Arrowhead Physical Medicine
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New Patient Paperwork

First Name: ________________________________ Last Name: ____

Date of Birth: ______________________________ Phone Number:_____________________________________

Primary Address: ____ City: _____________________

State: ___________ Zip Code: ________________

Secondary Address: ____ City: _____________________

State: ___________ Zip Code: ________________ Email: ____

Marital Status: ____

Travel Plans (Snowbird? Traveling for extended period in next couples weeks/months?):

____

How did you hear about us? *(Newspaper Ad, Facebook, Instagram, TV ad, mutual patient, other-please specify)*

____

What brings you in today?

____

____

When did this initially start?

____

Has the pain recently returned or gotten worse? If so, how long ago did this occur?

____

Any known traumas, slip/falls, or surgeries in the past?: yes/no, *(If yes, please specify including approximate date)*

____

Where is your pain? Is it only one-sided or do both sides of the specific area bother you? *(for example: left low back pain vs left and right mid back pain)*

____

Do you have any loss of function such as stumbling/holding walls or furniture, dropping items, or frequent falls? Any weakness or history of paralysis (complete or partial loss of muscle function)-*please specify*

____

____

____

Do you have any bowel or bladder incontinence? (loss of bowel/bladder control, inability to control these functions)-*please specify*

____

____

What previous work-up have you had? (Primary Care Physician, Neurologist, Rheumatologist, Orthopedic Specialist, Chiropractic, Podiatrist, etc.) –*please specify type of provider you have seen in past and their name and location, in sections below*

1) Name of Provider: ________________________________

Type of Provider/Specialty: ___________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

2) Name of Provider: ________________________________

Type of Provider/Specialty: ___________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

Previous work-up continued (if applicable):

3) Name of Provider: ________________________________

Type of Provider/Specialty: ___________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

4) Name of Provider: ______________________________

Type of Provider/Specialty: _________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

5) Name of Provider: ______________________________

Type of Provider/Specialty: _________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

Do you have any current providers under your care? (Primary Care Physician, Neurosurgeon, Neurologist, Pain Management Specialist, Chiropractor, Physical Therapist, Massage Therapist, Podiatrist, Rheumatologist, Orthopedic Specialist, Endocrinologist, Cardiologist, etc.) –*please specify type of provider you have seen in past and their name and location, in sections below*

1) Name of Provider: ________________________________

Type of Provider/Specialty: ___________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

2) Name of Provider: ________________________________

Type of Provider/Specialty: ___________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

3) Name of Provider: ________________________________

Type of Provider/Specialty: ___________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

4) Name of Provider: ________________________________

Type of Provider/Specialty: ___________________________

Location (City, State and/or office name): ____

Phone Number of Provider: ____

DIAGNOSTIC TESTS:

What diagnostic tests or lab work have you had in the past? *(X-Rays, CT Scan, MRI, Ultrasound, specific blood work, EMG/NCS, etc.)-please specify including region of are imaged if you have had imaging as well as approximate date this was performed and what doctor had ordered this. Please also include name/location of imaging center if known. Use lines below for each that apply.*

X-RAY IMAGING:

X-Ray: Yes/No, If Yes, what area? (neck, mid back, low back, hips, knees, wrists/hands, feet/ankles, etc.-please specify

____, Date: _____________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: _______________________

____

X-Ray: Yes/No, If Yes, what area? (neck, mid back, low back, hips, knees, wrists/hands, feet/ankles, etc.-please specify

____, Date: _____________________

MRI IMAGING:

MRI: Yes/No, If Yes, what area? (neck, mid back, low back, hips, knees, wrists/hands, feet/ankles, etc.-please specify

____, Date: _______________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: _________________________

____

MRI: Yes/No, If Yes, what area? (neck, mid back, low back, hips, knees, wrists/hands, feet/ankles, etc.-please specify

____, Date: _______________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: _________________________

____

CT IMAGING:

CT: Yes/No, If Yes, what area? (neck, mid back, low back, hips, knees, wrists/hands, feet/ankles, etc.-please specify

____, Date: ___________________________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: _____________________________________

____

CT: Yes/No, If Yes, what area? (neck, mid back, low back, hips, knees, wrists/hands, feet/ankles, etc.-please specify

____, Date: ___________________________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: _____________________________________

