AZ Pain Medicine Clinic, LLC

Patient Initial Assessment

Complete this form before your first appointment at AZ Pain Medicine Clinic, LLC. Your careful answers will help us to understand your pain problem and design the best treatment program for you.

You may feel concerned about what happens to the information you provide, as much of it is personal. Our records are strictly confidential. No outsider is permitted to see your case record without your written permission unless we are required to do so by law.

Name _____ Date _____

Age: _____ Height: _____ Weight: _____

Would you like a clinical summary of today's visit? ☐ No ☐ Yes

CHARACTERISTICS OF PAIN (Chief Complaint).

What is the main problem for which you are seeking treatment at Pain Consultants of Arizona?

_____

_____

HISTORY OF PRESENT ILLNESS

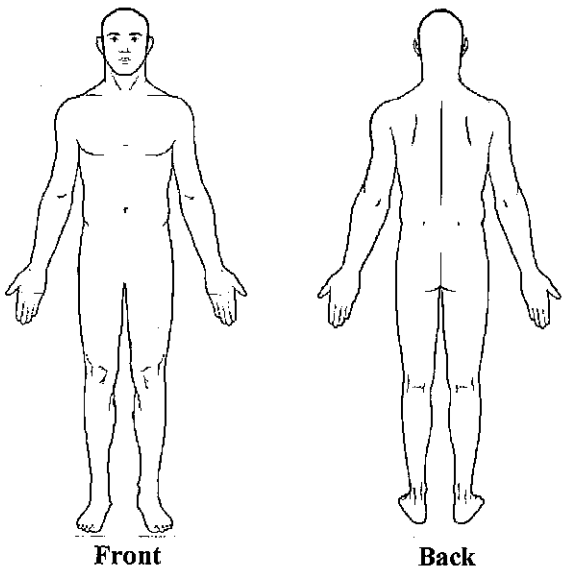
Pain Location

Please describe the location(s) of your pain:

_____

_____

Please mark the location(s) of your pain on the diagrams above with an "X." If whole areas are painful, please shade in the painful area.



Front **Back**

Onset of Pain (Cause)

How did your current pain start?

☐ Injury at work
☐ Injury, not at work
☐ Treatment caused (e.g., radiation, surgery, etc.)
☐ Motor vehicle accident
☐ Illness Undetermined

Progression of Pain

☐ Acute (quick/severe)
☐ Sudden (unexpected)
☐ Gradual (slow)
☐ Variable (intermittent)

Pain Rating

VAS – Visual Analog Scale

	0	1	2	3	4	5	6	7	8	9	10
Current Pain Level	☺										☹
Minimum Pain Level	☺										☹
Maximum Pain Level	☺										☹

Pain Duration

How long have you had your current pain problem(s)?

_____weeks _____months _____ years

Frequency / Timing of Pain

How often do you have your pain? (please check one)

☐ Constantly (100% of the time)
☐ Nearly constantly (60% to 95% of the time)
☐ Intermittently (30% to 60% of the time)
☐ Occasionally (less than 30% of the time)

In general, during the past month, when has your pain been the worst? (please check one)

☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ No typical pattern

Activities and Your Pain

Place a check mark next to the activities that you have avoided or limited during the past month because of pain:

☐ Going to work
☐ Performing household chores
☐ Doing yard work or shopping
☐ Socializing with friends
☐ Participating in recreation
☐ Having sexual relations
☐ Exercise
☐ Sitting
☐ Standing
☐ Walking

Associated Symptoms

☐ "pins and needles" ☐ Numbness ☐ Tingling ☐ Weakness

Pain Quality

How would you describe the pain?

