Arizona Pain Care Center – Patient Intake Form

Exam Room (staff use): 1 2 3 4 Procedure Room

Please circle the provider you are here to see:

Samir P. Patel, D.O. Chad E. Pletnick, M.D. Kayven Farshad, M.D. Shannon Morgenstern, NP Katherine Grimes, NP

Name:_____ DOB:_____ Today's date: _____

Address:_____

Contact Phone: ( )_____- _____Email:_____@_____._____

Primary Care Physician:_____

Referring Physician:_____

Reason for Visit:

Neck Pain / Shoulder Pain / Arm Pain / Hand Pain / Chest Pain / Upper Back Pain / Low Back Pain / Buttock Pain / Leg Pain / Hip Pain / Knee Pain / Foot Pain /Groin Pain/ Stomach Pain / Generalized Pain / Other

(please specify if other) _____

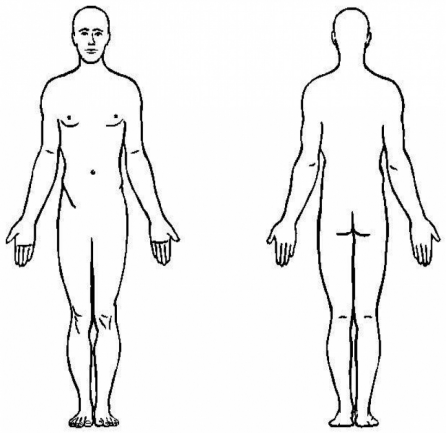
Pain Description **Draw where your pain is.**

When did it start? (circle one) Days/Weeks/Months/Years

How many?_____

Did it start with a specific incident? Yes/No (circle one). If so, what happened?
_____

How does it feel? (circle all that apply)
Dull/Aching/Burning/Electrical/Shooting/Stabbing/Cramping/Sharp/
Tingling/Numbing/Other (describe if other)
_____



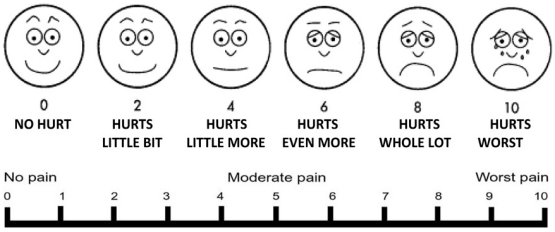
What makes it better? (circle all that apply)
Medication/Lying Down/Sitting/Standing/Walking/Stretching/Change in Position/Exercise/Movement/Rest/Other

(please describe if other) _____

What makes it worse?(circle all that apply)
Lying Down/Sitting/Standing/Walking/Stretching/Change in Position/Exercise/Movement/Rest/Other

(please describe if other)_____

Rate your Pain on a scale of 0 to 10 with 0 being no pain:



Worst Pain ____ / 10 Least Pain ____ / 10 Current Pain____ / 10

(STAFF USE):
Vitals: BP_____/_____ HR_____ TEMP_____

Height_____ Weight_____

ORT: _____ EASI-sa: _____

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PLEASE LIST MEDICATION ALLERGIES:

_____

Please list all medications including non-pain medications and supplements:
(use the back of the sheet if necessary)

Medications:	Dose:	Frequency:	How Long:	Who Prescribed:
Example: Ibuprofen	600_mg	4 times a day	5 weeks	Dr. Smith

_____

_____

_____

_____

Have you used any of the listed modalities for your current pain? (circle all that apply)

	Effective	How many weeks?	How long ago?
TENS	yes / no		
Brace	yes / no		
Ice	yes / no		
Heat	yes / no		
Massage	yes / no		
Physical Therapy	yes / no		
Chiropractic Therapy	yes / no		
Acupuncture	yes / no		

Have you been seen by another physician for your pain condition? (circle all that apply)

	Who?	From when to when? (MM/YY to MM/YY)
Pain Management		
Neurologist		
Neurosurgeon		
Orthopedic Surgeon		
Primary Care		

Please list any injections that you have had:

Epidural Steroids / Nerve Blocks / Radiofrequency Ablations/ Trigger Point Injections / Spinal Cord Stimulation / Joint Replacements /Arthroscopies / Neck or Back Surgeries /Other

Physician:	Treatment:	When?	Effective? Yes/No
Example:			
Dr. Smith	Cervical Epidural	12/20/2015	Yes for 6 months

_____

_____

_____

_____

Please list your Medical History and dates of diagnosis (stroke, heart attack, diabetes, high blood pressure, etc.):

_____

_____

_____

Fall Risk/Advanced Care Plan:

1. **Have you fallen in the last 12 months? YES / NO If so, how many times?**
   Did you hurt yourself? Please describe:

2. **Do you have an Advanced Care Plan? YES/ NO If so, who is your medical Power of Attorney?**
   Please provide a copy at your next visit.

