Active Life
Physical Medicine & Pain Center
PLLC

3400 N. DYSART RD. SUITE H131
AVONDALE, AZ 85392

P: 632.535.9777 | F: 623.236.3179

You have been referred to our office for an evaluation. Below is a detailed questionnaire that must be completely filled out and returned to our office before your apPOintment will be scheduled.

Questionnaire must be mailed, dropped off or faxed to address indicated above.

PATIENT REGISTRATION:

Patient Name: _____ Date: ___/___/___
Last Name First Name Middle Name

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: (_____) _____-_____

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Date of Birth _____/_____/_____

Social Security Number: _____-_____-_____

Marital Status: M ☐ S ☐ D ☐ W ☐

Employer: _____

Employer Address: _____

Pharmacy: _____

Primary Care Physician: _____

Referring Physician: _____

SUBSCRIBER INFORMATION:

Address: _____ Phone: (_____) _____-_____

City: _____ State: _____ Zip: _____

Employer Address: _____ Phone: (_____) _____-_____

INSURANCE:

1. _____
Primary Insurance CO. Name Address

_____
Subscriber's Name Subscriber's ID # Group

Phone: (_____) _____-_____

2. _____
Primary Insurance CO. Name Address

_____
Subscriber's Name Subscriber's ID # Group

Phone: (_____) _____-_____

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Address: _____

Phone: (_____) _____-_____

Name: _____

NEW PATIENT DATABASE:

Sex: Male ☐ Female ☐ **Age: _____ Right/Left Handed: _____**

History:

1. What is the primary reason you are seeing the doctor?
_____

2. Do yo uhave any other concerns or complaints of pain?
_____

3. When did the primary problem begin?
_____

4. What makes it better? Worse?
_____

5. Standing makes the pain... Worse ☐ Better ☐ Same ☐
   Walking makes the pain... Worse ☐ Better ☐ Same ☐
   Sitting makes the pain... Worse ☐ Better ☐ Same ☐

6. Is it constant or intermittent?
_____

7. Do you have weekness? Y ☐ N ☐ If yes, explain:_____

8. Since the start of the symptom(s) has it become: Better ☐ Unchanged ☐ Worse ☐

9. Is this a result of an injury? Y ☐ N ☐ If yes, please explain: _____

10. Are you receiving disability benefits? Y ☐ N ☐

11. Is this a Workman's Compensation problem? Y ☐ N ☐ Do you have a lawyer? Y ☐ N ☐

12. What other treatment(s) have you had?
Injections ☐ Chiropractic ☐ Physical Therapy ☐ Acupuncture ☐ TENS ☐ Biofeedback ☐

13. Did any of the above help to relieve your symptoms? _____

14. Have you been at a pain center before? Y ☐ N ☐ Where? _____

15. Have you ever been dismissed from a pain center? Y ☐ N ☐ Reason? _____

16. Are you willing to try injections to help relieve your pain? Y ☐ N ☐

CURRENT PAIN SCALE DIAGRAM: Name: _____

Please specify the amount of pain you are in now.

NO PAIN 0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ WORST PAIN EVER 10

