NEW PATIENT INTAKE PAPERWORK

Name: _____ Date of Birth: _____ Today's Date: _____

Gender: ❑ Male ❑ Female Height: _____ Weight: _____lbs

Marital Status: ❑Married ❑ Single ❑ Divorced ❑ Widowed

Primary Language: ❑ English ❑ Spanish ❑ Other: _____

Street Address: _____

City/State/Zip: _____

Mailing Address if different from physical address: _____

Email: _____

Preferred Phone: _____ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: _____ ❑ Home ❑ Mobile ❑ Work

Emergency Contact: _____ Phone: _____ Relationship: _____

Preferred Pharmacy: _____ Phone: _____

Pharmacy Address: _____

How did you hear about us? ❑ Internet ❑ Friend ❑ Family Member

❑ Referring Physician Name _____

Primary Insurance: _____ Policy/I.D. Number: _____

Group Number: _____ Policy Holder: ❑ Self ❑ Spouse ❑ Other: _____

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

Date of Birth: _____ Social Security Number: _____

Secondary Insurance: _____ Policy/I.D. Number: _____

Group Number: _____ Policy Holder: ❑ Self ❑ Spouse ❑ Other: _____

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

Date of Birth: _____ Social Security Number: _____

COMPLETE THIS SECTION ONLY IF YOUR VISIT TODAY IS RELATED TO A WORKERS COMPENSATION CLAIM:

Workers Comp Company: _____

Agent Name: _____ State of Injury: _____

Phone Number: _____ Fax Number: _____

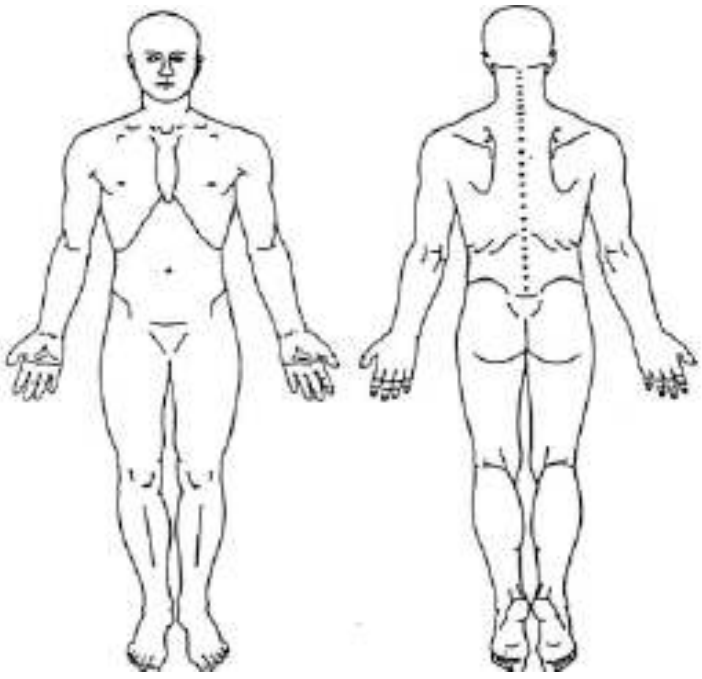
Claim Number: _____ Date of Initial Injury: _____

INJURY CLAIM: 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

ONSET OF SYMPTOMS AND REASON FOR VISIT TODAY

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

"**N**"umbness "**P**"ins and Needles "**A**"ching "**S**"tabbing "**B**"urning



What is your **current** pain level: _____ What is your **worst** pain level: _____

Where is your worst area of pain located? _____

Please list additional areas of pain: _____

Have you seen other physicians for current pain issue? ❑ Yes ❑ No If yes, who? _____

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

Since your pain began, has your pain ❑ Increased ❑ Decreased ❑ Stayed the same

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

Check all that describes your pain **today**:

❑ Aching	❑ Hot/Burning	❑ Spasms	❑ Throbbing
❑ Cold	❑ Numb	❑ Squeezing	❑ Tingling/Pins and Needles
❑ Cramping	❑ Shocking	❑ Stabbing/Sharp	❑ Shooting
❑ Dull			

CURRENT MEDICATIONS:

Are you taking a **prescribed blood thinner or aspirin?** If so, please list them here: _____

_____

Name and phone number of physician that prescribes your blood thinner: _____

_____

Please list **ALL** medications you are currently taking. Attached additional sheet if needed.

