integrativepain
center of arizona

INSTRUCTIONS FOR FILLING OUT NEW PATIENT PACKET

1. PLEASE USE **BLACK INK ONLY**
2. **ANSWER** EACH QUESTION. IF IT DOES NOT APPLY TO YOU, PLEASE WRITE “NOT APPLICABLE” OR “N/A”.
3. FILL OUT THE UPPER **LEFT HAND CORNER OF EVERY PAGE** COMPLETELY WITH YOUR NAME AND YOUR DATE OF BIRTH.
4. INITIAL AND DATE THE **BOTTOM RIGHT HAND SIDE OF EVERY PAGE**. THIS INDICATES THAT EVERY PAGE HAS BEEN COMPLETED.
5. PLEASE COMPLETE THIS PACKET BEFORE YOUR APPOINTMENT TIME.
6. **ARRIVE 30 MINUTES** PRIOR TO YOUR NEW PATIENT APPOINTMENT.

THANK YOU FOR YOUR COOPERATION IN COMPLETING YOUR NEW PATIENT PACKET.

Patient Initials _________ DOS/Appt Date ________________

Patient Name____DOB____________

integrativepain
center of arizona

Goals for Treatment

List what you would like to be doing that you cannot currently do because of your pain:

Social Status

Marital Status ❑Married ❑Single ❑Divorced ❑Widowed ❑Other

Are You Working? ❑Yes ❑No ❑Retired If Yes, Employer

Job Description ____ If Retired, what type of work did you do

Are you on disability? ❑Yes ❑No If Yes, why and since when? _______________________________

Exercise

Do you exercise? ❑Yes ❑No ❑Retired If Yes, how many days per week

What type of exercise do you perform?

How much time do you exercise on the days you do exercise? ____

Diet

Do you feel you eat a healthy diet on a daily basis? ❑Yes ❑No

Do you consume caffeinated beverages? ❑Yes ❑No If Yes, how many per day ___________________

Do you have any food allergies, sensitivities, or intolerances? ❑Yes ❑No

If Yes, what foods and what is the reaction? ____

____

Sleep

How many hours do you sleep on average each night? ____

Do you wake feeling refreshed? (circle one) Very A Little No

Social History

Are you capable of becoming pregnant? ❑Yes ❑No *If so,* are you currently pregnant? ❑Yes ❑No

Highest level of education obtained: ❑Grammar school ❑High School ❑College ❑Post-graduate

Alcohol Use: ❑Daily ________# per day ❑Weekly________# per week ❑Rarely
❑Active in AA ❑DUI in last 10 years ❑Never drink alcohol

Tobacco Use: ❑Current Tobacco User Packs per day _________ How many years of smoking? __________
❑Former Tobacco User ❑Never Used Tobacco

 Patient Initials _________ DOS/Appt Date _________________

integrativepain center of arizona

Patient Name____________________DOB__________

Illegal Drug Use:
❑Not now and never used Any Illegal Drugs
❑Currently Use Illegal Drugs / List all: ____________________
❑Currently Use Someone Else's Prescription Medications / List all: ____________________
❑Formerly Used Illegal Drugs (not currently using) List all: ____________________
❑Active in NA

Have you ever abused narcotic or prescription medications? ❑Yes ❑No / List all: ____________________

Do you have any history of physical, sexual, or emotional abuse? ❑Yes ❑No
If you feel comfortable, please explain ____________________

____

Past Surgical History

Please indicate any surgical procedures you have had done in the past, including the date, type, and any pertinent details.

Abdominal Surgery
❑Gallbladder removal
❑Appendectomy
❑Other

Female Surgery
❑Caesarean section
❑Hysterectomy
❑Laparoscopy
❑Ovarian
❑Other

Heart Surgery
❑Valve replacement
❑Aneurysm repair
❑Stent placement

Joint Surgery
❑Shoulder
❑Hip
❑Knee
❑Other

Spine/Back Surgery
❑Discectomy (levels)
❑Laminectomy
❑Spinal fusion (levels)
❑Other

Other Surgeries
❑Hemorrhoid surgery
❑Hernia repair
❑Thyroidectomy
❑Vascular surgery
❑Other

❑I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE.