____

EMG/NCS (Electromyography/Nerve Conduction Study)

EMG/NCS: Yes/No, If Yes, what area? (Arms, legs, etc.-please specify)

____, Date: __________________________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: ____________________________________

____

EMG/NCS: Yes/No, If Yes, what area? (Arms, legs, etc.-please specify)

____, Date: __________________________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: ____________________________________

____

Blood Work/Other *(specify below)*

____, Date: __________________________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: ____________________________________

Blood Work/Other *(specify below)*

____, Date: ________________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: ________________________

____

Blood Work/Other *(specify below, if applicable)*

____, Date: ________________________

Ordering Medical Provider and/or Imaging Center where you had this performed at: ________________________

Motor Symptoms:

Do you have any of the following? If so, please specify where:

Condition	Yes	No	Specific location
Weakness			
Paralysis			
Foot Drop			
Arm Swing			
Hand Grip			
Contractures			

Autonomic Symptoms:

Do you have any of the following?

Condition	Yes	No
Orthostatic Hypotension		
Low Blood Pressure:		
Dizziness		
Vertigo:		
GI (stomach) problems:		

For Neuropathy Patients Only:

Do you know the cause of your neuropathy? If so, please check yes/no next to which apply:

Condition	Yes	No
Unknown (Idiopathic)		
Traumatic		
Nutritional		
Infectious		
Toxic		
Chemical		
Autoimmune		
Entrapment Syndrome		
Surgical		
Diabetes		

What treatments have you tried that did not work? (*Gabapentin, Lyrica, Cymbalta, Over-the-counter medications, injections, etc.-please specify)*:

____

____

____

What treatment have you tried in the past that has worked the best for you? *(please specify)*

____

____

____

What makes your pain better? *(rest, sitting, ice/heat, over-the-counter medication such as Tylenol or Advil, prescription medication, etc.-please specify)*

____

____

____

What makes your pain worse? *(lifting, bending, standing, etc.-please specify)*

____

____

____

Have you tried TEN's (transcutaneous electrical nerve stimulation) therapy in the past? Yes/No *(please circle)*

Have you tried injection therapy in the past? (cortisone injectons, epidurals, facet injections, homeopathic injections, PRP, prolotherapy, etc.) Yes/No (please circle) If yes, please specify.

Type of injection & area of body injected: ____Date: ______________

Type of injection & area of body injected: ____Date: ______________

Type of injection & area of body injected: ____Date: ______________

Type of injection & area of body injected: ____Date: ______________

On a scale of 1-10, 1 = minimal pain, 10 = hospital bound, worst pain of life, please rate your pain:

Today: _____________________, At its worst: _____________________,

If the following apply to you, please rate the following symptoms on a scale of 1-10, 1= minimal, 10 = the worst
Numbness: ________________________, N/A
Tingling: ________________________, N/A
Burning: ________________________, N/A
Tightness: ________________________, N/A

Do you have any sleep issues? (Insomnia, Restless Leg Syndrome, Periodic Limb Movement Syndrome, Excessive Daytime Sleepiness, etc.) Yes/No (please circle)

If yes, please specify condition: ____

____

If yes, is this treated with medication? Yes/No (please circle) specify medication: ________________________

____

If treated with medication, are these sleep issues controlled? Yes/No (please circle)

Do you have any psychiatric conditions, such as Depression, Anxiety, Post-Traumatic Stress Disorder, Bipolar I/II, etc.) Yes/No (please circle)

If yes, specify condition: ____

____

If yes, is this treated with medication? Yes/No (please circle) specify medication: ________________________

____

If treated with medication, is this condition controlled? Yes/No (please circle)

Medications: *(please list all medications and supplements you take, dosage, and frequency)*
Example: Lisinopril 5mg 1 tab twice/day