☐ Burning ☐ Cutting ☐ Other ☐ Sharp ☐ Throbbing
☐ Cramping ☐ Dull, Aching ☐ Pressure ☐ Shooting

Relieving and Aggravating Factors

How do the following affect your pain? (please check one for each item)

	Decrease	No Change	Increase
Lying down	☐	☐	☐
Standing	☐	☐	☐
Sitting	☐	☐	☐
Walking	☐	☐	☐
Exercise	☐	☐	☐
Medications	☐	☐	☐
Relaxation	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Urination	☐	☐	☐
Bowel movements	☐	☐	☐

Attempted Treatments

Please check all of the treatments you have tried for your pain and then complete the appropriate column at the right.

Treatment	Date (approx)	No Relief	Moderate Relief	Excellent Relief
☐ Bed rest		☐	☐	☐
☐ Traction		☐	☐	☐
☐ Surgery		☐	☐	☐
☐ Hypnosis		☐	☐	☐
☐ Acupuncture		☐	☐	☐
☐ Nerve block or other injections		☐	☐	☐
☐ TENS		☐	☐	☐
☐ Physical therapy		☐	☐	☐
☐ Exercise		☐	☐	☐
☐ Heat		☐	☐	☐
☐ Ice		☐	☐	☐
☐ Biofeedback		☐	☐	☐
☐ Psychotherapy		☐	☐	☐
☐ Chiropractic		☐	☐	☐
☐ Other		☐	☐	☐

Effect on Sleep

☐ No effect ☐ Pain makes it difficult to fall asleep ☐ Pain makes it difficult to stay asleep

Effect on Bowel and Bladder Control
☐ No effect
☐ Loss of bladder control
☐ Loss of bowel control

Assisting Device

Devices used to assist ambulation

☐Cane ☐Walker ☐Wheelchair ☐None

PAST MEDICAL HISTORY
Medical

Have you had any of the following health problems? (please check all that apply)

☐ Angina or chest pain	☐ Chronic cough	☐ Kidney disease	☐ Seizure or epilepsy
☐ Arthritis	☐ Diabetes or high blood sugar	☐ Liver disease	☐ Thyroid Disease
☐ Asthma or wheezing	☐ Heart attack	☐ Peptic Ulcer	☐ TIA or stroke
☐ Bleeding problem	☐ High blood pressure	☐ Reflux (GERD)	

☐ Cancer: please specify what type _____
☐ Other: please specify _____

Surgeries

Date (approximate)	Hospital	Type of Operation

ALLERGIES
Please indicate the names of any medications to which you are allergic.

_____

_____

☐Yes, I am allergic to dye put into my body ("X-ray dye")

MEDICATIONS
Please list any medication that you are currently taking: (list ALL medications)

_____

_____

Please list any pain medication that you have tried in the past:

_____

_____

REVIEW OF SYSTEMS
Please check all items you feel are applicable to you.
General:
☐ Chills?
☐ Fatigue?

☐ Fever? ☐ Daily ☐ Every few days ☐ High ☐ Low ☐ Recurrent ☐ Weekly

☐ Night sweats?
☐ Tiredness?
☐ Weight change? ☐ Gain? ☐ Loss?

Skin:
☐ Do you have itching?
☐ Do you have rashes?

HEENT:
☐Change in Vision? _____
☐ Ringing in the ears?
☐ Vertigo?
☐ Seasonal allergies?

Respiratory:
☐ Difficulty Breathing?

Cardiovascular:
☐ Chest pain?
☐ Palpitations (awareness of fast heart)?

GI:
☐ Abdominal pain?
☐ Constipation?
☐ Diarrhea?

Musculoskeletal:
☐ Pain in joints?
☐ Stiffness in joints?
☐ Swelling in joints?

Neurological:
☐ Dizziness
☐ Fainting spells?
☐ Headaches?
☐ Stool incontinence?
☐ Urine incontinence?
☐ Numbness
☐ Trouble walking?
☐ Unsteadiness?
☐ Weakness?

Psychiatric:
☐ Anxiety?
☐ Depression?
☐ Insomnia?
☐ Memory loss?
☐ Suicidal ideation?

