ESTABLISHED VISIT INTAKE FORM

Please inform the front desk personnel if your phone number, pharmacy information, or insurance has changed since the last visit.

Today's Date: _____ Patient's Full Name: _____

DOB: _____

Reason for Today's Visit: ❑ Medication Refill ❑ Medication Change ❑ Post-Procedure Assessment

❑ Review Test Results ❑ New Pain or Injury:

What is your current pain level **right now? _____** Where is your worst area of pain located? _____

Since Your Last Visit:

Has your pain: ❑ Increased ❑ Decreased ❑ Stayed the Same

Did you have a procedure: ❑ No ❑ Yes **If yes,** how much pain relief did you obtain? _____%

Were there any problems? ❑ No ❑ Yes **If yes,** please explain: _____

Any new imaging studies? ❑ No ❑ Yes Please List:

Any new allergies? ❑ No ❑ Yes Please List:

Any new medications side effects? ❑ No ❑ Yes Please List:

Any new medications? ❑ No ❑ Yes Please List:

Do you currently have an implanted ICD, pacemaker or defibrillator? ❑ No ❑ Yes

REVIEW OF SYSTEMS: Mark any of the following symptoms that you **currently** suffer from.

Cardiovascular/Respiratory:
❑ Chest Pain
❑ Cough
❑ Difficulty Breathing
❑ Fainting
❑ High Blood Pressure
❑ Swelling in Feet

Constitutional:
❑ Chills
❑ Difficulty Sleeping
❑ Fatigue
❑ Fevers
❑ Night Sweats

Ears/Nose/Throat:
❑ Earaches
❑ Hay Fever/Allergies ❑ Sinus Problems
❑ Nosebleeds ❑ Ringing in the Ears

Gastrointestinal:
❑ Constipation
❑ Dark/Tarry Stools
❑ Diarrhea
❑ Nausea/vomiting

Genitourinary/Nephrology:
❑ Blood in Urine
❑ Involuntary Urination
❑ Loss of Bowel Control
❑ Painful Urination
❑ Pelvic Pressure

Musculoskeletal:
❑ Back Pain
❑ Joint Pain
❑ Neck Pain

Neurological:
❑ Dizziness
❑ Headaches
❑ Instability When Walking
❑ Numbness/Tingling
❑ Weakness

Psychiatric:
❑ Anxiety/Stress
❑ Depressed Mood
❑ Suicidal Thoughts
❑ Suicidal Planning

Women Only:
Are you currently pregnant?
❑ No ❑ Yes
Are you capable of becoming pregnant?
❑ No ❑ Yes

Consent and Authorization

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I voluntarily request that The Pain Experts of Arizona provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risks prior to the performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize The Pain Experts of Arizona physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

_____ _____

Signature of Patient or Representative Date

_____

Relationship to Patient