805 E. Warner Rd., #102
Phone: 480.782.1763
Fax: 480.732.9868

1) Patient Name ____ SS# _________-_____-_________

2) D.O.B. ______ /______ /_______ Sex M / F Marital Status M / S / D / W No. of Children _____

3) Home Phone (______) _________ - ______________ Cell Phone (______) ________ - ______________

4) Address ____ Apt # ___________

City ____ State ________ Zip ________________

5) Employer ______________________________ Address ____

Occupation ______________________________ Bus. Phone (_______) _________ - _____________

Length of Employment ______________________

6) Health Insurance Company ____

Group Name ______________________________ Secondary Insurance ________________________

7) Insured's Name ____________________________________ Employer ____________________________

SS# ___________ - ________ - _______________ D.O.B. _________ / _________ / ___________

8) Employer's Address__________________________________ Bus. Phone (_____) ________ - __________

9) In case of emergency, name of relative or friend NOT living with you (different address):

Name ____ Phone (_____) ________ - __________

I understand that if I am accepted as a patient by the physicians of East Valley Pain Solutions, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risks regarding pain management treatment will be explained to me upon my request.

I authorize my insurance company/attorney to pay directly and/or lien to East Valley Pain Solutions any and all monies due to them on my account. A Photostat copy of this statement shall be considered as valid as the original.

Signature of Patient or Guardian ____ Date _________

East Valley Pain Solutions

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Name ____ **Date** ____________________

Referred by ______________________________ **Primary Care Doctor** ______________________________

Reason for today's visit ____

Location of pain____

If pain radiates, to where?____

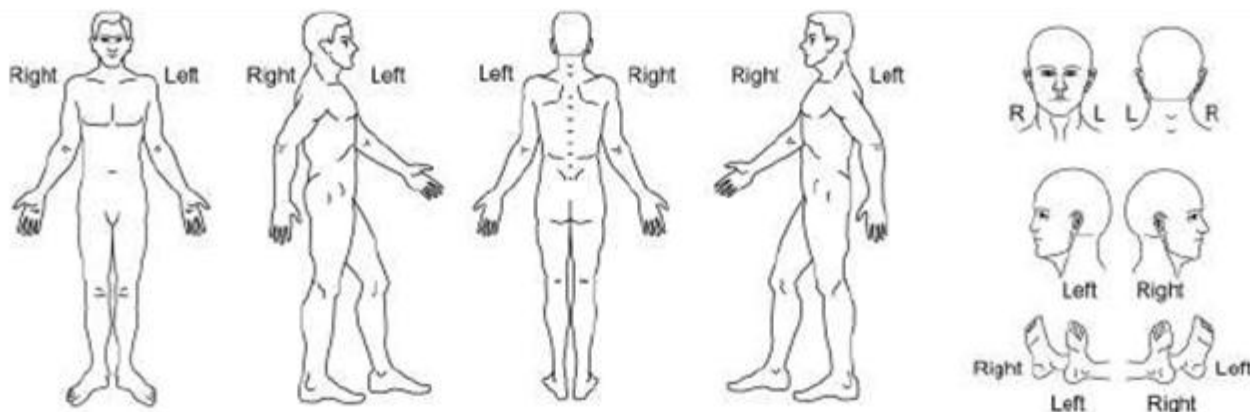
When did the pain start?__________________________**Was it gradual or sudden?**__________________________

How would you rate the pain from 0-10?_____________**What % of your day do you feel the pain?**_____________

What aggravates the pain?_________________________**What relieves the pain?**_____________________________

Does your primary pain make you have pain in other locations?_______**Where?**______________________________

Please mark where your pain is -



SOCIAL HISTORY

Marital Status	**M D S W**	
Are you pregnant?	**Yes / No**	
Education: last grade completed	**9 / 10 / 11 / 12 Some college Associates Degree Bachelors Degree Graduates Degree**	
Any legal actions related to a pain condition	**Yes / No**	**Explain:**
Are you working?	**Yes / No**	**Occupation:**
Are you disabled?	**Yes / No**	**Reason:**

