Welcome to Nevada Pain!

Your completed intake paperwork helps our providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best care possible. Please take your time and inquire at our front desk or call (702) 912-4100 if you have any questions or are unsure how to complete any section of this form.

New Patient Intake Paperwork

Patient Information

Today's Date ____________ Social Security Number: ____________

Your Name: ____________ Driver's License # / State: ____________

Date of Birth: ____________ Age: ______ Gender: ❑ Male ❑ Female

Street Address: ____________

City/State/Zip: ____________

Email: ____________

Physical Address Same as Mailing? ❑ Yes ❑ No If not, please list mailing address: ____________

____

____

Preferred Phone: ____________ ❑ Home ❑ Mobile ❑ Work

Secondary Phone: ____________ ❑ Home ❑ Mobile ❑ Work

Emergency Contact Name: ____________

Emergency Contact Phone: ____________ ❑ Home ❑ Mobile ❑ Work

Relationship: ____________

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

Race: ❑ American Indian or Alaskan Native ❑ Asian or Pacific Islander ❑ Black ❑ White ❑ Refuse to Report

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Refuse to Report

Primary Language: ❑ English ❑ Spanish ❑ Other ____________

Preferred Pharmacy

Pharmacy Name: ______________________ Phone Number: ______________________

Street Address: ______________________ City/State/Zip: ______________________

Primary Insurance Plan

Payer (e.g. BC/BS): ______________________ Plan: ______________________

Policy/I.D. Number: ______________________ Group Number: ______________________

Complete this box if you are *not* the policy holder for your primary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: ______________________

Policy Holder Name: ______________________ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: ______________________ Social Security Number: ______________________

Secondary Insurance Plan (if any)

Payer (e.g. BC/BS): ______________________ Plan: ______________________

Policy/I.D. Number: ______________________ Group Number: ______________________

Complete this box if you are *not* the policy holder for your secondary insurance

Insurance policy holder: ❑ Self ❑Spouse ❑ Child ❑ Other: ______________________

Policy Holder Name: ______________________ Policy Holder Gender: ❑ Female ❑ Male

Date of Birth: ______________________ Social Security Number: ______________________

Workers Compensation Claim Information

Complete this section only if your visit today is related to a Workers Compensation claim

Workers Comp Company: ______________________

Agent Name: ______________________ State of Injury: ______________________

Phone number: ______________________ Fax number: ______________________

Claim Number: ______________________ Date of initial injury: ______________________

Injury Claim

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 If yes, you will be asked to complete a separate form

I certify that the above information is accurate, complete and true. I give my consent for Arizona Pain Specialists DBA Nevada Pain to retrieve and review my medication history. I understand that this will become part of my medical record.

Patient Signature:______________________ Date: ______________________

CLINICAL INFORMATION

Your Name: ______________________________ **Today's Date** ____________________

Height: ____________ **Weight:** ________ lbs

Referral

Were you referred to our clinic by another physician? If so, whom? ______________________________

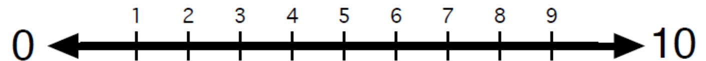
↳ If not, how did you hear about us? ❑ TV ❑ Radio ❑ Insurance Company ❑ Family ❑ Friend ❑ PCP

❑ www.NevadaPain.com ❑ Facebook ❑ Twitter ❑ YouTube ❑ Other Website ____________________

Pain Description

Use the pain scale described below to rate your pain for the questions below:

0 – Pain-free
1 – Very minor annoyance, occasional minor twinges
2 – Minor annoyance, occasional strong twinges
3 – Annoying enough to be distracting
4 – Can be ignored if you are really involved in your work/task, but still distracting
5 – Cannot be ignored for more than 30 minutes
6 – Cannot be ignored for any length of time, but you can still go to work and participate in social activities
7 – Makes it difficult to concentrate, interferes with sleep, but you can still function with effort
8 – Physical activity is severely limited. You can read and talk with effort. Nausea and dizziness caused by pain.
9 – Unable to speak, crying out or moaning uncontrollably, near delirium
10 – Unconscious, pain makes you pass out



