

**Arizona Pain Specialists  
Patient Intake Sheet**

**Patient information**

Name: \_\_\_\_\_ Home Phone: (    ) \_\_\_\_\_

Street: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

City: \_\_\_\_\_ Emergency Phone: (    ) \_\_\_\_\_

State: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Zip: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Soc. Sec. No. \_\_\_\_\_ Employer: \_\_\_\_\_

Email: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Who referred you?: \_\_\_\_\_ Your Occupation: \_\_\_\_\_

How did you hear about us?  Internet  TV  Radio  Insurance Co.  Family  Friend  PCP

Who is your primary care physician?: \_\_\_\_\_ Who is your Surgeon?: \_\_\_\_\_

Where is your worst area of pain?	Does your Pain Radiate?	Please List your other areas of pain?
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**Details of your pain:**

How did your current episode begin?: Suddenly \_\_\_\_\_ Gradually \_\_\_\_\_

When did your current pain episode begin? \_\_\_\_\_

What caused your current pain episode? \_\_\_\_\_

Has the pain lessened, worsened or stayed the same? \_\_\_\_\_

Is this a work-related injury? \_\_\_\_\_ If yes, date of injury: \_\_\_\_\_

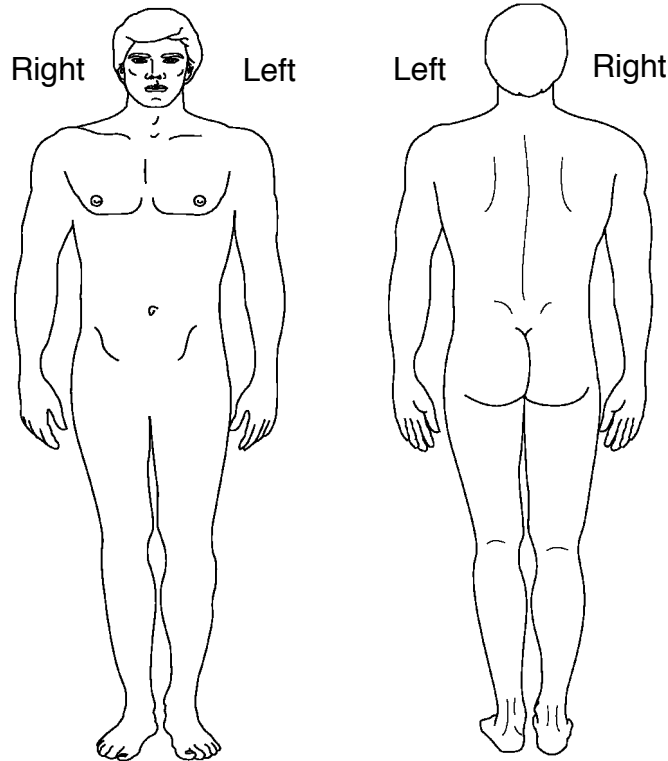
Is this a motor vehicle injury? \_\_\_\_\_ If yes, date of injury: \_\_\_\_\_ (Put details on page 7)

Patient Name/DOB:

## Location of pain

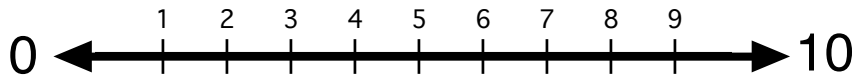
Use this diagram to indicate the location and type of pain. Mark the drawing with the following letters that best indicate your symptoms.

- “N” = numbness.
- “S” = stabbing pain.
- “B” = burning pain.
- “P” = pins and needles.
- “A” = aching pain.



## What is your pain level today?

Mark on the line where your pain is today



- \_\_\_\_\_ Which number (0-10) describes your pain right now?
- \_\_\_\_\_ Which number (0-10) is your worst pain?
- \_\_\_\_\_ Which number (0-10) is your least pain?
- \_\_\_\_\_ Which number (0-10) describes your average pain over the past week

### **Please use the following scale to give us an estimate of your pain:**

- 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, but still distracting
- 5:** Can't be ignored for more than 30 minutes
- 6:** Can't 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, you can still function with effort
- 8:** Physical activity severely limited, you can read and converse with effort, nausea and dizziness set in as factors of pain
- 9:** Unable to speak, crying out or moaning uncontrollably, near delirium
- 10:** Unconscious, pain makes you pass out

Patient Name/DOB:

**What does the pain feel like?**

Check all the following that apply to the quality of your pain.

- Throbbing
- Cramping
- Shooting
- Hot-Burning
- Stabbing
- Aching
- Sharp
- Tiring-Exhausting

**How does your pain change over time?**

Check the word or words which best describe the pattern of your pain.

