

New Patient General Intake Form

Scottsdale Pain Rehabilitation & Wellness

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Date: _____

Name: _____ Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

E-mail _____

Highest level of education: _____

Occupation: _____ Employer: _____ Hours work per week: _____

Marital Status (circle): Single Married Separated Divorced with Partner Widow(er)

Spouse's Name _____

Person to call in case of Emergency: _____ Relationship to you: _____

Phone number contact for them: _____

Regular Physician: _____ Phone#: _____

Please indicate how you found out about our office?

_____ Newspaper- Which one? _____

_____ Health Magazine- Which one? _____

_____ Local talk or lecture- Which one? _____

_____ Internet- Which category? _____

_____ Doctor referral- Who? _____

_____ Friend or Relative- Who? _____

List in Order of Importance what your concerns are:

1-
2-
3-
4-
5-

Last time you had blood work done and with what doctor: _____

[illegible]

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Supplements:	Dosage	Frequency/How Often	Purpose

Review Of Systems:

Present Weight: _____ Weight one year ago: _____

Height: _____

Ideal Weight: _____

Overall Energy Level: 0 (the worst) to 10 (the best) – circle the level that best describes your energy level now.

0 1 2 3 4 5 6 7 8 9 10

If you have fatigue, when in morning, afternoon, evening is it the worst?: _____

If you have fatigue, can you do what you need to during the day ? : Y N

Overall Sleep Level: 0 (the worst) to 10 (the best) – circle the level that best describes your quality of sleep now.

0 1 2 3 4 5 6 7 8 9 10

Overall Digestion Level: 0 (the worst) to 10 (the best) – circle the level that best describes your quality of digestion now.

0 1 2 3 4 5 6 7 8 9 10

Overall Stress Level: 0 (the worst) to 10 (the best) – circle the level that best describes your stress level now.

0 1 2 3 4 5 6 7 8 9 10

REGARDING THE NEXT LONG SECTION:

Please Circle Y if you have the problem **NOW**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

Skin:

Rash: Y N P

Hives: Y N P

Psoriasis/eczema: Y N P

Dry: Y N P

Cancer: Y N P

Color Change: Y N P

Lump: Y N P

Itchy: Y N P

Perspiration: Y N P

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Headache: Y N P
Dandruff: Y N P
Oil/dry hair: Y N P

Head:

Migraine: Y N P
Head Injury: Y N P
Hair loss: Y N P

Dry/Watery: Y N P
Double vision: Y N P
Glaucoma: Y N P
Strain: Y N P
Itchy: Y N P

Eyes:

Blurry vision: Y N P
Cataracts: Y N P
Dark under eyelid: Y N P
Discharge: Y N P

Frequent colds: Y N P
Congestion: Y N P
Polyps: Y N P

Nose:

Nosebleeds: Y N P
Post nasal drip: Y N P
Seasonal allergies: Y N P

Canker sores: Y N P
Sore throat: Y N P
Dentures: Y N P
Loss of taste: Y N P

Mouth/Throat:

Cold sores: Y N P
Gum disease: Y N P
Hoarseness: Y N P

Stiffness: Y N P
Full movement: Y N P

Neck:

Swollen glands: Y N P
Tension: Y N P

Cough: Y N P
Shortness of breath with exertion: Y N P
Pneumonia: Y N P
Asthma: Y N P

Respiratory:

Wheezing: Y N P
Bronchitis: Y N P
Painful breathing: Y N P

High blood pressure: Y N P
Low blood pressure: Y N P
Arrhythmias: Y N P
Swelling: Y N P

Cardiovascular:

Murmurs: Y N P
Palpitations: Y N P
Chest pain: Y N P

Heartburn: Y N P
Indigestion: Y N P
Bloating: Y N P
Nausea: Y N P
Vomiting: Y N P
Change in Appetite: Y N P
Pancreatitis: Y N P

Gastrointestinal:

Bowel movement frequency: _____
Recent change in BM: Y N P
Diarrhea or constipation: Y N P
Hemorrhoids: Y N P
Gall bladder disease: Y N P
Liver disease: Y N P
Ulcer: Y N P

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Urinary Tract:

Incontinence: Y N P
Frequent infections: Y N P
Urgency: Y N P

Pain with urination: Y N P
Kidney stones: Y N P
Discharge/blood: Y N P

Male Genitalia: (Male Only)

Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P
Impotency: Y N P

Sexually active: Y N P
Sexually transmitted disease: Y N P
Prostate disease/symptoms: Y N P

Female Genitalia: (Female Only)

Age periods began: _____
How long periods last: _____
Date of last period: _____

How often periods occur: _____
Menopausal since what age: _____

Periods:

Heavy Bleeding: Y N P
Cramping: Y N P
Pain: Y N P
PMS: Y N P
Food Cravings: Y N P
Last Pap Smear: _____

Times Pregnant: _____
How many births: _____
Miscarriages: _____
Abortions: _____
Sexual Active: Y N P
Healthy Libido: Y N P
Pain With Intercourse: Y N P
Dry Vagina: Y N P
Vaginitis: Y N P

Diagnosis: _____

Any abnormal paps: Y N P
When was abnormal: Y N P
Any Birth Control (please list types and ages used): _____
Mammography: Y N P
Dexa Scan: Y N P If Yes, what were the results: _____
Use of Hormones: Y N P

Musculoskeletal:

Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P

Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

Nervous:

Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P

Sciatica: Y N P
Carpal tunnel syndrome: Y N P
Fainting: Y N P

Mental/Emotional:

Depression: Y N P
Suicidal: Y N P
Anxiety: Y N P

Anger/irritability: Y N P
High Stress: Y N P
Fear/Panic: Y N P

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Exercise:

How often: _____

What type(s): _____

For How long: _____

Sleep:

How long per night: _____

If you wake up frequently, what is the reason: _____

Nightmares: Y N P

Wake refreshed: Y N P

Must Nap during the day: Y N P

Sleep walk: Y N P

Grind Teeth: Y N P

Snore: Y N P

Food:

Appetite Good? Y N P

Foods crave: _____

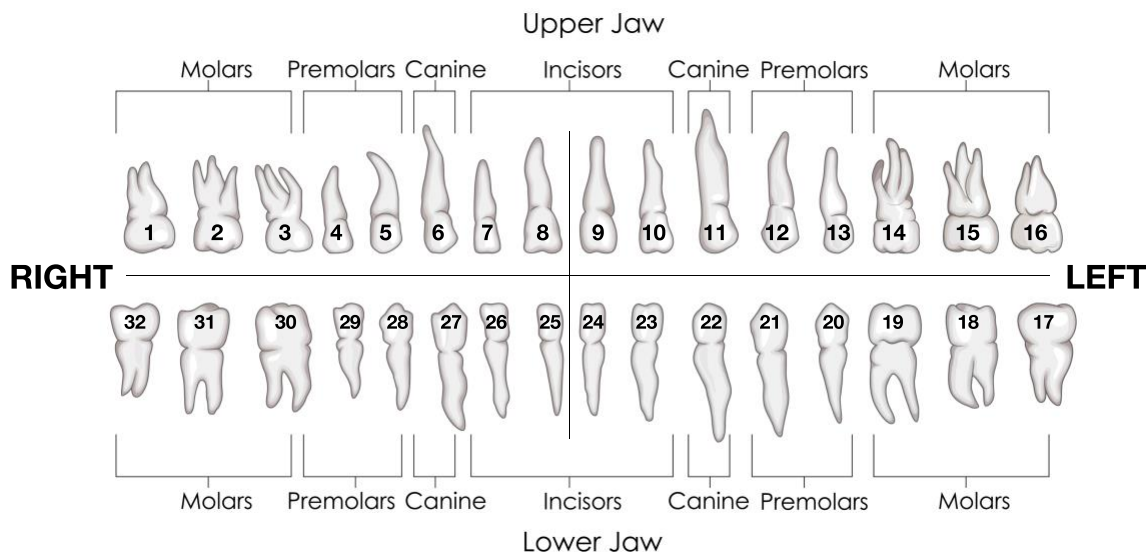
Foods Dislike: _____

Foods that don't sit well: _____

Dental Chart:

On the Dental Chart below, please indicate date(s) incurred & your age at that time each of the following dental procedures

- Amalgam (silver) fillings (AF)
- Root Canal Teeth (RCT)
- Dental Implants (DI)
- Dental extractions (DE)
- Other dental procedures (indicate the procedure)



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Health Line:

Indicate any health condition(s) and your age (yo) when it started on the time line below:

Example: root canal, age 20yo; diabetes, age 42, yo; hypertension, age 49; etc

Example

			20 yo	Root Canal				49 yo	hypertension			
Birth	10 yo	20 yo	30 yo	40 yo	50 yo	60 yo	70 yo	80 yo	90 yo			
					42 yo	diabetes						

Birth	10 yo	20 yo	30 yo	40 yo	50 yo	60 yo	70 yo	80 yo	90 yo
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BUSINESS INFORMATION:

I will be paying by CASH_____CHECK_____CREDIT CARD_____

- I Understand and agree that, regardless of my insurance status, I am responsible for all charges at this office at the time professional services are rendered. I agree to the services and fees rendered in this office and that they will not be subject to dispute by my insurance company.
- I certify that the information on this patient information form is true and correct to the best of my ability.
- I agree to notify you of any changes in my health status, address, etc.
- I understand that there is an OFFICE VISIT CHARGE for evaluation or re-evaluation for all visits, in addition to any TREATMENT CHARGE.
- I understand that this office is NOT A MEDICARE PROVIDER and Medicare will NOT reimburse me for my medical expenses here and I will NOT submit any claims from this office to Medicare.
- I understand that the Doctor or his staff will not submit claims to Medicare and that the doctor will not receive any direct or indirect payments from Medicare or Medicare related plans.
- I understand that this office is not a provider for other health care plans or insurance and that this office will not submit claims to them.
- I understand that the Doctor does not provide emergency or urgent care services as defined in the Social Security Act.
- I understand that all services normally covered by Medicare, such as X-Rays, Lab work and physical therapy, will not be covered under this Doctor's prescription.

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Release of Information:

Unless I indicate otherwise, I give the Doctor(s) and Staff of Scottsdale Pain Rehabilitation and Wellness permission to discuss and/or release my personal health information to family members, other physicians, testing facilities, and diagnostic centers on an individual basis.

If there is any specific person or organization, I do not wish my personal health information to be released to, I will indicate that on this form:

Do not discuss or release my personal health information to the following:

_____ Anyone or any organization.

_____ The following specific individual(s) or organization(s):

1.

2.

3

Patient's
Signature _____ Date _____