Please list any other surgeries and dates (attach an additional sheet if necessary).

Patient Initials _________ DOS/Appt Date ______________

integrativepain
center of arizona

Patient Name___________________________________DOB___________

Past Medical History

Mark the following conditions/diseases that you have been treated for in the past:

General Medicine

❑Cancer _______________

❑Diabetes Type __________

❑HIV/AIDS

Head/Eyes/Ears/Nose/Throat

❑Headaches

❑Head Injury

❑Hyperthyroidism

❑Hypothyroidism

❑Glaucoma

Cardiovascular/Hematologic

❑Anemia

❑Bleeding Disorders

❑Heart Attack

❑High Blood Pressure

❑High Cholesterol

❑Mitral Valve Prolapse

❑Murmur

❑Phlebitis

❑Poor Circulation

❑Stroke

❑Coronary Artery Disease

❑Pacemaker/Defibrillator

Respiratory

❑Asthma

❑Bronchitis

❑Emphysema/COPD

❑Pneumonia

❑Tuberculosis

❑Valley Fever

Gastrointestinal

❑Bowel Incontinence

❑GERD (Acid Reflux)

❑Gastrointestinal Bleeding

❑Constipation

Musculoskeletal

❑Amputation

❑Bursitis

❑Carpal Tunnel Syndrome

❑Chronic Low Back Pain

❑Chronic Neck Pain

❑Chronic Joint Pain

❑Fibromyalgia

❑Joint Injury

❑Osteoarthritis

❑Osteoporosis

❑Phantom Limb Pain

❑Rheumatoid Arthritis

❑Tennis Elbow

❑Vertebral Compression Fracture

Genitourinary/Nephrology

❑Bladder Infection(s)

❑Dialysis

❑Kidney Infection(s)

❑Kidney Stones

❑Urinary Incontinence

Hepatic

❑Hepatitis A
(active / inactive / unsure)

❑Hepatitis B
(active / inactive / unsure)

❑Hepatitis C
(active / inactive / unsure)

Neuro-psychosocial

❑Alcohol abuse

❑Alzheimer's Disease

❑Bipolar Disorder

❑Depression

❑Epilepsy

❑Prescription Drug Abuse

❑Multiple Sclerosis

❑Paralysis

❑Peripheral Neuropathy

❑Schizophrenia

❑Seizures

❑Reflex Sympathetic Dystrophy/CRPS

❑Other Diagnosed Conditions:

Patient Initials _________ DOS/Appt Date ________________

Patient Name_______________________________________DOB____________

integrativepain
center of arizona

Current Medications

Please indicate which (if any) of the following **blood-thinners** you are taking:

❑Aggrenox ❑Coumadin/Warfarin ❑Effient ❑Lovenox ❑Plavix ❑Pletal ❑Pradaxa ❑Prasugrel
❑Ticlid ❑Other

Drug Name	Dose per pill	Do you take this every day	When do you take this during the day	How many do you take at a time	How many do you take in a day/week/month (pick one to answer: day, week or month)	Who prescribes this medication
Example: Benadryl	25mg	No	at bedtime	1 or 2	2 times a week	Provider's name

I certify that this list is both current, and accurate:

Date: Patient Initials:

______/______/______ ____________

______/______/______ ____________

______/______/______ ____________

______/______/______ ____________

Patient Name_________________________________DOB__________

integrativepain center of arizona

Allergies

Topical Allergies: ❑Iodine ❑Latex ❑Tape

Are you allergic to shellfish: ❑Yes ❑No

Do you have any known drug allergies? ❑Yes ❑No

If so, please list all medications you are allergic to:

Medication Name	**Allergic Reaction Type**

Family History

Mark all appropriate diagnoses as they pertain to your biological ***MOTHER AND FATHER*** only:

	Arthritis	Cancer	Diabetes	Headaches	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Problems	Liver Problems	Osteoporosis	Rheumatoid Arthritis	Seizures	Stroke
Mother													
Father													