- Continuous
- Intermittent
- Other details: \_\_\_\_\_

**Mark the effect of each of the following on your pain:**

	Increases my pain	Decreases my pain	No change in my pain
Sitting	_____	_____	_____
Standing	_____	_____	_____
Rising from sitting	_____	_____	_____
Bending forward	_____	_____	_____
Bending backward	_____	_____	_____
Walking	_____	_____	_____
Climbing stairs	_____	_____	_____
Lying on your back	_____	_____	_____
Lying on your stomach	_____	_____	_____
Driving	_____	_____	_____
Coughing/sneezing	_____	_____	_____
Lifting objects	_____	_____	_____
Other factors	_____	_____	_____

**Are there other details of your pain or medical conditions we should know about?**

Do you have:

- Weakness if yes, where \_\_\_\_\_
- Bladder Incontinence
- Bowel Incontinence
- Fever/Chills
- Nausea/Vomitting
- Other

Patient Name/DOB:

\_\_\_\_\_

**Please mark all of the following treatments you have used for pain relief:**

	Helped pain	Worsened pain	No change
Massage therapy	_____	_____	_____
Hot or cold packs	_____	_____	_____
Biofeedback	_____	_____	_____
Physical therapy	_____	_____	_____
Chiropractic	_____	_____	_____
Acupuncture	_____	_____	_____
Traction	_____	_____	_____
Brace support	_____	_____	_____
TENS unit	_____	_____	_____
Injection therapy	_____	_____	_____
Medications	_____	_____	_____

**Treatment for your pain:**

Please mark all of the following physicians or specialists you have consulted

**ONLY FOR PAIN RELIEF FOR THE CURRENT PROBLEM, NOT FOR OTHER PROBLEMS.**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acupuncturist    | <input type="checkbox"/> General Physician  | <input type="checkbox"/> Pain Clinic               |
| <input type="checkbox"/> Anesthesiologist | <input type="checkbox"/> Hypnotist          | <input type="checkbox"/> Physical Therapist        |
| <input type="checkbox"/> Chiropractor     | <input type="checkbox"/> Internist          | <input type="checkbox"/> Plastic Surgeon           |
| <input type="checkbox"/> Dentist          | <input type="checkbox"/> Neurologist        | <input type="checkbox"/> Podiatrist                |
| <input type="checkbox"/> ENT Physician    | <input type="checkbox"/> Neurosurgeon       | <input type="checkbox"/> Psychiatrist/Psychologist |
| <input type="checkbox"/> Endocrinologist  | <input type="checkbox"/> Ophthalmologist    | <input type="checkbox"/> Rheumatologist            |
| <input type="checkbox"/> Faith Healer     | <input type="checkbox"/> Orthopedic Surgeon | <input type="checkbox"/> Other: _____              |

**Medications: (Dosages/ Frequency Per Day) | Allergies:**

Patient Name/DOB:

**Review of medical history (please mark all appropriate boxes):**

**General**

- |   |                                   |  |
|---|-----------------------------------|--|
| <input type="checkbox"/> Insomnia                 | <input type="checkbox"/> Fatigue  | <input type="checkbox"/> Low sex drive |
| <input type="checkbox"/> Fevers                   | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Alcohol (Quantify _____) | <input type="checkbox"/> Weakness | <input type="checkbox"/> Diabetes      |
|   | <input type="checkbox"/> Tremors  | <input type="checkbox"/> Other: _____  |

**Head, Eyes, Ears, Nose and Throat**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Eye problems     | <input type="checkbox"/> Earaches               | <input type="checkbox"/> Dental problems  |
| <input type="checkbox"/> Ringing in ears  | <input type="checkbox"/> Sinus problems         | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Nose bleeds            | <input type="checkbox"/> Head injury      |
| <input type="checkbox"/> Headaches        | <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Other: _____     |

**Cardiovascular**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Chest pain       | <input type="checkbox"/> Irregular heartbeats | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Swelling in feet     | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Heart attack     | <input type="checkbox"/> MVP                  | <input type="checkbox"/> Valve replacement   |
| <input type="checkbox"/> Murmur           | <input type="checkbox"/> Phlebitis            | <input type="checkbox"/> High cholesterol    |
| <input type="checkbox"/> Stroke           | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Other: _____        |

**Respiratory**

- |  |  |                                       |
|--|--|---------------------------------------|
| <input type="checkbox"/> Wheezing                  | <input type="checkbox"/> Short of breath | <input type="checkbox"/> Pneumonia    |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Valley Fever    | <input type="checkbox"/> Cough        |
| <input type="checkbox"/> Smoking (packs/day _____) | <input type="checkbox"/> Emphysema       | <input type="checkbox"/> Tuberculosis |
|  | <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Other: _____ |

**Gastrointestinal**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Abd. cramps                  | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Acid reflux     | <input type="checkbox"/> GI bleeding from medications | <input type="checkbox"/> Other: _____ |

