New Patient Paperwork

Colorado Pain Care
Got Pain? Get Relief!

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. If you have any questions or are unsure about how to complete any section of this form, inquire at our front desk or call 303-277-0700.

Patient Information

Your Name _____ Today's Date _____

Driver's License #/State _____ Social Security Number: _____

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: _____

Phone: _____ Relationship: _____

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 _____

Referral

Who is your Primary Care Provider? _____

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.coloradopaincare.com ❑ Facebook ❑ Twitter ❑ YouTube ❑ Other Website _____

Social Status

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

Preferred Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Street Address: _____ City/State/Zip: _____

Do you have a Prescription Drug ID card? ❑Yes ❑No Member ID # _____

RX Bin # _____ RX Group # _____

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

Secondary Insurance Plan (if any)

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

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

Date of Birth: _____ Social Security Number: _____

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: _____

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

Workers Compensation Claim Information

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? ❑ Yes ❑No

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

Patient Signature: _____ Date: _____

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CLINICAL INFORMATION

Today's Date _____

Your Name: _____ **Height:** _____ **Weight**: _____ lbs

Onset of Symptoms

Where is your worst area of pain located, please list one area? What is the main reason for today's visit?

_____

Does the pain radiate?, if yes, where? _____

Please list additional areas of pain _____

Approximately when did this pain begin? _____

What caused your current and/or chronic pain episode? _____

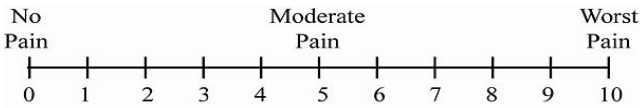
_____

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

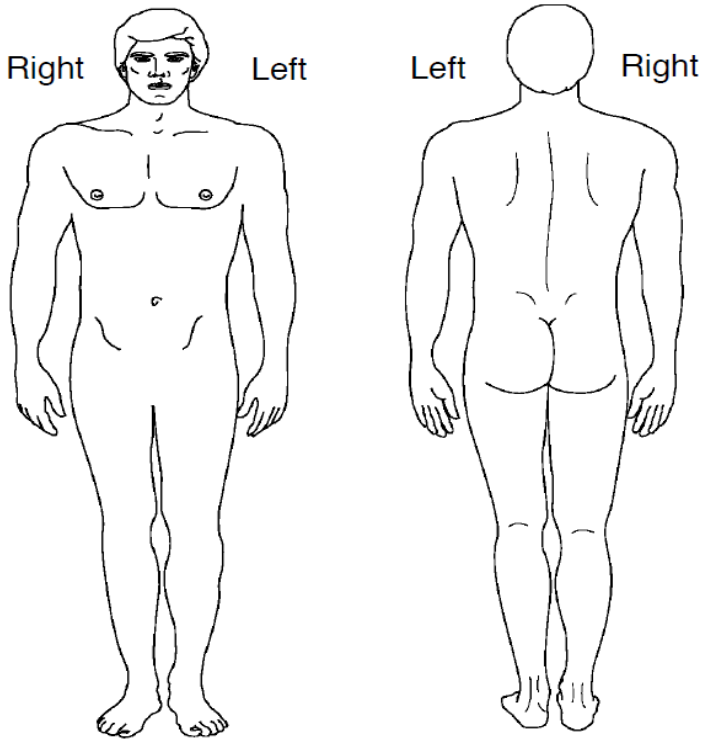
Since your pain began, how has it changed? ❑ Decreased ❑ Increased ❑ Stayed the same

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



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



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

❑ Aching ❑ Numbness ❑ Spasming ❑ Throbbing

❑ Cramping ❑ Shock-like ❑ Squeezing ❑ Tingling/Pins & Needles
❑ Hot/Burning ❑ Shooting ❑ Stabbing/Sharp/Dull ❑ Tiring/Exhausting

Pain Frequency

What word best describes the frequency of your pain? ❑ Constant ❑ Intermittent

When is the pain at its worst? ❑ Mornings ❑ During the day ❑ Evenings ❑ Middle of the night

In the past three months have you developed any new:

❑ Balance Problems ❑ Bladder incontinence ❑ Bowel incontinence ❑ Chills
❑ Difficulty Walking ❑ Fevers ❑ Nausea ❑ Vomiting
❑ Numbness/Tingling? Please list where _____
❑ Weakness? Please list where _____

❑ 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 symptoms:

❑ 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 any of the following pain treatments you have undergone **prior** to today's visit:

❑ Chiropractic ❑ Physical Therapy ❑ Spine Surgery ❑ Psychological Therapy
❑ Epidural Steroid Injection: check all levels that apply ❑ Cervical ❑ Thoracic ❑ Lumbar
❑ Medial Branch Blocks or Facet Injections: check all levels that apply ❑ Cervical ❑ Thoracic ❑ Lumbar
❑ Radiofrequency Ablation: check all levels that apply ❑ Cervical ❑ Thoracic ❑ Lumbar
❑ Spinal Column Stimulator: check one ❑ Trial Only ❑ Permanent Implant
❑ Trigger Point Injections, where _____
❑ Other Treatments : _____

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

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 _____

Who prescribes your blood thinner medication? Doctor's name and phone number:

_____

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.		