Medication Name	Dosage	Frequency

Past Medical History: (*please check in appropriate boxes)*

Condition	Yes	No	Condition	Yes	No
High Blood Pressure			Migraines		
High Cholesterol			Gastroesophageal Reflux Disease (GERD)		
Congestive Heart Failure			Valley Fever		
Chronic Kidney Disease/Kidney Failure			Tuberculosis		
Liver Disease			Polio		
Diabetes Type I			Lupus		
Diabetes Type II			Osteoarthritis		
Peripheral Neuropathy			Osteoporosis		
Memory Issues/Dementia			Depression		
Coronary Artery Disease			Anxiety		
Myocardial Infarction (Heart Attack)			Anemia		
Stroke			Blood Disorders (specify: ________________)		
TIA			Bipolar Disorder I		
Hyperthyroidism			Bipolar Disorder II		
Hypothyroidism			Other (specify: ________________________)		
HIV			Other (specify: ________________________)		
Herpes Simplex 1			Other (specify: ________________________)		
Herpes Simplex 2			Other (specify: ________________________)		
Shingles			Other (specify: ________________________)		
COPD			Other (specify: ________________________)		
Bronchitis			Other (specify: ________________________)		
Glaucoma			Other (specify: ________________________)		
Cancer (specify: _________________________________)			Other (specify: ________________________)		
DVT/Blood Clots (please circle)			Other (specify: ________________________)		
Aneurysm			Other (specify: ________________________)		
Atrial Fibrillation			Other (specify: ________________________)		
Epilepsy			Other (specify: ________________________)		

Diabetic Patients Only:

Please answer the following if you have a history of Diabetes:
When were you first diagnosed with this? How many years have you had Diabetes?
____
Is your Diabetes stable or unstable? __________________________________
Do you know your average Fasting Blood Sugar Levels? If so, please specify range: ______________________
Recent HgbA1c value from recent blood work: __________________________________

<u>Family History:</u> *(Note: you do not need to fill this section out in its entirety, mother/father information and any other information you find pertinent is sufficient)*

Family Member	**Condition *(please specify any known health condition)***	**Alive/Deceased**	**Approx. Age when Deceased**	**Reason for Death, if known**
Mother				
Father				
Brother 1				
Brother 2				
Brother 3				
Sister 1				
Sister 2				
Sister 3				
Maternal Grandmother				
Maternal Grandfather				
Maternal Aunt				
Maternal Uncle				
Paternal Grandmother				
Paternal Grandfather				
Paternal Aunt				
Paternal Uncle				

Surgical History:

Surgery	Yes	No	Date
Pacemaker Implantation			
Defibrillator Implantation			
Coronary Artery Bypass Graft			
Heart Valve Repair			
Laminectomy (please specify region/levels if known): ______________________ ______________________			
Fusion (please specify region/levels if known): ______________________ ______________________			
Total Shoulder Replacement (please specify specific shoulder): ______________________			
Total Knee Replacement (please specify specific knee): ______________________			
Total Hip Replacement (please specify specific hip): ______________________			
Fracture Repair (please specify region): ______________________			
Appendectomy (Appendix Removal)			
Tonsillectomy (Tonsils Removal)			
Adenoidectomy (Adenoids Removal)			
Cholecystectomy (Gallbladder Removal)			
Hysterectomy (please specify if total/partial and reason) ______________________ ______________________			
Other (please specify) ______________________			
Other (please specify) ______________________			
Other (please specify) ______________________			
Other (please specify) ______________________			

Allergies:

Are you allergic to any medications/topical creams/cleansing agents, etc.? Yes/No (please circle)
If so, please specify in lines provided below and it allergic reaction:

1) ____, Reaction:________________________

2) ____, Reaction:________________________

3) ____, Reaction:________________________

4) ____, Reaction:________________________

5) ____, Reaction:________________________

Food Allergies:

1) ____, Reaction:________________________

2) ____, Reaction:________________________

3) ____, Reaction:________________________

4) ____, Reaction:________________________

5) ____, Reaction:________________________

Social History:

Alcohol Use? Yes/no (please circle)
If Yes: Social Drinker? Yes/ no (please circle)
Every Day Drinker? Yes/ no (please circle)
Approximately how many drinks and what type of drinks do you consume per day/week?:
____

Tobacco/Nicotine Use? Yes/no (please circle)

Please circle item that applies: Never Smoker, Former Smoker, Current Smoker
-If Former Smoker, how many cigarettes or packs per day did you smoke and for how many years?
Amount of cigarettes/packs per day: ____
Years of smoking: ____
Approximate year that you quit: ____

-If Current Smoker:
Amount of cigarettes/packs per day: ____
Years of smoking: ____

Illegal Drug Use? yes/no
If yes, past/present? (please circle)
Please specify illicit drugs used: ____
History of Drug Abuse? ____