Other medical problems:

____

____

____

❑ I have no significant family medical history ❑ I am adopted (no medical history available)

Pain Description

Check all of the following that describe your pain:

❑Aching ❑Stabbing ❑Tender ❑Heavy ❑Sickening
❑Throbbing ❑Gnawing ❑Hot/Burning ❑Exhausting ❑Fearful
❑Shooting ❑Sharp ❑Cramping ❑Tiring ❑Punishing/Cruel

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

Patient Initials __________ DOS/Appt Date _________________

Patient Name_____________________________________DOB___________

integrativepain center of arizona

Pain Description – Part 1

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

N = numbness	**S** = stabbing	**B** = burning	**P** = pins and needles	**A** = aching	**O** = other pain

Where is your worst area of pain located? ______________________________

Does this pain radiate? If so, where: ______________________________

Please list any additional areas of pain: ______________________________

____

Pain Description – Part 2

Circle the ONE number in each category that best describes how, **during the PAST 24 HOURS**, pain has interfered with the following:

	Does not interfere									Completely interferes
General Activity	1	2	3	4	5	6	7	8	9	10
Mood	1	2	3	4	5	6	7	8	9	10
Walking ability	1	2	3	4	5	6	7	8	9	10
Normal Work (include both work outside the home and housework)	1	2	3	4	5	6	7	8	9	10
Relationships	1	2	3	4	5	6	7	8	9	10
Sleep	1	2	3	4	5	6	7	8	9	10
Enjoyment of life	1	2	3	4	5	6	7	8	9	10

Patient Initials _________ DOS/Appt Date ________________

Patient Name_______________________________________DOB____________ integrativepain center of arizona

Pain Scale Instructions

Pain is a *subjective* experience. Use this scale to help us understand the severity of your pain. *(Circle one)*

1-4	Pain that does not prevent you from participating and completing daily activities
5	Pain that makes you feel you need medication, but does not force you to stop your activity
6-7	Pain that is severe enough to stop any task and necessitates immediate medication
8-9	Pain so severe and debilitating that someone else has to get your medications for you
10	Absolutely the worst pain. You are completely disabled.

1 2 3 4 5 6 7 8 9 10

No Pain — Hurts a little — Hurts more — Hurts a lot — Hurts terrible — Worst pain

Which face/number shows how much you hurt *now*?

Which face/number best describes your pain at its ***worst*** in the last 24 hours?

Which face/number best describes your pain at its ***least*** in the last 24 hours?

Which face/number best describes how much you hurt on ***average***? ____

Onset of Symptoms

Approximately when did this pain begin?

What caused your current pain episode?

Is your pain the result of a Motor Vehicle Accident or Personal Injury (legal term describing injury sustained to your person by negligence of another) ❑Yes ❑No

How did your current pain episode begin? ❑Gradually ❑Suddenly

Since your pain began, how has it changed? ❑Decreased ❑Increased ❑Stayed the same

Diagnostic Tests and Imaging

Mark all of the following tests you have had that are related to your current pain complaints:

❑MRI of the ____ Date_________Facility ____________________________

❑X-ray of the _______________________________________ Date _________Facility ____________________________

❑CT of the ____ Date_________Facility ____________________________

❑EMG/NCV of the ___________________________________ Date_________Facility ____________________________

❑Other diagnostic testing ____

❑I HAVE NOT HAD ANY DIAGNOSTIC TESTS PERFORMED FOR MY CURRENT PAIN COMPLAINTS.

Patient Initials _________ DOS/Appt Date ________________

Patient Name____________________________________DOB___________

integrativepain center of arizona

Pain Treatment History

Mark all of the following pain treatments you have undergone prior to today's visit:

❑Chiropractic ❑Physical Therapy ❑Spine Surgery ❑Psychological Therapy ❑Podiatrist Treatment

❑Discogram – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑Epidural Steroid Injection – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑Joint Injection – Joint(s) ____

❑Medial Branch Blocks or Facet Injections – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑Nerve Blocks – Area/Nerve(s) ______________________________________

❑Radiofrequency Ablation – (circle all levels that apply) Cervical / Thoracic / Lumbar

❑Spinal Column Stimulator – (circle one) Trial Only / Permanent Implant

❑Trigger Point Injection – Where? _____________________________________

❑Vertebroplasty / Kyphoplasty – Level(s) _________________________________

❑Medications:

Name	Strength	How did you take it?	Why was it stopped?

