PAIN SOLUTIONS
MEDICAL GROUP

NEW PATIENT INTAKE FORMS

Name_____ **Nickname**_____ **How did you hear about us**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Cell Phone_____ **Home Phone** _____ **SSN**_____

Home Email_____ **Date of Birth**_____ **Age**_____ **Gender** ☐ **Male** ☐ **Female** ☐ **Unspecified**

Emergency Contact_____ **Contact Phone #**_____

Marital Status ☐ Single ☐ Married ☐ Other **Children** ☐ Yes ☐ No How Many?_____

Employment Status ☐ Employed ☐ FT Student ☐ PT Student ☐ Other Retired Self Employed _____

Occupation_____ **Employer**_____ **Employer Phone**_____

Do you have insurance? ☐ Yes ☐ No Insurance Name_____

Are you the Primary insured? ☐ Yes ☐ No If no, primary insured name and relationship of:_____ Their DOB_____

Family Physician_____ Phone _____

Current medications, COMPLETE FULLY:

RX Medication/Over The Counter	Dosage
1	
2	
3	
4	
5	

Known Medical Conditions:

1. _____
2. _____
3. _____
4. _____
5. _____

List any known allergies you have had to any medications, foods or environment:

1) _____ 3) _____

2) _____ 4) _____

Do you suffer from seasonal allergies? ☐ **Yes** ☐ **No** **If Yes, have you had allergy testing before?** ☐ **Yes** ☐ **No**
Do you suffer from food sensitivity? ☐ **Yes** ☐ **No** **If Yes, have you had food sensitivity testing before?** ☐ **Yes** ☐ **No**

FAMILY HISTORY: Please check any condition that YOU or YOUR FAMILY have or have had in the past. **(P) for Patient or (F) for family

☐ Alcoholism	☐ (P or F) ☐	☐ High Blood Pressure	☐ (P or F) ☐	☐ Stroke	☐ (P or F) ☐
☐ Anemia	☐ (P or F) ☐	☐ Kidney Disease	☐ (P or F) ☐	☐ Suicide Attempt	☐ (P or F) ☐
☐ Asthma	☐ (P or F) ☐	☐ Live Disease	☐ (P or F) ☐	☐ Thyroid Disease	☐ (P or F) ☐
☐ Cancer/Tumor	☐ (P or F) ☐	☐ Hepatitis	☐ (P or F) ☐	☐ Heat Disease	☐ (P or F) ☐
☐ Diabetes	☐ (P or F) ☐	☐ Lung Disease	☐ (P or F) ☐	☐ Ulcers	☐ (P or F) ☐
☐ Drug Abuse	☐ (P or F) ☐	☐ Rheumatic Arthritis	☐ (P or F) ☐	☐ HIV / Other Immune Disease	☐ (P or F) ☐
☐ Depression	☐ (P or F) ☐	☐ Osteoarthritis	☐ (P or F) ☐	☐ Thyroid Disease	☐ (P or F) ☐
☐ Epilepsy/Seizures	☐ (P or F) ☐	☐ Osteoporosis	☐ (P or F) ☐	☐ Other _____	☐ (P or F) ☐

Past Health History: Please mark any condition you have now or had in the past

General
- ☐ Weight Loss
- ☐ Fatigue
- ☐ Fever

MSK
- ☐ Joint Pain
- ☐ Stiffness
- ☐ Muscle Pain
- ☐ Swollen Joints

Psychiatric
- ☐ Anxiety
- ☐ Depression

GU
- ☐ Erectile Dysfunction
- ☐ Leaky Bladder
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Painful urination

ENT
- ☐ Difficult Hearing
- ☐ Ear Ringing
- ☐ Vertigo
- ☐ Sinus Trouble
- ☐ Chronic Sore Throat

