Patient Demographic Information

Patient Name: _____ Date of Birth: _____
Last Name First Name Initial

Gender: ☐Male ☐Female Single Married Divorced Widow Social Security Number: ___-___-___

Address: _____ City: _____ State: _____ Zip: _____

Preferred Phone: _____ ☐ Home ☐ Mobile ☐ Work

Secondary Phone: _____ ☐ Home ☐ Mobile ☐ Work

How would you like to receive appointment reminders: ☐ voicemail ☐ text message ☐ opt out of appt. confirm

Employer: _____

Primary Care Physician: _____ Phone: _____

Pharmacy: _____ Ph: _____
NAME ADDRESS OR MAIN CROSS STREETS

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Preferred language: _____ E-mail: _____

Ethnicity: (circle one) Hispanic/Latino Non-Hispanic/Non-Latino Refuse to report

Race: (circle one) American Indian Asian Black/African American White Hispanic Other_____ Refuse to report

INSURANCE INFORMATION

Primary Insurance Company: _____

ID/Subsciber# _____ Group#: _____

Complete this box if you are **NOT** the policy holder for this Insurance

Policy Holder Name: _____ Date of birth: _____

Social Security Number: _____ Relation to patient _____

Secondary Insurance Company: _____

ID/Subscriber #: _____ Group#: _____

Complete this box if you are **NOT** the policy holder for this Insurance

Policy Holder Name: _____ Date of birth: _____

Social Security Number: _____ Relation to patient _____

Workers Compensation Company: _____

Claim #: _____ Date of Injury: _____

Claim Adjuster's Name: _____ Phone: _____

ADVANCED PAIN MODALITIES

PRACTICE CODE OF CONDUCT

Reasons you may be discharged from our service:

- Rude or violent behavior to our staff via in-person or telephone – this also applies to your family members and/or friends.
- Repeated no shows, cancellations, or continual late arrivals of appointments
- Refusal to adhere to the plan of care as outlined by your clinician of to follow health insurance or government guidelines

Please read and Initial each of the following:

_____ **Co-Pay**: Your insurance may require a co-pay. It is your responsibility to know what your co-pay is. Payment will be collected at the time of service.

_____ **Cancellation Policy**: We require a 24-hour notice for cancellations. If you do not give 24-hour notice or No-Show for your appointment you will be charged a **$75.00** fee. Fee must be collected prior to making anymore appointments.

_____ **Insurance**: If you do not provide us with current insurance at the time of each visit, you will be responsible for the bill. You are responsible for obtaining the appropriate referral from your Primary Care Physician. If your insurance denies your claim for lack of referral, you are responsible and must pay for services rendered.

_____ **Return Check Fee**: $35.00 fee for each incident

Certification/Agreement/Assignment of Benefits:

I certify that the above information is accurate complete and true. I understand that this will become part of my medical record. I hereby assign all medical and surgical benefits and authorize my insurance carrier(s) to issue payment directly to the Practice. I understand that I am financially responsible for all services I receive from the Practice.

Printed Name:_____

Signed:_____ Date:_____

Patient or Guardian or Patient Representative

PATIENT NAME:_____ DATE:_____

CONSTITUTIONAL:

FATIGUE	Yes	No
LOSS OF APPETITE	Yes	No
WEAKNESS	Yes	No
WEIGHT LOSS/GAIN	Yes	No
TROUBLE SLEEPING	Yes	No

GENERAL:

SKIN RASH	Yes	No
COLOR CHANGES	Yes	No
HAIR/NAIL CHANGES	Yes	No

HEENT:

VISION LOSS/CHANGE	Yes	No
RINGING IN EARS	Yes	No
LOSS OF SMELL	Yes	No
TROUBLE SWALLOWING	Yes	No

CARDIOLOGY:

CHEST PAIN	Yes	No
IRREGULAR HEARTBEAT	Yes	No
SHORTNESS OF BREATH	Yes	No
DIZZINESS	Yes	No
COLD EXTREMITIES	Yes	No

RESPIRATORY:

COUGH	Yes	No
WHEEZING	Yes	No
PAINFUL BREATHING	Yes	No

GI:

CONSTIPATION	Yes	No
DIARRHEA	Yes	No
NAUSEA/VOMITING	Yes	No

HEMATOLOGICAL/LYMPH:

ABNORMAL BLEEDING	Yes	No
ABNORMAL BRUISING	Yes	No

PSYCHIATRIC:

ANXIETY	Yes	No
DEPRESSION	Yes	No
MEMORY LOSS	Yes	No

ENDOCRINOLOGY:

EXCESSIVE THIRST	Yes	No
FREQUENT URINATION	Yes	No
EXCESSIVE SWEATING	Yes	No
HEAT/COLD INTOLERANCE	Yes	No

MUSCULOSKELETAL:

JOINT PAIN/STIFFNESS	Yes	No
LEG CRAMPS	Yes	No
MUSCLE CRAMPS	Yes	No

NEUROLOGICAL:

HEADACHE	Yes	No
SEIZURES	Yes	No
TINGLING/NUMBNESS	Yes	No
LOSS OF FEELING IN LEGS	Yes	No

PAST MEDICAL HISTORY:

ASTHMA	Yes	No
COPD/EMPHYSEMA	Yes	No
SLEEP APNEA	Yes	No
DIABETES	Yes	No
HYPERTENSION	Yes	No
HIGH CHOLESTEROL	Yes	No
HEART DISEASE	Yes	No
LIVER DISEASE/HEPATITIS	Yes	No
EPILEPSY/SEIZURES	Yes	No
VASCULAR DISEASE	Yes	No
KIDNEY DISEASE	Yes	No
AIDS	Yes	No
STROKE/TIA	Yes	No
MIGRAINES	Yes	No
SHINGLES	Yes	No
TUBERCULOSIS	Yes	No
FIBROMYALGIA	Yes	No
ARTHRITIS	Yes	No
RHEUMATOID ARTHRITIS	Yes	No
CANCER	Yes	No
THYROID DISEASE	Yes	No

HISTORY AND PHYSICAL - FILL OUT COMPLETELY

Patient Name:_____ Today's Date:_____

Referring Physician/Provider: _____

Is your pain the result of an accident? ☐Yes ☐No How long have you had this pain? _____

Do you have a history of Depression? ☐Yes ☐No If Yes, are you being treated for it? ☐Yes ☐No

Height _____ Weight _____

Diagnostic Tests and Imaging:

- ☐ 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

Have you had any of the following for your current pain complaints?

- ☐ Chiropractic
- ☐ Physical therapy
- ☐ Massage therapy

Surgical History: List Procedure and Year or Circle **NONE**

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Family History: Check all boxes that apply

	STATUS	DIABETES	HIGH BLOOD PRESSURE	HEART DISEASE	STROKE	MENTAL DISEASE	CANCER	UNKNOWN OR NONE
MOTHER	☐ ALIVE ☐ DECEASED ☐ UNKNOWN							
FATHER	☐ ALIVE ☐ DECEASED ☐ UNKNOWN							

Allergies

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

If yes, list medication and reaction type: _____

_____

Patient Name: _____ Today's Date: _____

CURRENT MEDICATIONS:

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.		

Are you taking a prescribed blood-thinner medication? ☐Yes ☐No

If Yes please check which one:

- ☐ Aggrenox
- ☐ Coumadin
- ☐ Effient
- ☐ Pleta
- ☐ Pradaxa
- ☐ Ticlid
- ☐ Eliquis
- ☐ Lovenox
- ☐ Plavix
- ☐ Warfarin
- ☐ Xarelto
- ☐ Other _____

SOCIAL HISTORY:

Tobacco Use? Yes_____ No_____ If yes, How much? _____ How often? _____

Alcohol Use? Yes_____ No_____ If yes, How much? _____ How often? _____

Have you ever abused narcotic medication? Yes_____ No_____ If Yes, When? _____

Have you ever used illicit drugs? Yes_____ No_____ If Yes, When? _____

Are you pregnant? Yes_____ No_____

ADVANCE DIRECTIVES:

Do you have an advance directive? (Living Will, Power of Attorney or CPR Directive) Yes_____ No_____

Advanced Pain Modalities

ADVANCED PAIN MODALITIES OFFICE
3195 W RAY RD SUITE 1
CHANDLER AZ 85226-2417
Ph: 480-756-6789 Fax:480-246-8902

OPIOID Risk Tool (2018 Edition)

Name: _____ **Date:** _____

FAMILY HISTORY OF SUBSTANCE ABUSE
Check only those boxes that apply

Family Hx Alcohol?	☐ Yes	☐ No
Family Hx Illegal Drugs?	☐ Yes	☐ No
Family Hx Rx Drugs?	☐ Yes	☐ No

PERSONAL HISTORY OF SUBSTANCE ABUSE
Check only those boxes that apply

Personal Hx Alcohol?	☐ Yes	☐ No
Personal Hx Illegal Drugs?	☐ Yes	☐ No
Personal Hx Rx Drugs?	☐ Yes	☐ No
Age between 16-45 years?	☐ Yes	☐ No
History of Preadolescent Sexual Abuse?	☐ Yes	☐ No

PSYCHOLOGIC DISEASE
Check only those boxes that apply

ADD, OCD, Bipolar, Schizophrenia?	☐ Yes	☐ No
Depression?	☐ Yes	☐ No

Source: Adapted from materials prepared by:Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk tool. Pain Med. 2005:6(6):432
Powered By eClinicalWorks LLC.