**Musculoskeletal**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Neck pain      | <input type="checkbox"/> Back pain            | <input type="checkbox"/> Tennis elbow           |
| <input type="checkbox"/> Joint pain     | <input type="checkbox"/> Muscle spasms        | <input type="checkbox"/> Carpal tunnel syndrome |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Bursitis               |
|   | <input type="checkbox"/> Joint injury         | <input type="checkbox"/> Other: _____           |

**Renal**

- |                                   |   |  |
|-----------------------------------|---|--|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Kidney infections  | <input type="checkbox"/> Kidney problems |
|                                   | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Other: _____    |

**Hepatic**

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Hepatitis (Active? _____) | <input type="checkbox"/> Other: _____ |
|--|---------------------------------------|

**Neuropsychological**

- |   |   |
|---|---|
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Anxiety            |
| <input type="checkbox"/> Stress problems  | <input type="checkbox"/> Drug/alcohol abuse |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Other: _____       |

Patient Name/DOB:

## Osteoporosis screening

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Cushing syndrome                  | <input type="checkbox"/> Post-menopausal *              | <input type="checkbox"/> Fractures after minor mishaps        |
| <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Cigarette smoking              | <input type="checkbox"/> Long term use of steroids *          |
| <input type="checkbox"/> Low calcium diet                  | <input type="checkbox"/> Lack of exercise               | <input type="checkbox"/> Use of thyroid medications           |
| <input type="checkbox"/> Heavy alcohol use                 | <input type="checkbox"/> Family history of osteoporosis | <input type="checkbox"/> Known osteoporosis                   |
| <input type="checkbox"/> Hyperparathyroidism *             | <input type="checkbox"/> Thin or small frame            | <input type="checkbox"/> Vertebral abnormalities *            |
| <input type="checkbox"/> Caucasian or Asian                | <input type="checkbox"/> Never had DEXA scan            | <input type="checkbox"/> Hysterectomy/oophorectomy            |
| <input type="checkbox"/> Ulcerative colitis                | <input type="checkbox"/> Hormone replacement therapy    | <input type="checkbox"/> Prostate cancer with hormone therapy |
| <input type="checkbox"/> Over 2 years since last DEXA scan | <input type="checkbox"/> Previous abnormal DEXA scan    |   |

Date of last DEXA scan: \_\_\_\_\_

## Past surgical history (please list all surgeries and dates):

## Have you had a recent MRI/ CT of a Painful area? Date?

## Social history:

Married/living with significant other \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_

Do you have children? \_\_\_\_\_ If yes, what are their ages? \_\_\_\_\_

Do any children live at home? \_\_\_\_\_

Alcohol use? \_\_\_\_\_ How much? \_\_\_\_\_

Tobacco use? \_\_\_\_\_ How much? \_\_\_\_\_

Illegal drug use? \_\_\_\_\_ How much and when? \_\_\_\_\_

Patient Name/DOB:

Have you ever abused narcotics or prescription medications? \_\_\_\_\_

**Family history: Please indicate which family members have the following medical problems**

Disease:	Which family member(s)?
Headaches	_____
Heart disease	_____
Stroke	_____
Diabetes	_____
High blood pressure	_____
Increased cholesterol	_____
Arthritis	_____
Rheumatoid arthritis	_____
Kidney problems	_____
Liver problems	_____
Seizures	_____
Osteoporosis	_____
Cancer	_____
Other medical problems:	_____

**Accident information:**

If your injury/pain is the result of an accident or some other incident, please provide the following details:  
- Date of injury, location of injury and treatment at time of injury  
- Describe how the injury occurred

Patient Name/DOB:

**Please tell us whether you are on or you are planning to apply for these programs?:**

	<b>I am on this program</b>	<b>I am applying for this program</b>	<b>I am planning to apply for this program</b>
Social Security	_____	_____	_____
State Disability	_____	_____	_____
Private Disability	_____	_____	_____
Worker's Compensation	_____	_____	_____

**Have you hired an attorney for your accident or pain condition?**

- No, I have not hired a lawyer \_\_\_\_\_
- No, but I plan to hire an attorney \_\_\_\_\_
- Yes, I have and the case is in litigation \_\_\_\_\_
- Yes, I have and the case is settled \_\_\_\_\_

**If there is potential or ongoing litigation, please provide the following information:**

Your attorney's name and address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Your attorney's telephone number: \_\_\_\_\_  
Name of defendant: \_\_\_\_\_  
Defendant's address: \_\_\_\_\_  
Defendant's attorney: \_\_\_\_\_  
Court case number: \_\_\_\_\_

**Sources of health care coverage for this patient include the following:**

- Private insurance \_\_\_\_\_
- Medicare \_\_\_\_\_
- State medicaid \_\_\_\_\_
- HMO plan \_\_\_\_\_
- PPO plan \_\_\_\_\_
- POS plan \_\_\_\_\_
- Worker's Compensation \_\_\_\_\_
- Self-pay \_\_\_\_\_
- Automobile insurance \_\_\_\_\_
- Other \_\_\_\_\_

Patient Name/DOB: