North Phoenix Pain Relief Center
3202 E. Greenway Rd., STE. 1619, Phoenix, AZ 85032
602.482.2282 main 602.482.2909 fax

Initial Visit Medical Intake Form

Date: _____ Name: _____ Date of Birth: _____
Address: _____City: _____ State: ____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____
Emergency Contact AND Number: _____
Referring MD: _____ Primary Care MD: _____
Other Physicians currently involved in care: _____
Gender: M _____ F _____ Weight: _____ lbs Height: _____ feet ___ inches

CURRENT MEDICATIONS *FOR PAIN*:

Name:	Dose:	Frequency:

My pain medications provide relief:
___none of the time ___some of the time ___most of the time ___ALL of the time

CURRENT MEDICATIONS *NOT FOR PAIN*:

Name:	Dose:	Frequency:

Drug ALLERGIES (Please write name of medicine and allergic reactions):

_____

_____

I am allergic to contrast dye used for x-rays: _____yes _____no
Do you take Aspirin, Plavix, or Coumadin? _____yes _____no

PAST MEDICAL HISTORY (check all that apply):

Hypertension	Chest Pain or Angina	Seizures or Epilepsy
Heart Attack	Diabetes	Lyme's Disease
Emphysema	Kidney Disease	Hepatitis
Stroke	Bleeding Problem	Cancer (specify type)
Depression	Anxiety	Thyroid Disease
Fibromyalgia	Arthritis	HIV/AIDS
Bipolar	_____Other	_____Other

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PAST SURGICAL HISTORY

Approximate Date:	Type of Operation:

SOCIAL HISTORY

1. **Sleep:** Recent Changes in sleep patterns: ___YES ___NO
2. **Hand Dominance:** _____Right _____ Left _____Ambidextrous
3. **Have you ever been a smoker?** _____Yes/current _____Yes/past _____No/never
4. **Do you DRINK often?** _____Yes/current _____Yes/past _____No/never
5. **Employment:** Your current or most recent occupation_____
   _____ Employed time _____Part time _____Not working
   If you are unemployed, how long have you been off work? _____
   If you are unemployed, is it due to your present condition? ____yes ____no
6. **Legal Issues:** Indicate any of the following legal issues relate to your pain problem.
   ___ Worker's Comp. ___ Personal Inj/Liability ___ Social Security Disability Insurance (SSDI)

PSYCHOLOGICAL TREATMENT

Have you ever had a psychiatric evaluation or treatments for any problems? ____Yes ____No
What diagnoses were you treated for and when? _____
Please List your current or last therapists: _____
Have you ever considered Suicide? ____Yes ____No When? _____
Have you ever attempted Suicide? ____Yes ____No When? _____

SUBSTANCE ABUSE:

Do you have a history of alcoholism? ____Yes ____No ____Current Problem
Have you even abused PAIN MEDICATION? ____Yes ____No ____Current Problem
Cocaine or Intravenous substance abuse? ____Yes ____No ____Current Problem
How many years has it been since you abused alcohol or drugs? _____ Years

PAIN DESCRIPTION:

1. **What is the main problem in which you are seeking treatment?**

_____

How long have you had this problem? ____years ____months _____weeks
Please describe your pain (burning, throbbing…etc) _____

2. **ONEST (how did your pain start?)**

___Suddenly ___Gradually
___Lifting ___ Fall ___Bending ___Pulling
___Auto Accident___At work ___No apparent cause

3. **Severity of Pain** ___Mild ___Moderate ___Moderate-Severe ___Severe
4. **Timing of Pain** _____ Constant _____Nearly Constant _____ Intermittently

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HOW ARE THE FOLLOWING ACTIVITIES AFFECTED BY YOUR PAIN (check on for each)?

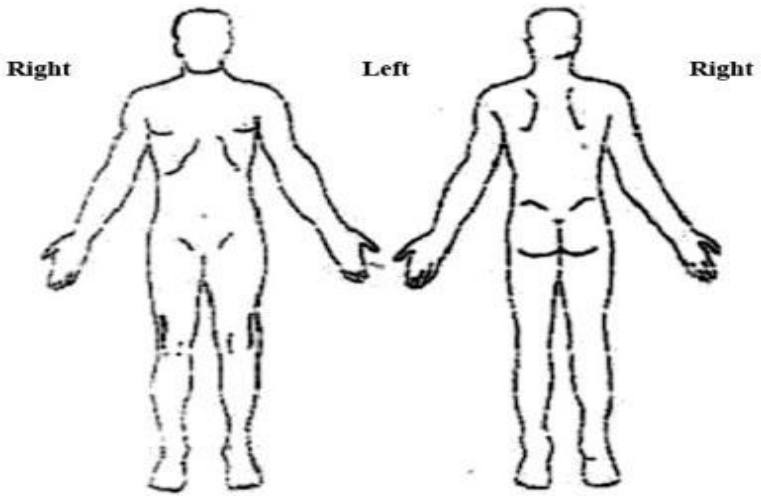
	DECREASE	NO CHANGE	INCREASE
Lying down			
Standing			
Sitting			
Walking			
Exercising			
Relaxation			
Coughing/Sneezing			
Push/Pull			
Bending			

Is your sleep disturbed by your pain? ____Yes ____No

PAIN TREATMENTS (check what treatments you have tried)

Treatment	*Never tried*	*No Relief*	*Moderate Relief*	*Excellent Relief*
Surgery				
Traction				
Injection				
Physical Therapy				
Acupuncture				
Chiropractic				

PAIN LOCATION (please mark the location(s) of your pain on the diagram)**:**



FRONT BACK

I have weakness in my: ____Upper extremities ____Lower Extremities

I drop objects: ____ Yes **I Fall often:** ____Yes

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ACTIVITIES and YOUR PAIN:

1. **How many blocks can you walk? _____**
2. **Is sitting tolerance limited? ____**No ____Yes **Is standing limited? ____**No ____Yes
3. **To assist with walking I use a ….**…____Cane ____Walker ___Wheelchair ___No assistance
4. **Have you had a recent change in bowel or bladder habits? ____**No ____Yes
5. **Are you activities of daily living limited by your pain? ____**No ____ Yes
6. **Have you seen a pain doctor prior? _____ If so, name? _____**
7. **Have you ever had nerve testing (EMG/NCV)? ____**Yes ____No ____Not sure

Have you ever had any of the following tests for YOU CURRENT CONDITION?

X-rays ___YES ___NO CT ___YES ___NO EMG ___YES ___NO
Discogram___YES ___NO MRI___YES ___NO DEXA (bone density test)___YES ___NO

PLEASE LIST ANY PRIOR OPIOD PAIN MEDICATIONS AND RESPONSES

Medication	Have you taken this prior?	If yes, did it help?	Were there side effects?
Hydrocodone (vicodin)	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Fentora	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Dilaudid	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Magnacet	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Oxycodone (Percocet)	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Darvocet	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Codeine	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Methadone	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Fentanyl (Duragesic)	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Morphine/MSContin	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Opana/Opana ER	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Oxycontin	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Cymbaita	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Lyrica	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Soma	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Skelaxin	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Amrix	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____
Flexeril	Yes_____ No_____	Yes___ No___ Not Sure__	Yes_____ No_____

REVIEW OF SYSTEMS:

PLEASE CHECK ALL ITEMS THAT YOU FEEL ARE APPLICABLE TO YOU

1. **General/Constitutional**
   ___Recent/Significant Gain of Weight ___Fever
   ___Recent/Significant Loss of Weight ___Fatigue
2. **Head/Eyes/Ears/Nose/Throat**
   ___Difficulty Swallowing ___Decreased Hearing
   ___Facial Pain ___Vertigo
3. **Respiratory**
   ___Shortness of breath (dyspnea) ___Wheezing
4. **Cardiovascular**
   ___Edema (swelling of feet) ___Irregular Heart Beat

5. **Gastrointestinal**
   - ___Nausea
   - ___Vomiting
   - ___Diarrhea
   - ___Constipation
6. **Metabolic/Endocrine**
   - ___Jaundice
   - ___Insulin Reactions
7. **Neuro/Psychiatric**
   - ___Memory Loss
   - ___Dizziness
   - ___Seizures
   - ___Incoordination
   - ___Anxiety
   - ___Depression
8. **Dermatological**
   - ___Pruritus
   - ___Rash
9. **Musculoskeletal**
   - ___Back Pain
   - ___Muscle Pain (myalgia)
10. **Hematologic**
    - ___Easy or Excessive Bleeding

Patient Rights and Responsibilities

This facility and medical staff have adopted the following list of patient rights and responsibilities. This list includes, but is not limited to:

PATIENT RIGHTS

Impartial treatment without regard to race, color, sex, national origin, religion, handicap or disability.

Considerate and respectful care at all times and under all circumstances

Knowledge of the name and professional status of those caring for you.

To receive information from the surgeons about your diagnosis, treatment plan and prognosis to the best of the physicians' knowledge.

To participate actively in decisions regarding your medical care. To the extent permitted by law, this includes the right to refuse treatment.

Full consideration of privacy concerning your medical care program. Case discussion, examination and treatment are confidential and should be conducted discretely.

To be informed that Advanced Directives cannot be honored at this facility and to be advised that should an unexpected life threatening event occur the patient will be transferred to a facility that will honor this directive.

Confidential treatment of all communications and records pertaining to care. Written permission shall be obtained before medical records can be made available to anyone not directly concerned with your care.

Responsible responses to any reasonable request for service.

To leave the facility even against medical advice.

To expect reasonable continuity of care.

To be advised if the physician proposes to engage in or perform experimentation affecting your care or treatment and the right to refuse to participate in this activity.

To be informed of the continuing health care requirements following discharge from the center.

Examine and receive an explanation of a bill for service, regardless of source of payment.

To report any comments concerning the quality of care provided to you and expect follow-up on your comments.

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PATIENT RESPONSIBILITES

To provide accurate and complete information concerning his/her present complaints, past medical history and other matters relating to their health.

To notify us of the existence of an Advanced Directive (e.g. a living will) as those cannot be honored at this facility.

To make it known whether he/she clearly comprehends the course of treatment and what is expected of him/her.

For following the treatment plan established by the physician, including the instructions of nurses and other health care professional as they carry out the physicians' orders.

For keeping his/her appointment and notifying the facility if unable to do so.

For assuring that the financial obligations of their care is fulfilled as promptly as possible.

Being considerate of the rights of other patients and facility personnel.

FEEDBACK

Our goal is to provide the best surgical experience possible while in our Patients, clients, families or visitors have the right to express complaints or concerns about any aspects of their care or experience with our office. Please be assured that expressing a complaint or concern will not compromise your care and will be addressed according to our policy. Concerns may be directed to any facility staff or the office, or you may mail your comments to us.

Patient Signature: _____ Date: _____

DISCLOSURE AND CONSENT
MEDICAL AND SURGICAL PROCEDURES

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I (we) understand that the following surgical, medical, and/or diagnostic procedures are planned for me and I (we) voluntarily consent and authorize these procedures

Examination and Health History **X-rays (only if instructed by the physician)**

2. I (we) understand that no warranty or guarantee has been made to me as to the result of treatment or possibility of cure.

3. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the surgical, medical, and/or diagnostic procedures planned for me. -Local pain ***-nerve irritation -bruising or hematoma - worsening of condition***

4. I (we) give permission for a corporate medical representative to be present during my procedure on a consultative basis.

5. I (we) have been given an opportunity to ask questions about my condition, alternative forms of anesthesia and treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, potential benefits, risks, or side effects, including potential problems related to recuperation and the likelihood of achieving care, treatment, and service goals.

6. I (we) believe that I (we) have sufficient information to give this informed consent. I (we) certify this form has been fully explained to me and that I (we) have read it or have had it read to me, that the blank spaces have been filled in, and that I (we) understand its contents.

_____ _____

Patient signature **Date**

_____ _____

Other Legally responsible person **Relationship (if other than patient)**

_____ _____

Witness signature **Date**

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PATIENT ASSIGNMENT OF BENEFITS AUTHORIZATION AND FINANCIAL RESPONSIBILITY DISCLOSURE STATEMENT

This agreement is made and entered into on this _____ day of _____ 20_____ between ***North Phoenix Pain Relief Center*** the provider of medical services, hereinafter referred to as *PROVIDER* and you the patient receiving medical services, hereinafter referred to as *PATIENT*. All Charges for medical services rendered by *PROVIDER* are due and payable by *PATIENT* at the time of service.

ASSIGNMENT OF BENEFITS AUTHORIZATION:

_____*PATIENT* authorizes and assigns payment of benefits due to *PATIENT* under terms of any insurance policy or policies that may cover the medical procedure performed on *PATIENT* by *PROVIDER* at the address designated by *PROVIDER* on any claim form submitted to *PATIENT'*s insurance carrier. *PATIENT* agrees that payment to *PROVIDER* pursuant to this assignment authorization by *PATIENT'*s insurance company shall discharge said insurance company of any and all obligations under *PATIENT'*s policy to the extent of such payment. *PATIENT* understands and agrees that *PATIENT* is financially responsible for charges not covered by PATIENT's assignment authorization, and *PATIENT* authorizes *PROVIDER* to contact *PATIENT's* employer for the purpose of determining the existence of any insurance benefits.

MEDICAL INSURANCE:

_____As a courtesy to *PATIENT*, *PROVIDER* will verify *PATIENT's* coverage and bill relevant insurance carrier(s). However, *PATIENT* is ultimately responsible for payment of bills and any deductibles or co-payment / co-insurance as determined by *PATIENT's* insurance carrier contract. Co-payment / co-insurance are due and payable at the time of service (NO EXCEPTIONS). If *PATIENT's* insurance carrier denies any part of claim, or if *PROVIDER* elects to continue past *PATIENT's* approved period, *PATIENT* is responsible for the balance in full. Cash *PATIENTS* are required to pay in full at the time of service. Further, *PATIENT* is required:

_____ 1. To present current official identification prior to each visit e.g. driver's license and insurance card(s).

_____ 2. To advise *PROVIDER's* office of current address and phone number(s).

_____ 3. To verify at each visit that *PATIENT's* information is current by completing and signing *PROVIDER's* Patient History Information form, Updated Patient History form or other relevant data forms.

_____ 4. To be aware of how *PATIENT's* insurance coverage works e.g. any referral authorization *PATIENT* may require, including designated labs, imaging facilities e.g. X-ray and mammogram.

_____ 5. To pay any additional monies owing within 30-days of receiving a statement from *PROVIDER's* office. (When *PROVIDER's* office receives an Explanation of Benefits (EOB) from *PATIENT's* insurance company, any monies owing will be billed to *PATIENT*.)

_____ 6. To give *PROVIDER's* office 24-hour advance notice if *PATIENT* wishes to cancel an appointment or PATIENT will be billed a $25.00 cancellation fee.

_____ *PATIENT* may be discharged from care for two (2) consecutive or three (3) appointments "No Shows" or four (4) cancellations. Discharge notice to be sent via certified mail.

RETURNED CHECK POLICY:

_____ If a payment is made on an account by check, and the check is returned for any reason e.g. Non-Sufficient Funds (NSF), Account Closed (AC), Refer to Maker (RTM), etc., *PATIENT* will be responsible for the original check amount and an additional $20.00 service charge, plus any and all bank charges pertaining to said returned check. Once notice is received of the returned check, *PROVIDER's* office will notify *PATIENT* in writing. If a response is not received from *PATIENT* within 15 days from the notice date, the account may be turned over to a collection agency and a collection fee of 50% will be added to the outstanding balance - in addition to the $20.00 service charge plus any and all bank charges pertaining to said returned check.

NON-PAYMENT ON ACCOUNT:

_____ Should collection proceedings or other legal action become necessary to collect an overdue account, *PATIENT* understands that *PROVIDER* has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The *PATIENT* understand that he/she is responsible for all costs of collection including, but not limited to, all court costs and Attorney's fees, and a collection fee of 50% which will be added to the outstanding balance.

BILLING:

_____ To avoid unnecessary costs to *PATIENTS*, monthly statements will not be sent to *PATIENTS*. Please note that *PROVIDER* will make every effort to obtain payment from *PATIENT's* insurance carrier, however, billing may be delayed due to various issues e.g. medical appeal, carrier request for medical records and other information.

SELF-PAY:

_____If *PATIENT* does not have health insurance; *PATIENT* agrees to take responsibility for the full and entire amount of medical services rendered by *PROVIDER.*

RESPONSIBILITY FOR VALUABLES

_____ *PATIENT* understands and acknowledges that *PROVIDER* is not responsible for the loss or damage to, or theft of any of *PATIENT's* or dependents' personal possessions, including, but not limited to money, jewelry, clothing or valuables, while *PATIENT* or dependent(s) are on *PROVIDER's* premises.

FOR MEDICARE PATIENTS ONLY: Authorization to release Information and Payment Request

_____*PATIENT* hereby request that payment of authorized Medicare benefits be made on *PATIENT's* behalf to *PROVIDER* for any services rendered by *PROVIDER. PATIENT* authorizes any holder of medical or other information about *PATIENT* to be released to the Health Care Financing Administration or its agents, intermediaries or carriers any information needed to determine these benefits or the benefits payable for related services. *PATIENT* further understands that deductibles, co-insurance and any other charges not covered by Medicare are *PATIENT's* responsibility.

By signing below, *PATIENT* agrees to accept full financial responsibility as a *PATIENT* who is receiving medical services from *PROVIDER. PATIENT's* signature verifies that *PATIENT* authorizes assignment of benefits, has read the disclosure statement, understands *PATIENT* responsibilities, and agrees to the terms and conditions described therein. *PATIENT* further agrees to abide by items on Attachment 1: Patient Responsibility Information (Physical Exams, Appointments, Labs, Prescriptions, Health Insurance and Billing)

_____ _____
Patient signature **Date**

_____ _____
Other Legally responsible person **Relationship (if other than patient)**

_____ _____
Oversight Physician **Date**