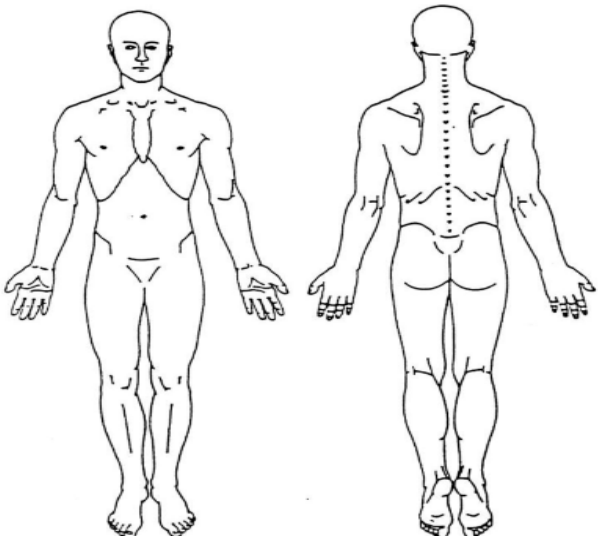
ARIZONA PAIN
WE CHANGE LIVES HERE

Today's Date: _____

Your Name: _____ Birth Date: _____

Reason for Today's Visit: ❑ Medication Refill ❑ Medication Change ❑ Post-Procedure Assessment
❑ Review MRI/EMG or Test Results ❑ New Pain or Injury: _____

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



What is your current pain level **right now**? (0-10)_____

What is your **worst** pain level? (0-10) _____

Where is your worst area of pain located?

_____

List any additional areas of pain: _____

_____

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

Check all that describe your pain today:

❑ Aching	❑ Hot/Burning	❑ Spasms	❑ Throbbing
❑ Cold	❑ Numb	❑ Squeezing	❑ Tingling/Pins and Needles
❑ Cramping	❑ Shock-like	❑ Stabbing/Sharp	❑ Tiring/Exhausting
❑ Dull	❑ Shooting		

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: _____

Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down? ❑ No ❑ Yes If yes, is your pain also alleviated with bending forward (using a shopping cart, leaning on the kitchen counter, etc.? ❑ No ❑ Yes

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

Any new conventional therapy? ❑ No ❑ Yes Type: ❑ Chiropractic ❑ Home Exercise ❑ Physical Therapy

Relief from conventional therapy? ❑ No ❑ Moderate ❑ Excellent # of Sessions: _____ Date(s): _____

Any new allergies? ❑ No ❑ Yes Please List: _____

Any new medication side effects? ❑ No ❑ Yes Please List: _____

Any new medications? ❑ No ❑ Yes Please List: _____

Are you currently pregnant? ❑ No ❑ Yes ❑ Post menopause Do you plan to become pregnant? ❑ No ❑ Yes

Have had two or more falls in the last year? ❑ No ❑ Yes

Have you received a pneumonia vaccination? ❑ No ❑ Yes Date (approx): _____

Have you been diagnosed with hypertension? ❑ No ❑ Yes Date (approx): _____

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

Review of Systems – Mark all of the following symptoms that you CURRENTLY suffer from:

Constitutional: ❑ Chills ❑ Difficulty Sleeping ❑ Fatigue ❑ Fevers ❑ Night Sweats **Cardiovascular/Respiratory**: ❑ Chest Pain ❑ Cough ❑ Difficulty Breathing ❑ Fainting ❑ High Blood Pressure ❑ Swelling in the Feet **Gastrointestinal**: ❑ Constipation ❑ Dark and Tarry Stools ❑ Diarrhea ❑ Nausea/Vomiting	**Genitourinary/Nephrology**: ❑ Blood in Urine ❑ Involuntary Urination ❑ Loss of Bowel Control ❑ Painful Urination ❑ Pelvic Pressure **Ears/Nose/Throat/Neck**: ❑ Difficulty Hearing ❑ Earaches ❑ Hay fever/Allergies ❑ Nosebleeds ❑ Recurrent Sore Throats ❑ Ringing in the Ears ❑ Sinus Problems **Eyes**: ❑ Recent Visual Changes	**Neurological**: ❑ Dizziness ❑ Headaches ❑ Instability When Walking ❑ Numbness/Tingling ❑ Weakness **Psychiatric**: ❑ Anxiety/Stress ❑ Depressed Mood ❑ Suicidal Thoughts ❑ Suicidal Planning **Musculoskeletal**: ❑ Back Pain ❑ Joint Pain ❑ Neck Pain

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 Arizona Pain 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.

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Arizona Pain 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.

DISCLAIMER: By typing your name below, you are signing this consent electronically. You agree that your electronic signature is the legal equivalent of your physical signature on this document.

_____ _____

Signature (Patient or if minor Signature of parent or guardian) Date