PATIENT NAME:_____ DATE:_____

PAIN DESCRIPTION: (circle all that apply today)

Describe your pain: 0 1 2 3 4 5 6 7 8 9 10

*Throbbing *Aching *Shooting *Tiring/Exhausting *Stabbing *Pinpoint *Sharp *Intermittent *Hot/Burning

*Diffuse *Continuous *Numbness

The Pain Occurs:

*Constantly *Daily *Frequently *Intermittently *Occasionally

The Pain Is Located:

*In the calf *Shoulder *Chest wall *Lower Back *Knee *In the Hand *In the Neck *In the hips *Foot *Ankle

The Pain Radiates:

*Down Leg(s) *Down Shoulder(s) *Down Buttock(s) *Down Hip(s) *Down Back *To Chest Wall *Into Fingertips

*Into Toes *Down Neck *Does Not Radiate

What Makes It Worse:

*Sitting *Weight Bearing *Standing *Rising from sitting *Bending Forward *Bending Backward *Any Movement

*Walking *Climbing Stairs *Deep Breathing *Lying on Back *Lying on Stomach *Driving *Long periods of sitting

*Coughing/Sneezing *Lifting Objects

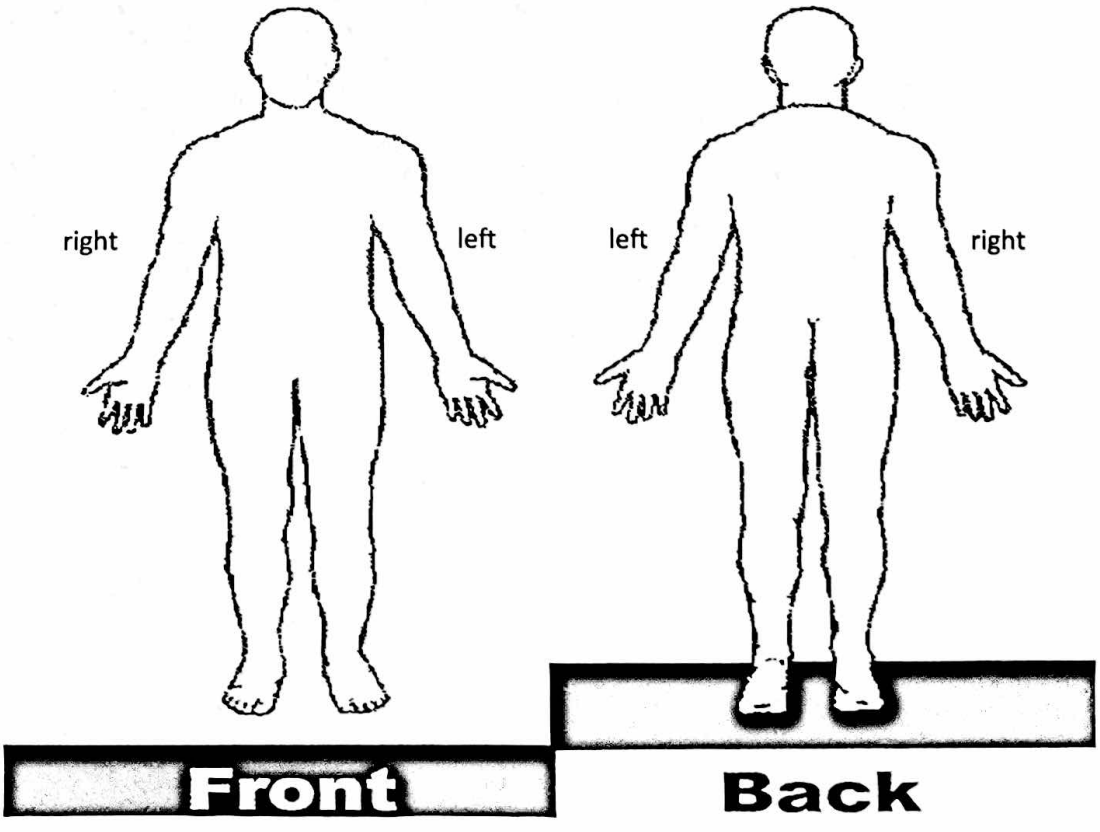
What Makes It Better:

*Sitting *Weight Bearing *Standing *Rising from Sitting *Bending Forward *Bending Backward *Any Movement

*Walking *Climbing Stairs *Deep Breathing *Lying on Back *Lying on Stomach *Driving *Long periods of sitting

*Coughing/Sneezing *Lifting Objects

Use this diagram to indicate the location of your pain



Advanced Pain Modalities (APM)

3195 W. Ray Rd. Suite 1, Chandler, AZ 85226 (480)756-6789

Pain Treatment Agreement

Patient Name: _____ Date of birth: _____

At APM if the provider finds it appropriate to prescribe any controlled substance, we ask that all our patients adhere to the following policy.