Hematology:
☐ Abnormal bleeding?
☐ Blood clots?
☐ Bruise easily?

<u>Psychological Treatment</u>
Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? ☐ Yes ☐ No

If yes, when? _____
Have you ever considered suicide? ☐ Yes ☐ No

GENERAL FAMILY ILLNESS

Please check any health problems that are known to run in your family:

☐ Angina or chest pain	☐ Chronic cough	☐ Kidney disease	☐ Seizure or epilepsy
☐ Arthritis	☐ Diabetes or high blood sugar	☐ Liver disease	☐ Thyroid Disease
☐ Asthma	☐ Heart attack	☐ Peptic Ulcer	☐ TIA or stroke
☐ Bleeding problem	☐ High blood pressure	☐ Reflux (GERD)	

☐ Cancer: please specify what type_____
☐ Other: please specify_____

SOCIAL HISTORY

Marital Status
☐ Divorced
☐ Engaged
☐ Married living w/ spouse
☐ Remarried
☐ Separated
☐ Single
☐ Spouse Deceased
☐ Significant other deceased

Living Arrangements
☐ Living alone
☐ Living with friends
☐ Living with children
☐ Living with spouse/partner
☐ Living with spouse/partner and children
☐ Living with other

Employment

Your current or former occupation:

_____

Current employment status (please check all that apply):
☐ Employed full-time
☐ Employed part-time
☐ Student
☐ Unemployed or working part time, because of pain
☐ Unemployed
☐ Retired
☐ Homemaker

If you are currently unemployed, indicate how long you have been off work:
☐ 1 - 3 weeks
☐ 1 - 3 months
☐ 4 - 7 months
☐ 8 - 11 months
☐ 12 - 18 months
☐ 19 - 24 months
☐ 25 or more months

Please indicate any of the following claims you have filed related to your pain problem:
☐ Workers' compensation
☐ Personal injury/liability (unrelated to work)
☐Social Security Disability Insurance (SSDI)
☐Other insurance
☐None

Substance Abuse

Do you have a history of:

☐ Tobacco use?	☐ Yes-currently	☐ Yes-in the past	☐ Never
☐ Alcoholism?	☐ Yes-currently	☐ Yes-in the past	☐ Never
☐ Illicit (illegal) drug abuse?	☐ Yes-currently	☐ Yes-in the past	☐ Never

Have you ever been in a detoxification program for drug abuse? ☐ Yes ☐ No

AZ Pain Medicine Clinic, LLC

Authorization to Release Information

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing the form will only give consent to release this information to the persons listed below.

You have the right to revoke this consent in writing.

I hereby authorize AZ Pain Medicine Clinic, LLC to communicate with the following individuals regarding all aspects of my medical care and financial obligations. (Please write First and Last name of any individual that you want us to be able to discuss your care, cancel/reschedule appointments, and discuss financial obligations.)

1. Name_____ Relationship_____ Phone_____

2. Name_____ Relationship_____ Phone_____

3. Name_____ Relationship_____ Phone_____

Patient Signature _____ **Date** _____

Patient Name (Please Print) _____

Authorization to Leave Messages with Household Members/Answering Machine

Occasionally it is necessary for the staff of AZ Pain Medicine Clinic, LLC to leave messages for patient. The purpose of these messages is to remind patients that they have an appointment, to notify the patient that the medical staff would like to discuss or schedule test results, or to ask a patient to call regarding an issue or concern. At no time will a representative of AZ Pain Medicine Clinic, LLC discuss your medical condition without your consent. The purpose of this consent is to leave messages with members of your household or on your answering machine.