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 _____

Female Surgeries
❑ Caesarean section _____
❑ Hysterectomy _____
❑ Laparoscopy _____
❑ Ovarian _____

Heart Surgery
❑ Valve replacement _____
❑ Aneurysm repair _____
❑ Stent placement _____

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**

Environmental Allergies

Are allergic to ❑ Iodine or ❑ Tape

Latex Allergy

Are you allergic to latex? ❑ Yes ❑ No

If yes: Do you require special medications or rescue measures to manage your latex allergy ❑ Yes ❑ No

Food Allergies

Are you allergic to shellfish? ❑ Yes ❑ No

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)**

Drug Allergies

Do you have any allergies or reactions to medications? ❑ Yes ❑No

If yes, please list all medications you are allergic to and the reaction you have:

Medication Name	**Allergic Reaction Type**

Past Medical History /Problem List

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

General Medical
- ❑ Cancer – Type ___
- ❑ Diabetes – Type ____
- ❑ HIV / AIDS

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

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

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

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

Musculoskeletal
- ❑ Amputation
- ❑ Bursitis
- ❑ Carpal Tunnel Syndrome
- ❑ Fibromyalgia
- ❑ Joint Injury
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Phantom Limb Pain
- ❑ Rheumatoid arthritis
- ❑ Vertebral Compression Fracture

Genitourinary/Nephrology
- ❑ Bladder Infection(s)
- ❑ Dialysis
- ❑ Kidney Infection(s)
- ❑ Kidney Stones
- ❑ Urinary Incontinence

Hepatic
- ❑ Hepatitis A – circle one
  active inactive unsure
- ❑ Hepatitis B – circle one
  active inactive unsure
- ❑ Hepatitis C – circle one
  active inactive unsure

Neuropsychological
- ❑ Alzheimer Disease
- ❑ Bipolar Disorder
- ❑ Depression
- ❑ Epilepsy
- ❑ Multiple Sclerosis
- ❑ Paralysis
- ❑ Peripheral Neuropathy
- ❑ Schizophrenia
- ❑ CRPS/Reflex Sympathetic Dystrophy

❑ **Other Diagnosed Conditions:**

_____

_____

_____

_____

_____

_____

Immunization History

Have you received a pneumonia vaccination? ❑ Yes ❑No If **yes**, when? _____

Social History

Are you capable of becoming pregnant? ❑ Yes ❑No If yes, are you currently pregnant? ❑ Yes ❑No

Highest level of education obtained: ❑ Grammar school ❑ High School ❑ College ❑ Post-graduate

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

Tobacco Use:
- ❑ Current Smoker/Tobacco User
- ❑ Former Smoker/Tobacco User

❑ Social Alcohol Use ❑ Never Smoked or Used Tobacco

Social History Continued:

Drug Use:

❑ Denies Any Illegal Drug Use

❑ Currently Using Illegal Drugs, list: _____

❑ Currently Using Someone Else's Prescription Medications, list _____

❑ Formerly Used Illegal Drugs (not currently using); list _____

_____

Have you ever abused narcotic or prescription medications? ❑ Yes ❑No Which ones: _____

_____

Are you working? ❑ Yes ❑ No ❑ Student ❑ Retired Are you on disability? ❑ Yes ❑ No

Activity

Do you exercise? ❑ Yes ❑ No If yes, how many days per week? _____

What type of exercise do you perform? ❑ Bicycle ❑ Cardio ❑ Strength ❑ Swimming ❑ Walking

Other _____

How much time do you exercise on the days that you do exercise? _____

Have you had two or more falls in the past year? ❑ Yes ❑ No

Global Pain Scale

INSTRUCTIONS: For each question, please indicate your response by circling a number from 0 to 10. Please answer all questions

YOUR PAIN:	**0 = No Pain**										**10 = Extreme Pain**
During the *past week,* the **best** my pain has been is.....	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, the **worst** my pain has been is	0	1	2	3	4	5	6	7	8	9	10
During the *past week*, my **average** pain has been.....	0	1	2	3	4	5	6	7	8	9	10
During the *past 3 months*, my **average** pain has been.....	0	1	2	3	4	5	6	7	8	9	10