______ What number on the pain scale (0-10) best describes your pain **right now**?

______ What number on the pain scale (0-10) best describes your **worst pain**?

______ What number on the pain scale (0-10) best describes your **least pain**?

______ What number on the pain scale (0-10) best describes your **average pain over the last month**?

Where is your worst area of pain located? ______________________________

Does this pain radiate? If so, where? ______________________________

Please list any additional areas of pain: ______________________________

Onset of Symptoms

Approximately when did this pain begin? ______________________________

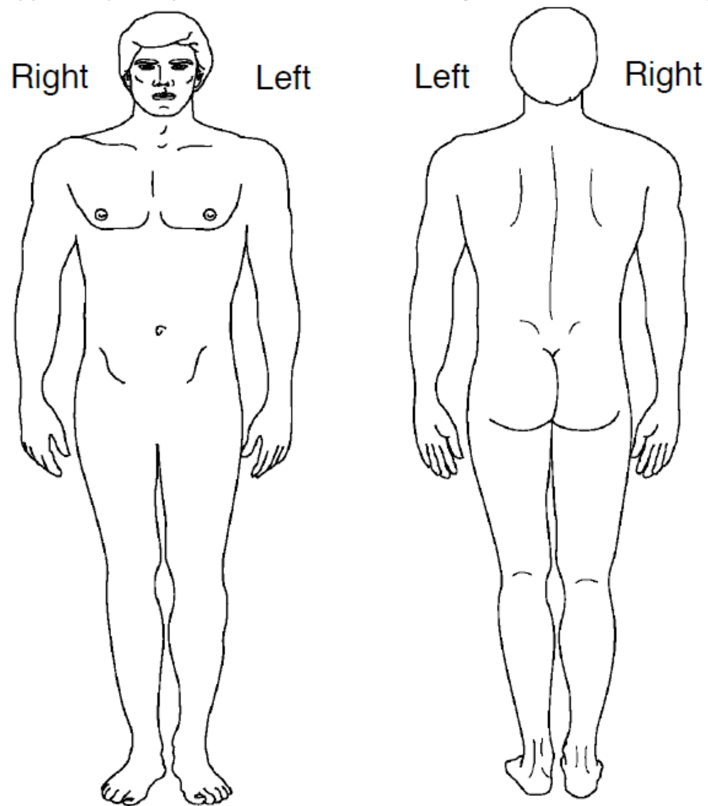
What caused your current pain episode? ______________________________

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

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

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



Pain Description - Check all of the following that describe of your pain:

- ☐ Aching
- ☐ Cramping
- ☐ Dull
- ☐ Hot/Burning
- ☐ Numbness
- ☐ Shock-like
- ☐ Shooting
- ☐ Spasming
- ☐ Squeezing
- ☐ Stabbing/Sharp
- ☐ Throbbing
- ☐ Tingling/Pins & Needles
- ☐ Tiring/Exhausting

Pain Frequency

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

Mark all of the following activities that are adversely/negatively affected by your pain

- ☐ Enjoyment of Life
- ☐ General Activity
- ☐ Mood
- ☐ My goal is to resume normal activities
- ☐ Normal Work
- ☐ Recreational Activities
- ☐ Relationships with People
- ☐ Sleep
- ☐ Walking
- ☐ Other: ____________________

In the past three months have you developed any new:

- ☐ Balance Problems
- ☐ Difficulty Walking
- ☐ Numbness/Tingling – Where?__________________
- ☐ Bladder incontinence
- ☐ Fevers
- ☐ Bowel incontinence
- ☐ Nausea
- ☐ Weakness – Where? ______________________
- ☐ Chills
- ☐ Vomiting

☐ **I HAVE NOT RECENTLY DEVELOPED ANY OF THE ABOVE CONDITIONS**

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 scan of the ______________________ Date: ____________ Facility: ______________

❑ EMG/NCV study of the ________________ Date: ____________ Facility: ______________