You have the right to revoke this consent in writing:

Patient Signature _____ **Date** _____

Patient Name (Please Print) _____

AZ Pain Medicine Clinic, LLC

Referred by: _____

How did you find out about our practice? _____

New Patient Information

All Information **MUST** be Completed

Last Name _____ First _____ MI _____

Social Security # _____ Date of Birth _____ Gender: ☐Male ☐Female

Address _____ Apt. No, _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell _____ Work _____

Email _____ Marital Status: ☐ Single ☐Married ☐Divorced ☐Widowed

Race ☐African American ☐American Indian or Alaska Native ☐White ☐Asian
☐Native Hawaiian or Other Pacific Islander

Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino Preferred Language _____

Primary Care Physician _____ Telephone _____

Address _____ City _____ State _____ Zip Code _____

EMERGENCY CONTACT

Name _____ Relationship _____ Telephone _____

APPOINTMENTS

We request our patients to come to their appointment **15 MINUTES** before their scheduled time in order to fill out the necessary paperwork. If you are late, at our discretion, we may need to reschedule your appointment for a later time and date.

Permission for Treatment

I hereby authorize AZ Pain Medicine Clinic, LLC to examine me and render treatment to me as deemed necessary.

Authorization to Release Patient Information

I authorize the staff at AZ Pain Medicine Clinic, LLC and its member physician to release and furnish on a confidential and strict need-to-know basis all medical and financial data related to me care that may be necessary now or in the future to facilitate treatment and payment by third parties, collection of data for the purpose of utilization review, quality assurance, or medical outcome evaluation purposes. Such information may be released to insurance companies, HMOs, PPOs, Managed Care organizations, IPAs, or third party payers or any organizations contracting with any of the entities to perform such functions. I also give my authorization to have a copy of my medical records delivered to a primary or specialist physician that is directly or indirectly responsible for my medical care or the payment thereof.

Receipt of Notice of Privacy Practices

I acknowledge that I have been provided an opportunity to review the Notice of Privacy Practices of AZ Pain Medicine Clinic, LLC, which describes the Practices' policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the Practices and agree to such notice. I also understand I have the right to request a restriction on the use and disclosure of my Protected Health Information.

AZ Pain Medicine Clinic, LLC

Treatment Policy

1. To insure the medical necessity and safety of any controlled substances that the physician may consider prescribing as part of the patient's treatment plan, drug testing shall be conducted and the results reviewed prior to the initial issuance or dispensing of a controlled substance prescription, and thereafter, on a random basis at least twice a year and when requested by the treating physician. Lab costs are the responsibility of the patient.
2. Refills given every **30 days** with physician's re-evaluation only.
3. Agreement that controlled substances for the treatment of chronic non-malignant pain shall be prescribed by a single treating physician unless authorized by the treating physician and documented in the medical records.
4. I understand that if I am found to be in violation of this agreement, I may be subject to dismissal from the treatment and/or a requirement that I consult with a pain management or addiction medicine specialist depending on the circumstance of the violation.

Patient Signature: _____ **Date:** _____

Patient Bill of Rights

- To be treated with respect, consideration, and dignity
- To expect quality care and service from this facility
- To know, in advance, the estimated fee for services
- To full consideration of privacy concerning my medical care
- To information concerning my diagnosis, treatment, prognosis, to the degree known, in terms I can understand. If concern for my health makes it inadvisable to provide such information, such information will be made available to an individual designated by me or to a legally authorized individual
- To receive from my physician sufficient information to be able to understand the procedure or treatment being provided in order to sign the operative consent
- To confidential treatment of my medical records and to know that I will be given the opportunity to approve or refuse their release to outside parties, except when otherwise required by law
- To refuse treatment and to be informed of the consequences of this action
- To be given the opportunity to participate in decisions involving my healthcare, except when such participation is contraindicated
- To be informed of any persons other than routine personnel that would be observing or participating in the treatment
- To be informed of continuing healthcare I will receive the following discharge
- To receive prompt pain assessment, treatment, and information concerning pain prevention and relief measures

I have read and acknowledge my rights and responsibilities as a patient by signing this document.

Patient Signature: _____ **Date:** _____

Patient Name (Please Print): _____