1. I will be required to follow up with an office appointment every month while on this contract. If I fail to follow-up, I will immediately be discharged from this contract unless I make arrangements with this pain physician. I must bring a complete medication list of all medications & dosages currently taking.

2. I will know at all times how much medication I have remaining.
   Refill requests will be called in 3-5 working days before running out.
   NO refill requests will be processed on Friday or if received after 1400 (2:00 PM) on Thursday.

3. I understand that medications that "run out" over weekends or holidays will **NOT** be replaced until a regular working day.

4. I understand it is my responsibility to safeguard my medications. Should they be lost, stolen, destroyed or if they are used up early, the medication(s) will under no circumstances be refilled.

5. I understand that allowing others to use my medications or using medications not prescribed to me, will result in termination of care.

6. I agree not to sale, lend or in any way give my medication to any other person.

7. I understand that narcotic medication, as well as some other medications such as Soma (muscle relaxants), diazepam (Valium) or Clonazepam (Klonopin) can be habit-forming and may result in dependency or addiction.

8. I understand that stopping these medications abruptly may cause dangerous withdrawal symptoms including seizures. I have been informed not to stop any controlled pain medications suddenly unless directed by a pain management provider.

9. I understand that these medications may cloud my judgment and adversely affect my ability to react. Therefore, my ability to make important decisions, to operate machinery, or perform similar activities may be depressed. Neuropsychiatric testing may be requested to help assess any functional impairment I may have.

10. I have been informed by my provider and I understand that I am not allowed to drive an automobile while taking narcotics or narcotic analgesics (opioids).

11. I will cooperate with interventions to decrease narcotic requirements including psychological modalities, physical therapy and/or invasive procedures.

12. I understand I may be subjected to random urine drug tests to verify compliance with medications and to check for illicit drug use. I understand I may have to assume part or all of the cost of said testing.

13. I understand that use of any illegal drugs, as verified by urine analysis, or improper use of prescribed medications are grounds for termination of care.

14. I understand that failure to obtain urine analysis within 24 hours of original request constitutes grounds for immediate discharge from the service.

15. I agree not to drink alcohol or use other mood-altering drugs while I am taking controlled pain medications.

16. If I am seen at any medical facility (i.e. urgent care clinic or emergency room), and given narcotics, I will inform my pain physician and bring him the discharge documents.

17. I understand that I can receive narcotic analgesics from other physicians for emergencies including dental, surgery and trauma. I will notify my pain provider of these situations and medications ASAP.

18. If an Arizona pharmacy report shows any other unauthorized prescriptions, I know I will be discharged from this contract.

19. If this pain provider feels that I am addicted to narcotics, I agree to see an addictionologist to undergo detoxification. My pain provider agrees to refer me to a physician if needed.

20. This contract can be terminated at any time by the patient or provider. A list of addictionologists will be available for me to use to come off the medication safely.

21. **I understand that failure to follow any of these guidelines may result in termination of care.**

- ✓ Please list name & phone number(s) of Primary care Physician and all other physicians

_____

- ✓ Please list the one pharmacy to be used (include cross streets and phone number):

_____

Patient's signature_____ Date_____

APM Provider's signature_____ Date_____

Patient label placed here (if applicable) or if labels are not used, minimum information below is required.
Name *(last, first)*
Birthdate *(yyyy-Mon-dd)*

Patient Health Questionnaire (PHQ-2 & PHQ-9)

PHQ 2

1. During the **past two weeks**, have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

2. During the **past two weeks**, have you often been bothered by feeling down, depressed or hopeless? ☐ Yes ☐ No

If the answer to both questions is No, the screen is negative for depression *(re-screen if indicated)*. If yes was selected for one or both questions, please consult appropriate discipline to complete the PHQ-9.

Date *(yyyy-Mon-dd)*	Signature

PHQ 9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use ✓ to indicate your answer)*	**Not at all** (score = 0)	**Several days** (score = 1)	**More than half the days** (score = 2)	**Nearly every day** (score = 3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling asleep, or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
TOTAL	0 +	+	+	+
TOTAL SCORE				

If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

PHQ-9 Score	**Meaning / Action**
Less than 5	Patient not likely depressed, re-screen if affect changes. Communicate results to the team and to any referral sites.
Between 5-9	Watchful waiting - patient to be closely monitored and re-screened if needed. Communicate results to the team and any referral sites.
Greater than 9	Patient has screened positive and requires further assessment by a certified professional for diagnosis and treatment. Notify attending, consider consulting psychiatry or psychology. Communicate results to the team and any referral sites.

http://phqscreeners.com/pdfs/02_PHQ-9/English.pdf

Date *(yyyy-Mon-dd)*	Signature