			If applicable, amount?
Do you smoke?	**Yes / No**	**Cigarettes / Cigars / Chew**	**Per Day:**
Do you drink alcohol?	**Yes / No**	**Beer / Wine / Liquor**	**Per Week:**
Do you drink caffeinated beverages?	**Yes / No**		**Per Day:**
Any present illicit drug use?	**Yes / No**	**Marijuana / Cocaine / Heroin / Illicit Rx. / Other**	
Any past illicit drug use?	**Yes / No**	**Marijuana / Cocaine / Heroin / Illicit Rx. / Other**	
Do you exercise?	**Yes / No**		**Per Week:**

MEDICATION AND ALLERGIES

Please list **all** current medications:

Medication / Strength	Dosage / Frequency	Medication / Strength	Dosage / Frequency

Please list **all allergies** below: Include medications, latex, tape, eggs, shellfish, IV contrast, iodine, etc.

☑ Check which reactions you've had.

Allergy	Nausea/Vomiting	Rash	Difficulty Breathing	Other

SOCIAL HISTORY

Marital Status	**M D S W**	
Are you pregnant?	**Yes / No**	
Education: last grade completed	**9 / 10 / 11 / 12 Some college Associates Degree Bachelors Degree Graduates Degree**	
Any legal actions related to a pain condition	**Yes / No**	**Explain:**
Are you working?	**Yes / No**	**Occupation:**
Are you disabled?	**Yes / No**	**Reason:**
What are your hobbies?		

			If applicable, amount?
Do you smoke?	**Yes / No**	**Cigarettes / Cigars / Chew**	**Per Day:**
Do you drink alcohol?	**Yes / No**	**Beer / Wine / Liquor**	**Per Week:**
Do you drink caffeinated beverages?	**Yes / No**		**Per Day:**
Any present illicit drug use?	**Yes / No**	**Marijuana / Cocaine / Heroin / Illicit Rx. / Other**	
Any past illicit drug use?	**Yes / No**	**Marijuana / Cocaine / Heroin / Illicit Rx. / Other**	
Have you ever had an eating disorde	**Yes / No**	**When?**	
Do you exercise?	**Yes / No**		**Per Week:**

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MEDICAL AND SURGICAL HISTORY

Please list **all** past surgery/operations**:**

Operation	Year	Operation	Year

ILLNESSES

Please check ☑ **any** of the following that you are currently experiencing.

	Night Sweats		**Abnormal Thirst**		**Chronic Bronchitis**
	Fever		**Weak Urine Stream**		**Pneumonia**
	Chills		**Difficulty Urinating**		**Tuberculosis**
	Fatigue		**Black Stool**		**Muscle/Joint Disease**
	Chronic Cough		**Heart Murmur**		**Diabetes**
	Palpitations		**Rheumatic Fever**		**Hepatitis**
	Light Headedness		**Heart Attack**		**Urinary Infection**
	Swelling of Limbs		**High Blood Pressure**		**Depression**
	Bleeding		**Blood Transfusion**		**Seizures/Convulsions**
	Dizziness		**Bleeding Disorder**		**Eating Disorders**
	Tremors		**Anemia**		**Anxiety/Panic Disorder**
	Headaches		**Stroke**		**Other Psychiatric Disease**
	Rashes		**Parkinson's Disease**		**Serious Injury**
	Chest Pain		**Dementia**		**Cancer**
	Shortness of Breath		**Emphysema**		**Sexually Transmitted Disease**
	Heartburn		**Asthma**		**HIV/AIDS**
	Other:				

FAMILY HISTORY

Family History (blood relatives): Please check ☑ **all** that apply.

	Father	Mother	Siblings	Children	Other Relatives	Spouse/Significant Other
Age at Death						
Cause of Death						
Heart Disease/Stroke						
High Blood Pressure						
Diabetes						
Cancer						
Epilepsy						
Nervous Breakdown						
Asthma/Hives/Hay Fever						
Blood Disease						
Chronic Pain						
Other						

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Please list any diagnostic tests, x-rays, etc. you have had.

TEST	X-RAY	CT SCAN	MRI SCAN	EMG	OTHER
WHEN					
WHERE					

____

____

____

What other providers have you seen for pain? (Please include other pain care clinics, specialists, and primary providers.)

____

____

____

What other types of treatments have you tried and were they effective? (Please include therapies and injections.)

____

____

____