Dental Problems
- Recurrent Sore Throats
- Earaches
- Ringing in the Ears
- Hearing Problems
- 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 Flank Pain Painful Urination

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

- Psychiatric: Depressed Mood Feeling Anxious Stress Problems
 Suicidal Thoughts 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 warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

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.

I acknowledge that I have had the opportunity to review Arizona Pain Specialists’ Notice of Privacy Practices, which 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 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 its facility and on its website.

Signed: _____ Date: _____