❑Other ____

❑I HAVE NOT HAD ANY PRIOR TREATMENTS FOR MY CURRENT PAIN COMPLAINTS

Have you seen any other specialists? ❑Yes ❑No If yes:

Who	What Specialty

Patient Initials _________ DOS/Appt Date ________________

integrativepain
center of arizona

Patient Name____DOB____________

Review of Symptoms

Mark any events that have occurred in the *LAST MONTH*:

GENERAL	❑Weight loss	❑Weight gain	❑Belts fit differently
❑Loss of appetite	❑Always tired	❑Increased appetite	❑Excessive thirst
❑Chills	❑Puffiness	❑Night sweats	❑Hot flashes
❑Intolerant of cold	❑Frequent infections	❑Lack of sex drive	❑Unable to orgasm
❑Swelling	❑Changes in hair	❑Changes in nails	❑Fever

HEAD/EYES/EARS/NOSE/THROAT	❑Allergies (seasonal)	❑Nasal discharge	❑Nasal congestion
❑Sinus pain	❑Ear pain	❑Ear discharge	❑Hearing loss
❑Change in vision	❑Sore mouth	❑Trouble swallowing	❑Tooth pain
❑Bleeding gums	❑Hoarseness	❑Sore throat	

RESPIRATORY	❑Shortness of breath	❑Wheezing	❑Breathing discomfort
❑Cough	❑Blood sputum	❑Snoring	❑Sleep apnea

CARDIOVASCULAR	❑Chest pain	❑Fainting	❑Irregular heartbeat
❑Bleeding disorder	❑High blood pressure	❑Deep vein thrombosis	❑Lightheadedness
❑Swelling in the feet	❑Ankle swelling	❑Calf or leg pain	

GASTROINTESTINAL	❑Nausea	❑Vomiting/dry heaves	❑Bloating
❑Excess gas	❑Heartburn	❑Dark and tarry stools	❑Bloody stools
❑Diarrhea	❑Constipation	❑Abdominal pain	❑Abdominal cramps
❑Rectal pain	❑Rectal bleeding		

GENITOURINARY	❑Weak stream	❑Loss of urine	❑Painful urination
❑Urinary urgency	❑Foul urine odor	❑Increased frequency	❑Difficulty starting stream
❑Waking at night to urinate			

SKIN	❑Rash	❑Tattoos	❑New growth or moles
❑Change in shape of moles	❑Change in color of moles	❑Discoloring	

LYMPHATIC/HEMATOLOGIC	❑Swollen glands	❑Easily bruised	❑Unexplained bruising
❑Free bladder			

NEUROLOGICAL	❑Headaches	❑Speech difficulties	❑Seizures
❑Memory difficulty	❑Visual disturbance	❑Dizziness	❑Poor balance
❑Tingling or numbness	❑Arm/leg weakness	❑Paralysis	❑Tremors

MENTAL HEALTH	❑Depression	❑Hallucinations	❑Change in sleep patterns
❑Sense of hopelessness	❑Changes in behavior	❑Difficulty concentrating	❑Poor impulse control
❑Difficulty organizing thoughts			

MEN	❑Penile discharge	❑Impotence	❑Difficult erections
❑Testicular lump(s)	❑Testicular pain	❑Swelling in scrotum	

WOMEN	❑Irregular periods	❑Prior breast lump changes	❑Breast pain
❑New breast lumps	❑Nipple discharge	❑Breast skin change	❑Pelvis pain
❑Vaginal yeast infections	❑No menstrual bleeding	❑Foul smelling vaginal discharge	
❑Breast feeding	❑Post hormonal	❑Taking hormone contraceptives or replacement therapy	
❑Pregnant			

Patient Initials __________ DOS/Appt Date _________________