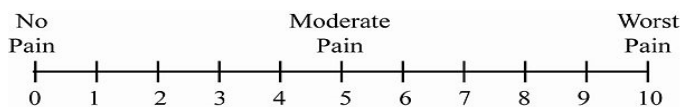
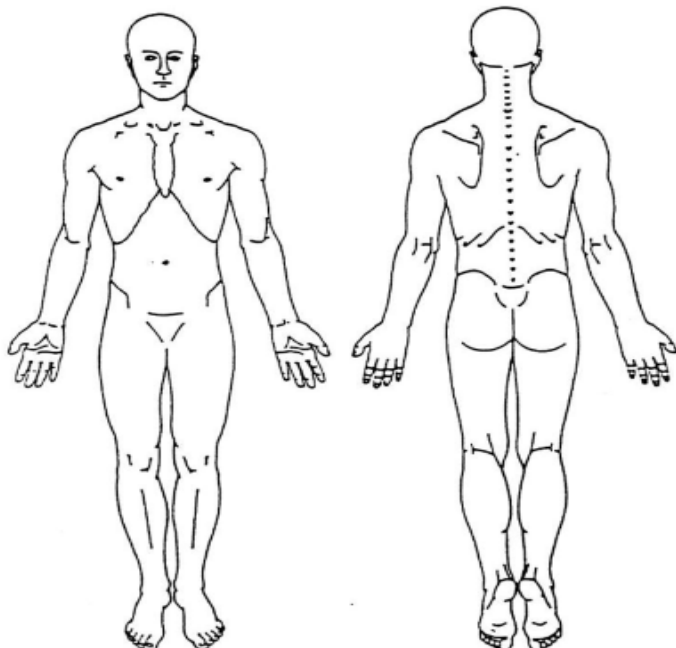


Today's Date: _____

Your Name: _____ Birth Date: _____

Reason for Today's Visit: Medication Refill Medication Change Post-Procedure Assessment
 Review MRI/EMG or Test Results New Pain or Injury: _____

Use the diagram to indicate the location and type of your pain. Mark the drawing with the following letters that best describe your symptoms: **"N"**umbness **"P"**ins and Needles **"A"**ching **"S"**tabbing **"B"**urning



What is your current pain level **right now**? _____

Where is your worst area of pain located?

List any additional areas of pain: _____

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

Check all that describe your pain today:

- | | | | |
|-----------------------------------|--------------------------------------|---|--|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Hot/Burning | <input type="checkbox"/> Spasms | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Numb | <input type="checkbox"/> Squeezing | <input type="checkbox"/> Tingling/Pins and Needles |
| <input type="checkbox"/> Cramping | <input type="checkbox"/> Shock-like | <input type="checkbox"/> Stabbing/Sharp | <input type="checkbox"/> Tiring/Exhausting |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Shooting | | |

Since Your Last Visit:

- Has your pain? Increased Decreased Stayed the Same
- Did you have a procedure? No Yes **If yes**, how much pain relief did you obtain? _____%. Were there any problems? No Yes If yes, please explain: _____
- Do you have significant back/buttock/leg pain with prolonged standing and/or prolonged walking that is relieved with sitting and/or lying down? No Yes If yes, is your pain also alleviated with bending forward (using a shopping cart, leaning on the kitchen counter, etc.)? No Yes
- Any new imaging studies? No Yes Please List: _____
- Any new allergies? No Yes Please List: _____
- Any new medication side effects? No Yes Please List: _____
- Any new medications? No Yes Please List: _____
- Are you currently pregnant? No Yes Post menopause Do you plan to become pregnant? No Yes
- Have had two or more falls in the last year? No Yes
- Have you received a pneumonia vaccination? No Yes
- Have you been diagnosed with hypertension? No Yes Date: _____
- Do you currently have an implanted ICD, pacemaker or defibrillator? No Yes

Review of Systems – Mark all of the following symptoms that you CURRENTLY suffer from:

<p><u>Constitutional:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chills <input type="checkbox"/> Difficulty Sleeping <input type="checkbox"/> Fatigue <input type="checkbox"/> Fevers <input type="checkbox"/> Night Sweats <p><u>Cardiovascular/Respiratory:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Fainting <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Swelling in the Feet <p><u>Gastrointestinal:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation <input type="checkbox"/> Dark and Tarry Stools <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea/Vomiting 	<p><u>Genitourinary/Nephrology:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Involuntary Urination <input type="checkbox"/> Loss of Bowel Control <input type="checkbox"/> Painful Urination <input type="checkbox"/> Pelvic Pressure <p><u>Ears/Nose/Throat/Neck:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty Hearing <input type="checkbox"/> Earaches <input type="checkbox"/> Hay fever/Allergies <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Recurrent Sore Throats <input type="checkbox"/> Ringing in the Ears <input type="checkbox"/> Sinus Problems <p><u>Eyes:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Recent Visual Changes 	<p><u>Neurological:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Instability When Walking <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Weakness <p><u>Psychiatric:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety/Stress <input type="checkbox"/> Depressed Mood <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Suicidal Planning <p><u>Musculoskeletal:</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Neck Pain
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Consent and Authorization

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time.

I voluntarily request that Arizona Pain Specialists provide pain management care, treatment, and services to me, as deemed reasonable and necessary by the assigned healthcare provider(s). I consent to reasonable and necessary medical examination, evaluation, testing and treatment which may include diagnostic, radiology and laboratory procedures. I understand I may be asked to provide urine, oral swab, and/or blood samples. I have the right to refuse specific tests but understand this may impact my pain management treatment. If invasive interventional treatment is recommended, I will be informed of the benefits and risk prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Arizona Pain Specialists physicians, and/or their staff, to obtain my medication history and other relevant health care information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

Signature of Patient or Representative

Date

Relationship to Patient