❑ Ultrasound of the ____________________ Date: ____________ Facility: ______________

❑ Other diagnostic testing: ____

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

Pain Treatment History

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

❑ Chiropractic ❑ Physical Therapy ❑ 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

❑ Spine Surgery

❑ Trigger Point Injection – Where? ____

❑ Vertebroplasty / Kyphoplasty – Level(s) _____________________________________

❑ Other: ____

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

Anesthesia History

Have you ever had anesthesia (sedation for a surgical procedure)? ❑ Yes ❑No

If so, have you ever had any adverse reaction to anesthesia? ❑ Yes ❑No

Which type of anesthesia did you react adversely to? Please check all that apply.

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

Do you have a family history of adverse reactions to anesthesia? If so, to which of the following?

❑ Local anesthesia ❑ Epidural ❑ General anesthesia ❑ IV Sedation

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 Surgeries

- ❑ Caesarean section ____________________
- ❑ Hysterectomy ____________________
- ❑ Laparoscopy ____________________
- ❑ Ovarian ____________________
- ❑ Other ____________________

Heart Surgery

- ❑ Valve replacement ____________________
- ❑ Aneurysm repair ____________________
- ❑ Stent placement ____________________
- ❑ Other ____________________

Joint Surgery

- ❑ Shoulder ____________________
- ❑ Hip ____________________
- ❑ Knee ____________________

Spine / Back Surgery

- ❑ Discectomy (levels)____________________
- ❑ Laminectomy ____________________
- ❑ Spinal fusion (levels) ____________________

Other Common Surgeries

- ❑ Hemorrhoid surgery ____________________
- ❑ Hernia repair ____________________
- ❑ Thyroidectomy ____________________
- ❑ Tonsillectomy ____________________
- ❑ Vascular surgery ____________________

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

____

❑ **I HAVE NEVER HAD ANY SURGICAL PROCEDURES DONE**

Current Medications

Are you taking a prescribed **blood-thinner** medication? ❑Yes ❑No If yes, please check which one:

❑ Aggrenox ❑ Coumadin ❑ Effient ❑ Eliquis ❑ Lovenox ❑ Plavix ❑ Pletal ❑ Pradaxa
❑ Ticlid ❑ Warfarin ❑ Xarelto ❑ Other ____________________

Please list **ALL** medications you are currently taking. Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Allergies

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

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

Medication Name **Allergic Reaction Type**

____

____

____

____

Please check if you are allergic to ❑ Iodine or ❑ Tape Are you allergic to shellfish? ❑ Yes ❑ No

***Are you allergic to latex?** ❑Yes ❑No If yes, you will be asked to complete a separate questionnaire

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)**

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: ❑ Current Alcoholism ❑ Daily Limited Alcohol Use ❑ History of Alcoholism ❑ Never Drinks Alcohol ❑ Social Alcohol Use

Tobacco Use: ❑ Current Tobacco User ❑ Former Tobacco User ❑ Never Used Tobacco

Drug Use: ❑ Denies Any Illegal Drug Use ❑ Currently Using Illegal Drugs (Which: ____________)
❑ Currently Using Someone Else's Prescription Medications
❑ Formerly Used Illegal Drugs (not currently using) (Which: ____________)

Have you ever abused narcotic or prescription medications? ❑ Yes ❑No (Which: ____________)

Past Medical History

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

General Medical
- ❑ Cancer – Type ______________
- ❑ Diabetes – Type ____________
- ❑ HIV / AIDS

Head/Eyes/Ears/Nose/Throat
- ❑ Glaucoma
- ❑ Headaches
- ❑ Head Injury
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Migraines

Cardiovascular / Hematologic
- ❑ Anemia
- ❑ Bleeding Disorders
- ❑ Coronary Artery Disease
- ❑ Heart Attack
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Mitral Valve Prolapse
- ❑ Murmur
- ❑ Pacemaker/Defibrillator
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Stroke

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema / COPD
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Valley Fever

Gastrointestinal
- ❑ Bowel Incontinence
- ❑ Acid Reflux (GERD)
- ❑ 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)

