AZ PAIN DOCTORS

In order to ensure that you are getting the best possible health care, we need this form completed in its entirety every visit. We **cannot accept the word "same"** - current health status is required.

Your Name:_________________________________ **Date of Birth:**____________ **Today's Date:** ______________

Has your medical coverage changed from your last visit? ☐Yes ☐ No

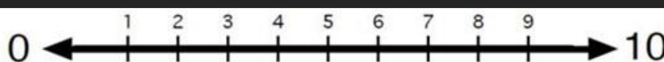
Has your address changed since from your last visit? ☐ Yes ☐ No

Reason For Today's Visit

☐ Medication Refill ☐ Medication Change ☐ Post-Procedure Assessment ☐ Review MRI

☐ Review Test Results ☐ Other:

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

Height: ______________ Weight:________________

Please rate your pain using a 0-10 scale:

___________ Your pain **right now**?

___________ Your **worst pain**?

___________ Your **least pain**?

___________ Your **average pain over the last month**?

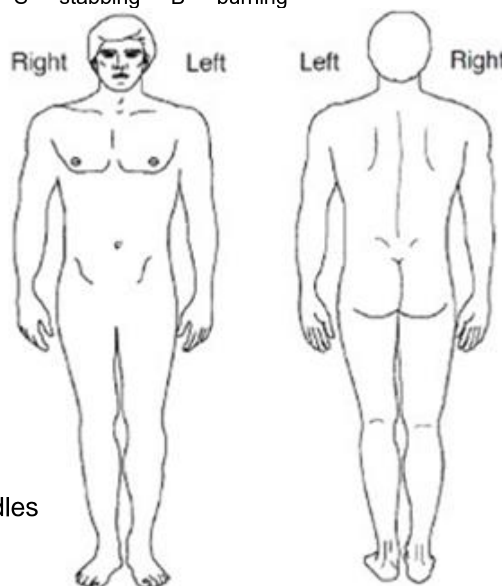
Where is your worst area of pain located?

____

Does this pain radiate? If so, where?

____

Use the diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms:
"N" = numbness "P" = pins and needles "A"= aching
"S" = stabbing "B" = burning



Check all that describe your pain today:

☐ Aching ☐ Hot/Burning ☐ Shooting ☐ Throbbing
☐ Cramping ☐ Numb ☐ Spasming ☐ Tingling/Pin&Needles
☐ Dull ☐ Shock-like ☐ Stabbing/Sharp ☐ Tiring/Exhausted

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 all of the following activities that are adversely/negatively affected by your pain

☐ Enjoyment of Life ☐ Normal Work ☐ Sleep
☐ General Activity ☐ Recreational Activities ☐ Walking
☐ Mood ☐ Relationships with People ☐ Other: ______________________

Since your last visit, 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 Problems With Any Of The Above Conditions Since My Last Visit.**

Changes Since your Last Visit

Have you developed new pain complaints since your last visit you would like to discuss today? ☐Yes ☐No
***If so, is the new pain due to a motor vehicle accident or personal injury?* ☐ Yes ☐ No**
Since your last appointment, how as your pain changed? ☐ Decreased ☐ Increased ☐ Same
If you had a procedure, how much pain relief did you obtain?
☐ None ☐ 10% ☐ 20% ☐ 30% ☐ 40% ☐ 50% ☐ 60% ☐ 70% ☐ 80% ☐ 90% ☐ 100%
Were there any problems? ☐ Yes ☐ No If yes, please explain: ______________________________

Current Medications

Please list any changes since your last visit in the medications you are currently taking.

Medication Name:	Dose:	Change:

Are you currently taking any blood-thinners or anticoagulants? ☐ Yes ☐ No
If you are taking narcotic pain relievers, when was your last dose?

Medications Effects

Mark the following medication side-effects you are experiencing, if any:

☐ Confusion ☐ Constipation ☐ Dizziness ☐ Drowsiness
☐ Dry Mouth ☐ Nausea ☐ Vomiting ☐ Weight Gain

☐ I do not have any adverse side effects from current medications.
☐ I am stable on my current medication regimen.
☐ My medications help to improve my functioning and quality of life.

Allergies

Are you allergic to latex? ☐ Yes ☐ No
Other Known Allergies: ____

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Review of Symptoms

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
- ☐ Fever

Respiratory:
- ☐ Shortness of Breath on Exertion/Effort
- ☐ Shortness of Breath at rest
- ☐ Cough
- ☐ Wheezing
- ☐ Pulmonary Embolism

Musculoskeletal:
- ☐ Joint Swelling
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Joint Pain
- ☐ Muscle Spasms
- ☐ Joint Stiffness

Eyes:
- ☐ Recent Visual Changes

Ears/ Nose/ Throat/Neck:
- ☐ Nosebleeds
- ☐ Dental Problems
- ☐ Recurrent Sore Throats
- ☐ Earaches
- ☐ Ringing in the Ear
- ☐ Hearing Problems
- ☐ Sinus Problems
- ☐ Allergies

Gastrointestinal:
- ☐ Abdominal Cramps
- ☐ Hernia
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dark and Tarry Stools
- ☐ Vomiting
- ☐ Acid Reflux

Neurological:
- ☐ Instability when walking
- ☐ Carpal Tunnel Syndrome
- ☐ Numbness/Tingling
- ☐ Dizziness
- ☐ Seizures
- ☐ Headaches

Cardiovascular:
- ☐ Fainting
- ☐ Shortness of Breath During Sleep
- ☐ Bleeding Disorders
- ☐ High Blood pressure
- ☐ Chest Pain
- ☐ Irregular Heartbeat
- ☐ Swelling of the feet
- ☐ Deep Vein Thrombosis
- ☐ Lightheadedness

Genitourinary/Nephrology:
- ☐ Erectile Dysfunction
- ☐ Blood in Urine
- ☐ Flank Pain
- ☐ Decreased Urine Flow
- ☐ Painful Urination
- ☐ Pelvic Pressure

Psychiatric:
- ☐ Suicidal Thoughts
- ☐ Suicidal Planning
- ☐ Depression
- ☐ Feeling Anxious
- ☐ Stress Problems

Signature and Date

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine, oral swab and/or blood sample as requested.** I have the right to refuse specific tests but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to AZ Pain Doctors my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to AZ Pain Doctors. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether they are covered by my insurance. I understand that the laboratories may be out-of-network with my insurance. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed:_______________________________________Date: ____________________________