Please list your Surgical History and dates when performed (hernia repair, tonsilectomy, etc):

_____

_____

_____

Family History
Please indicate if your relative is alive or deceased and list any major medical illnesses:

Mother alive/deceased illnesses
_____

Father alive/deceased illnesses
_____

Other pertinent history: _____

Social History

Marital Status (circle one): Single / Married / Divorced / Widowed

Have you attempted suicide or had suicidal or homicidal thoughts? Yes / No When?_____

Working Status (circle one): Working / Retired / Disabled

Type of Job:_____ Last Worked:_____

Have you ever used tobacco products or smoke? Yes / No How many packs?_____How long?_____ Quit? Y / N When?_____

Have you used drugs? Never / Heroin / Marijuana / Cocaine / Meth Last Used?_____

Have you been treated for alcohol or drug addiction? Yes / No What substance?_____ When?_____

Do you drink alcohol? Never / Rarely / Socially / Daily

ORT Score (staff will fill in): _____

Review of Systems (circle all that apply):

General: itching / insomnia / rash / fever / weight gain / weight loss

Eyes: vision loss / blurred vision

ENT: sinus headaches / runny nose

Endocrine: night sweats / thyroid problems / diabetes

Respiratory: cough / shortness of breath

Cardiac: irregular heartbeat / chest pain / leg swelling

Gastrointestinal: nausea /heartburn / abdominal pain / bowel incontinence / vomiting

Hematological: blood thinners / cancer / HIV / hepatitis / recent infection / bleeding problems

Genitourinary: urinary incontinence / difficulty urinating

Musculoskeletal: joint pain / joint swelling

Neurological: numbness / headaches / weakness / tingling / stroke / seizures

Psychiatric: bipolar disorder / suicidal thoughts / anxiety / homicidal thoughts / depression

Past Diagnostics

Have you had any of the following and if so what part of the body, when, and what facility?

X-ray_____

MRI_____

CT Scan_____

EMG/NCS_____

Ultrasound_____

Bone Scan_____

EKG_____

I attest that the above is true and accurate to the best of my knowledge.

Signature:_____

Date:_____

Arizona Pain Care Center Opiate Prescription Policies:

In an effort to comply with the Centers for Disease Control's recommendations on opiate prescriptions to combat the high mortality associated with opiate use in our country, Arizona Pain Care Center (AZPCC) has adopted the following guidelines which are aligned with the AZ Board of Health's Opiate Prescription Guidelines and recent AZ legislation:

We do not prescribe more than a 30-day supply at a time. We regularly do not prescribe more than 50 morphine equivalents per day. AZ statute states that 90 morphine equivalents are the routine maximum for non-terminal illness pain. Using quantities of opiate medications greater than prescribed or asking for refills prior to the 30-day refill date is a violation of our opiate prescribing agreement and grounds for dismissal.

We do not prescribe both a benzodiazepine (Xanax, Klonopin, Valium, etc.) along with an opiate as recent evidence shows a 7 to 10 times greater chance of dying from a lack of breathing.

The Arizona Board of Pharmacy prescription database is checked at every visit and compliance with our policies and prescriptions is verified.

We will obtain Urine Drug Screening samples at the first visit and periodically thereafter. If you are found to have non-prescribed or illicit substances in that screen, you will be disqualified from obtaining an opiate prescription at our facility.

If you are of child-bearing age, we will obtain a urine pregnancy test.

If we prescribe opiates for your pain, you may not without our express consent, obtain opiates from any other provider unless you have been hospitalized and/or are in an emergency situation.

You must obtain your opiates from a single pharmacy that you have registered with us. You may not change this pharmacy without our express consent.

You may not under any circumstances share/trade your prescription or share/trade/use anyone else's prescription. You must keep your opiates in a locked, secured, and safe location away from the reach of others including children.

Prior to 2015 the powerful nature of opiates and their ability to cause harm was poorly understood, however, evidence from the last 20 years of prescribing has enlightened the Pain Specialist community on how to properly prescribe these powerful substances and avoid harm. We now know that there is a ceiling effect on opiates. That is to say prescribing too much decreases their ability to work and in fact, increases the risk of death.

Abuse, harassment, or over utilization of our staff regarding clinic matters or policies is also considered a violation of our agreement and grounds for dismissal.

By signing, you agree that you have read and understand the above statements, and that if you are to receive an opiate prescription, you agree to comply with these policies.

Signature:_____ Date:_____

Edited 6.9.22

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OFFICE USE BELOW THIS LINE

THIS PAGE WILL BE FILLED OUT BY YOUR PROVIDER. PLEASE FILL IN YOUR NAME AND DOB.

HPI NOTES: **Name**:_____**DOB:**_____

PE:

DIAGNOSIS:

- **(Cervical / Thoracic / Lumbar) Spondylosis without myelopathy**
- **(Cervical / Thoracic / Lumbar) Radiculopathy**
- **Spinal Stenosis with neurogenic claudication**
- **Sacroiliitis**
- **Idiopathic Neuropathy**
- **Pain in Shoulder (Left / Right / Bilateral)**
- **Pain in Knee (Left / Right / Bilateral)**
- **Pain in Hip (Left / Right / Bilateral)**
- **Trochanteric Bursitis**
- **Lumbago**
- **Cervicalgia**
- **Fibromyalgia**
- **Myalgia**
- **Pelvic Pain**
- **Chronic Pain Syndrome**
- **Long term Use of Opiates**
- **Long term Use of Anticoagulants**
- **Other:**_____

PLAN:

Medications:

Continue:_____

Discontinue:_____

New:_____

Conservative Therapies: Heat / Ice / TENS / Brace / Other_____

Interventional Therapies: TPI / MBNB / TFESI / ILESI / SIJ (R / L /B) / PNB / SCS / Other_____

Diagnostics:

Radiology: _____**X-ray / MRI / CT / CT with Myelography/ Ultrasound**

Urine: HCG / UDS

Other: EKG / BMP / CMP / Coags / CBC / Other_____

Referrals: Physical Therapy / Chiropractic / Psychology / Neurosurgery / Orthopedics / Neurology / ENT

Education: Pre-procedure / Opiate / Back Pain / Fibro / Pain Management / Medication / Smoking Cessation / CHG / Pre-Surgical

Return to clinic in (1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 / 11 / 12) Days / Weeks / Months / PRN / For Procedure

Obtain SF-12?: Y / N Obtain Release of Med Info? Y / N Obtain Consent Today? Y / N