Neuropsychological
- ❑ Alcohol Abuse
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Prescription Drug Abuse
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ Seizures
- ❑ Reflex Sympathetic Dystrophy/CRPS
- ❑ Other Diagnosed Conditions

____

Review of Systems

Mark the following symptoms that you currently suffer from. *Note: Diagnosed conditions/diseases should be noted under Past Medical History, above.*

Constitutional:
- ❑ Chills
- ❑ Difficulty Sleeping
- ❑ Easy Bruising
- ❑ Excessive Sweating
- ❑ Excessive Thirst
- ❑ Fatigue
- ❑ Fevers
- ❑ Insomnia
- ❑ Low Sex Drive
- ❑ Night Sweats
- ❑ Tremors
- ❑ Unexplained Weight Gain
- ❑ Unexplained Weight Loss
- ❑ Weakness

Eyes:
- ❑ Recent Visual Changes

Ears/Nose/Throat/Neck:
- ❑ Dental Problems
- ❑ Earaches
- ❑ Hearing Problems
- ❑ Nosebleeds
- ❑ Recurrent Sore Throats
- ❑ Ringing in the Ears
- ❑ Sinus Problems

Cardiovascular:
- ❑ Bleeding Disorder
- ❑ Chest Pain
- ❑ Deep Vein Thrombosis
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Lightheadedness
- ❑ Shortness of Breath During Sleep
- ❑ Swelling in the Feet

Respiratory:
- ❑ Cough
- ❑ Wheezing
- ❑ Pulmonary Embolism
- ❑ Shortness of Breath on Exertion/Effort
- ❑ Shortness of Breath at Rest

Gastrointestinal:
- ❑ Abdominal Cramps
- ❑ Acid Reflux
- ❑ Constipation
- ❑ Coffee Ground Appearance in Vomit
- ❑ Dark and Tarry Stools
- ❑ Diarrhea
- ❑ Hernia
- ❑ Vomiting

Musculoskeletal:
- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Stiffness
- ❑ Joint Swelling
- ❑ Muscle Spasms
- ❑ Neck Pain

Genitourinary/Nephrology:
- ❑ Blood in Urine
- ❑ Decreased Urine Flow/Frequency/Volume
- ❑ Erectile Dysfunction
- ❑ Flank Pain
- ❑ Painful Urination
- ❑ Pelvic Pressure

Neurological:
- ❑ Carpal Tunnel Syndrome
- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling
- ❑ Seizures
- ❑ Tremors

Psychiatric:
- ❑ Depressed Mood
- ❑ Feeling Anxious
- ❑ Stress Problems
- ❑ Suicidal Thoughts
- ❑ Suicidal Planning

Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Arizona Pain Specialists DBA Nevada Pain and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness. I give my consent for Arizona Pain Specialists DBA Nevada Pain to retrieve and review my medication history. I understand that this will become part of my medical record.

I acknowledge that I have had the opportunity to review Arizona Pain Specialists' Notice of Privacy Practices, which is displayed for public inspection at its facility and on its website. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Arizona Pain Specialists DBA Nevada Pain to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Arizona Pain Specialists DBA Nevada Pain to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Arizona Pain Specialists DBA Nevada Pain will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility and on its website.

In the event that I am asked to provide a urine, oral swab and/or blood sample, **I voluntarily seek laboratory services and hereby consent to provide a urine and/or blood sample as requested**. I have the right to refuse specific tests, but understand this may impact my pain management treatment. This agreement can be revoked by me at any time with written notification and is valid until revoked. I hereby assign to the Laboratory my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to the Laboratory. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for laboratory services and that I am financially responsible for all charges whether or not they are covered by my insurance. I also acknowledge that the Laboratory may be an out-of-network provider with my insurer. Payment in full is expected 30 days of being notified of any balance due. Please note that in the event that you fail to make payment when due, this account will be referred to a collection agency for collections. In that event, the contingency fee assessed by the collection agency will be added to the principal and interest due. You will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed:____ Date: ______________________