Medication Name **Dose** **Frequency**	**Medication Name** **Dose** **Frequency**
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

ALLERGIES: - Please list all allergies that you have (**do not list side effects)**

❑ No Known Allergies

	Medication:	**Allergic Reaction:**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Are you allergic to any of the following?

Iodine ❑ Yes ❑ No

Tape ❑ Yes ❑ No

Latex ❑ Yes ❑ No If yes, do you require special rescue measures for your latex allergy? ❑ Yes ❑ No

FAMILY HISTORY:

❑ Anxiety/Depression
❑ Arthritis
❑ Cancer
❑ Diabetes
❑ Headaches
❑ Heart Disease/Stroke
❑ High blood pressure
❑ Kidney Problems
❑ Liver problems
❑ Rheumatoid Arthritis
❑ Seizures
❑ Substance Abuse
❑ I HAVE NO SIGNIFICANT FAMILY MEDICAL HISTORY

SURGICAL HISTORY: Please list all surgical procedures you have had and include date of surgery

❑ I HAVE NOT HAD ANY SURGICAL PROCEDURES

_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY/PROBLEM LIST: Mark all conditions you have been diagnosed with

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

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

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

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

Hepatic

Hepatitis ❑ A ❑ B ❑ C

❑ Active ❑ Inactive ❑ Unsure

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

Musculoskeletal
- ❑ Amputation
- ❑ Phantom Limb Pain
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis/Osteoporosis
- ❑ Rheumatoid Arthritis
- ❑ Vertebral Compression Fracture

Neuro/Psychological
- ❑ Alzheimer Disease
- ❑ Anxiety/Depression
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ CRPS/Reflex Sympathetic Dystrophy

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

❑ **I HAVE NO SIGNIFICANT MEDICAL HISTORY**

SOCIAL HISTORY:

Alcohol Use: ❑ Current ❑ History of Alcoholism ❑ Never ❑ Social Alcohol Use

Smoking/Tobacco: ❑ Current ❑ Former Smoker ❑ Never Used

Marijuana: ❑ Current User ❑ Former User ❑ Never ❑ Marijuana Card Holder

Drug Use:
- ❑ I deny any illegal drug use
- ❑ I am currently using illegal drugs. List: _____
- ❑ I formerly used illegal drugs (not currently using). List: _____
- ❑ I formerly abused prescription narcotic medication. List: _____

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/Neck
- ❑ Difficulty Hearing
- ❑ Earaches
- ❑ Hay Fever
- ❑ Allergies
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears/Tinnitus
- ❑ Sinus Problems

Eyes: ❑ Recent Visual Changes

Gastrointestinal
- ❑ Constipation
- ❑ Dark/Tarry Stools
- ❑ Diarrhea
- ❑ Nausea/Vomiting

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

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?
❑ Yes ❑ No

Are you capable of becoming pregnant?
❑ Yes ❑ No

I certify the above information is accurate, complete, and true. I understand this will become part of my medical record.

Patient's Signature _____ Date _____

General Consent and Authorization for Treatment, Evaluation, and Information Release

This consent provides The Pain Experts of Arizona 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 certify that my Medical History is complete and accurate to the best of my knowledge and ability.

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 risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

PHOTOGRAPHS I consent to taking and reproducing pictures of me in any form (e.g., photograph, film, tape, etc.) in connection with my diagnosis, care, and treatment (including surgical procedures). These pictures will be used for purposes related to treatment, scientific and educational purposes, billing, coordination of care, and healthcare operations, such as quality assurance, patient safety, and identification.

RELEASE OF INFORMATION 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.

_____	_____
Printed Name of Patient or Representative	Signature of Patient or Representative
_____	_____
Relationship to Patient	Date