Hematology
- ☐ Easy Bruising
- ☐ Easy Bleeding

Endocrine
- ☐ Hair Loss
- ☐ Weight Gain

Respiratory
- ☐ Coughing
- ☐ Asthma
- ☐ Difficult Breathing

Cardiovascular
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Short of Breath
- ☐ Fainting
- ☐ Swollen Ankles

Females Only
- ☐ Abnormal Mammo
- ☐ Abnormal Pap
- ☐ Pregnant (How Long)_____
- ☐ Breastfeeding

GI
- ☐ Heartburn
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal Pain

Eyes
- ☐ Glasses
- ☐ Eye Pain
- ☐ Double Vision

Skin
- ☐ Rash
- ☐ Itching
- ☐ Lesions

Neurological
- ☐ Strength Loss
- ☐ Numbness
- ☐ Tremors
- ☐ Memory Loss
- ☐ Headaches
- ☐ Frequency_____

Patient Signature_____ Date_____ Dr Initials_____

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1st Chief Complaint: _____

Circle the current pain level of your complaint:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Mild Severe

When did it start?_____ Gradual / Sudden

Circle the percentage of the day you experience the complaint:

☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100

How would you rate the pain at its worst? (1 – 10) _____

2nd Chief Complaint :_____

Circle the current pain level of your complaint:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Mild Severe

When did it start?_____ Gradual / Sudden

Circle the percentage of the day you experience the complaint:

☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100

How would you rate the pain at its worst? (1 – 10) _____

3rd Chief Complaint: _____

Circle the current pain level of your complaint:

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Mild Severe

When did it start?_____ Gradual / Sudden

Circle the percentage of the day you experience the complaint:

☐10 ☐20 ☐30 ☐40 ☐50 ☐60 ☐70 ☐80 ☐90 ☐100

How would you rate the pain at its worst? (1 – 10) _____

Using the letters below, please show <u>where</u> you are experiencing <u>all</u> of your current complaints:

A: Ache

B: Burning

C: Cramping

D: Dull Pain

F: Stiffness

N: Numbness

R: Throbbing

S: Soreness

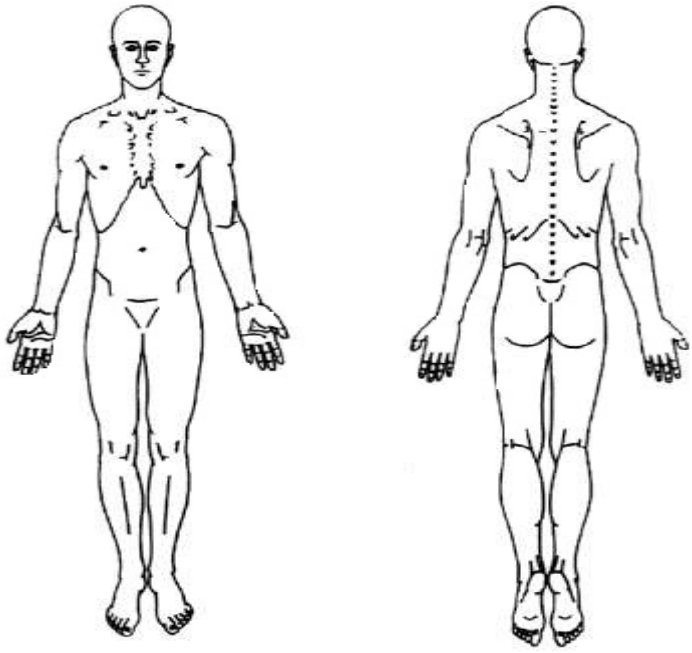
T: Tingling

X: Sharp Pain

SP: Shooting Pain

RP: Radiating Pain

Additional Notes:



Have you ever had tests for your present condition? ☐MRI ☐X-ray ☐CT ☐Other_____

Do you have a pacemaker? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No If Yes, what is frequency_____

Do you currently smoke tobacco of any kind? ☐Yes ☐Former smoker ☐Never been a smoker