YOUR FEELINGS: During the past week I have felt:	**0 = Strongly Disagree**										**10 = Strongly Agree**
Afraid.....	0	1	2	3	4	5	6	7	8	9	10
Depressed	0	1	2	3	4	5	6	7	8	9	10
Tired	0	1	2	3	4	5	6	7	8	9	10

Anxious 0 1 2 3 4 5 6 7 8 9 10

Stressed..... 0 1 2 3 4 5 6 7 8 9 10

YOUR CLINICAL OUTCOMES: During the past week: 0 = Strongly Disagree 10 = Strongly Agree

I had trouble sleeping 0 1 2 3 4 5 6 7 8 9 10

I had trouble feeling comfortable 0 1 2 3 4 5 6 7 8 9 10

I was less independent 0 1 2 3 4 5 6 7 8 9 10

I was unable to work (or perform normal tasks)..... 0 1 2 3 4 5 6 7 8 9 10

I needed to take more medication..... 0 1 2 3 4 5 6 7 8 9 10

YOUR ACTIVITIES: During the past week I was NOT able to: 0 = Strongly Disagree 10 = Strongly Agree

Go to the store 0 1 2 3 4 5 6 7 8 9 10

Do chores in my home..... 0 1 2 3 4 5 6 7 8 9 10

Enjoy my friends and family 0 1 2 3 4 5 6 7 8 9 10

Exercise (including walking)..... 0 1 2 3 4 5 6 7 8 9 10

Participate in my favorite hobbies..... 0 1 2 3 4 5 6 7 8 9 10

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
- ❑ Easy Bruising
- ❑ Excessive Sweating
- ❑ Excessive Thirst
- ❑ Fatigue
- ❑ Fevers
- ❑ Fevers
- ❑ Low Sex Drive
- ❑ Night Sweats
- ❑ Unexplained Weight Gain
- ❑ Unexplained Weight Loss
- ❑ Weakness

Cardiovascular/Respiratory:

- ❑ Chest Pain
- ❑ Cough
- ❑ Fainting
- ❑ High Blood Pressure
- ❑ High Blood Pressure
- ❑ Irregular Heartbeat
- ❑ Lightheadedness
- ❑ Shortness of Breath During Exertion
- ❑ Shortness of Breath During Rest
- ❑ Swelling in the Feet
- ❑ Wheezing

Gastrointestinal:

- ❑ Abdominal Cramps
- ❑ Acid Reflux
- ❑ Constipation
- ❑ Coffee Ground Appearance in Vomit

Genitourinary/Nephrology:

- ❑ Blood in Urine
- ❑ Decreased Urine in Flow, Frequency or Volume
- ❑ Erectile Dysfunction
- ❑ Flank Pain
- ❑ Painful Urination
- ❑ Pelvic Pressure
- ❑ Pelvic Pressure

Musculoskeletal:

- ❑ Back Pain
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Muscle Spasms
- ❑ Neck Pain

Neurological:

- ❑ Dizziness
- ❑ Headaches
- ❑ Instability When Walking
- ❑ Numbness/Tingling

❑ Dark and Tarry Stools
❑ Diarrhea
❑ Hernia
❑ Vomiting

❑ Seizures

Psychiatric:
❑ Anxiety/Stress
❑ Depressed Mood
❑ Suicidal Thoughts
❑ Suicidal Planning

Eyes:
❑ Recent Visual Changes

Ears/Nose/Throat/Neck:
❑ Difficulty Hearing
❑ Earaches
❑ Hay fever/Allergies
❑
Nosebleeds

❑
Nosebleeds
❑ Recurrent Sore Throats
❑ Ringing in the Ears
❑ Sinus Problems

Medical History and Consent for Treatment

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

I authorize Colorado Pain Care 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 Colorado 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 Colorado Pain Care's 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 Colorado Pain Care 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 Colorado Pain Care to release any information required in obtaining procedure authorization or the processing of any insurance claims.

I understand that Colorado Pain Care 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.

I agree to conduct myself (and my guests will conduct themselves) at all times in an honest, respectful and non-combative manner in all communications and interactions with CPC staff, patients, and visitors. I will refrain from inappropriate, discriminatory, harassing, threatening, or abusive language or behavior. I agree to report to my Providers and CPC staff, accurate and complete information, to the best of my knowledge, all relevant matters pertaining to my health, including my use, misuse, or abuse of medications, controlled substances, drugs or alcohol.

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. I understand that in the event that I 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. And I will be additionally liable for attorney fees. Both collection agency fees and attorney fees will increase the balance you owe.

Signed:_____ Date: _____