If yes, how often do you smoke?_____

When was your last Physical Examination?_____

When did you last have blood work? ☐Within a Year ☐Over a Year ☐Not Sure

Any Surgeries? ☐Yes ☐No f yes, list:_____

_____

Patient Name (please print)_____

Patient Signature_____Date_____ Dr. Initials_____

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1.) **General Consent to Treatments:** I hereby request and consent to the performance of the indicated procedures (or on the patient named below, for whom I am legally responsible) by the Doctors of Chiropractic, Medical Doctors, Nurse Practitioners, Physician Assistant, and/or Doctors of Physical Therapy and assistants who now or in the future work at this office or any other Pain Solutions Medical Group. Including and not limited to any and all necessary ancillary diagnostic services I have agreed to and acknowledge to have done. I have had an opportunity to discuss with the Doctors practicing in this clinic and/or with the other office or clinic personnel the nature and purpose of the procedures indicated for me. I understand that the results are not guaranteed. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic and physical therapy there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, and sprains. I do not expect the Doctor to be able to anticipate and explain all risks and possible complications, and I wish to rely upon the Doctor to exercise judgment during the course of procedure with what the Doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

2.) **Informed Consent for Injection Therapies**: By signing below, I authorize Pain Solutions Medical Group and staff to administer injections that my healthcare provider considers reasonable and necessary. I understand that all injection treatments are commonly, but not always, accompanied by risks, including, but not limited to, bruising, temporary increase in pain, inflammation, and temporary numbness. I also understand that more serious reactions may occur, including, but not limited to, infections, allergic reactions, prolonged numbness, weakness, paralysis, spinal headache from dural puncture, lung puncture or death as a result of or related to injection treatment. I understand that there are various types of injections that are commonplace in the practice of pain management including but not limited to trigger point, intramuscular, intra-articular (joint), tendon, ligament, nerve blocks or other forms of injections.

3.) **Right to refuse treatment**: I acknowledge that I have the opportunity to discuss the nature and purpose, alternative methods of treatments, the risks, potential complications and associated risks associated with any treatment or procedure recommended by a healthcare provider of my choice. I also understand that I retain the right to refuse any particular examinations, diagnostic tests, procedure, treatment, therapy or medication recommended or considered medically necessary by my healthcare provider. I also understand that due to the nature of the practice of medicine, there is no guarantee as to the results of my evaluation and/or treatment. I further acknowledge that I will ask any questions I have regarding my evaluation and treatment to my satisfaction, and I understand I may ask any addition questions I may have at any time.

4.) **Grievance/Concerns**: I understand that if for any reason I have an issue with any of the treatment provided to me or any billing concerns I understand that I have the right to complete a grievance form to discuss my concerns. In addition to Pain Solutions Medical Group, we also belong to Doctors Outpatient Surgical Center. Any concerns will be addressed in a timely manner.

5.) **Physician Ownership Disclosure:** It is required by the Centers for Medicare and Medicaid Services that we notify you of your physician's financial interest in this facility and that there are alternative facilities available to you. Your signature below will confirm that you have been made aware of your physician's ownership interest in Arizona Sports and Spine Center, and that you have been informed of alternative facilities should you choose to use them. You have the right to choose where to receive services, including the entity in which your physician may have a financial relationship.

6.) **Business Hours:** Normal Business hours are Mon., Wed., 9-7pm, Tues., Thurs., 1-7pm. Office Phone number is (480)855-0557. If for any reason you need to reach our office outside of our normal business hours due to a medical emergency please contact 911.
I intend for this consent to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment for at this office, or any other Pain Solutions Medical Group.
By signing below, you are indicating that you have read and understand and agree to the above conditions of this office:

_____ _____
Patient/Legal Guardian Signature Date

_____ _____
Staff Signature Date

Note: This is a confidential record and will be kept in this office. Information contained here and will not be released to anyone without authorization to do so.