0 1 2 3 4 5 6 7 8 9 10

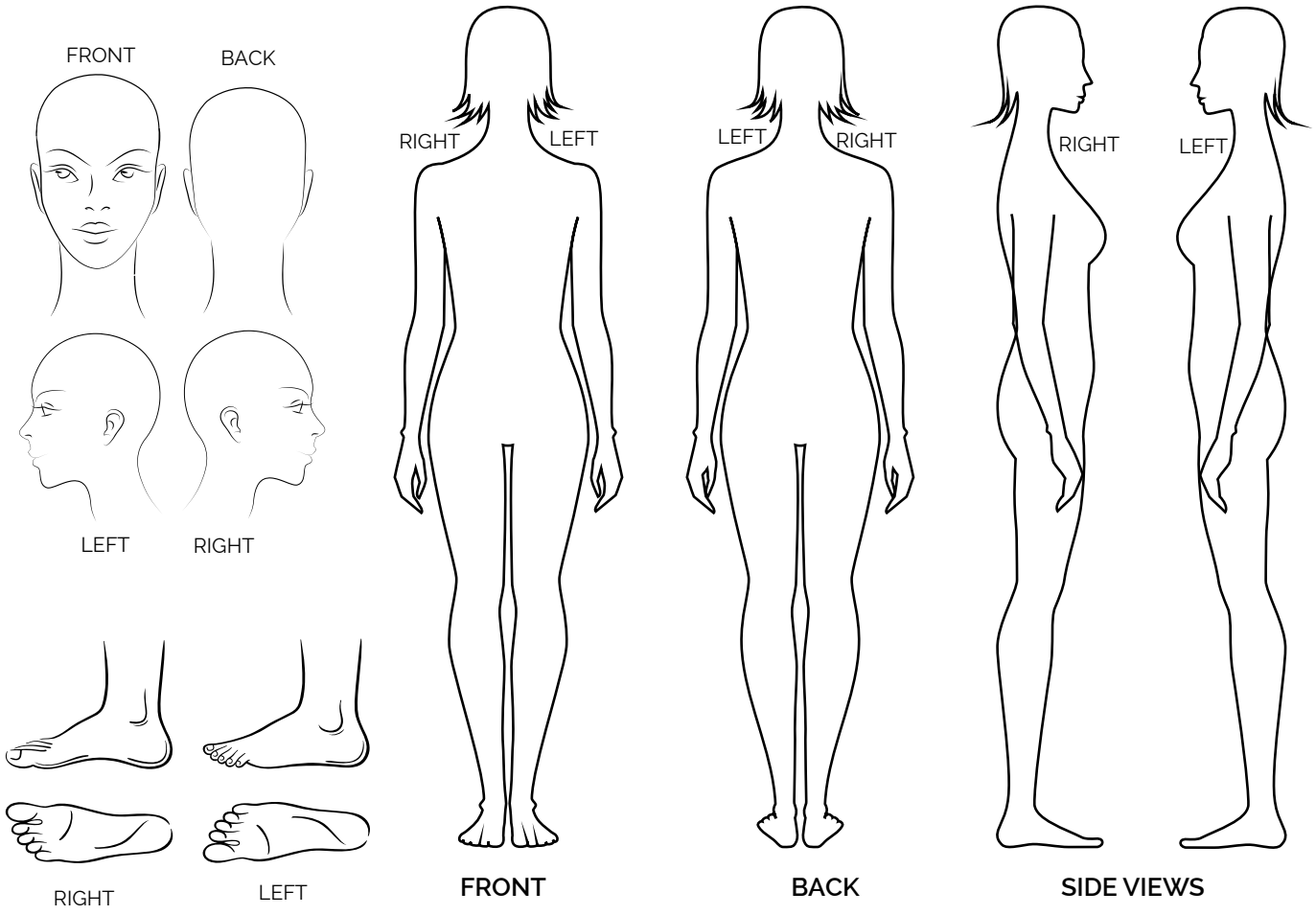
Please signify the worst amount of pain in the last week.

NO PAIN 0 ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ WORST PAIN EVER 10

0 1 2 3 4 5 6 7 8 9 10

Mark the areas on your body where you now feel pain. Use the symbols indicated below.
Include all affected areas.

Ache »»» Numbness ----- Pins & Needles •••• Burning xxxx Stabbing ///// Other +++++



Name: _____

PLEASE CHECK OFF MEDICATIONS TRIED IN THE PAST:

Neuromodulators:
gabapentin (Neurontin) ☐ pregabalin (Lyrica) ☐ tegretol ☐ gabitril ☐ cymbalta

Muscle Relaxants:
tizanidine (zanaflex) ☐ flexeril (cyclobenzaprine) ☐ Soma (casiprosodol) ☐ Baclofen
valium ☐ norflex ☐ skelaxin ☐

Narcotic Medications:
Hydrocodone (vicodin, lortab, norco) ☐ oxycodone (percocet, percodan, tylox) ☐
darvocet NlOO ☐ kadian (morphine) ☐ avinza (morphine) ☐ MSContin ☐
fentanyl (duragesic) ☐ methadone ☐ suboxone ☐ talwin ☐ opana ☐ opana ER ☐

Antidepressants/Anxiety:
xanax ☐ respiridol ☐ Zoloft ☐ lexapro ☐ prozac ☐ wellbutrin ☐ cymbalta ☐
pristiq ☐ zyprexa ☐

Antiinflammatories:
motrin (ibuprofen) ☐ diclofenac (voltaren, arthrotec) ☐ aspirin ☐ celebrex (celecoxib) ☐
dolobid (diflunisal) ☐ Lodine (etodolac) ☐ Orudis (ketoprofen) ☐ nabumetone (Relafen) ☐
Naproxen (Aleve, Naprosyn) ☐ Oxaprozin (daypro) ☐ peroxicam (feldene) ☐
salsalate (amigesic) ☐ sulindac (clinoril) ☐

Headache medications and other:
tramadol (ultram) ☐ fiorecet ☐ dolgic ☐ relpax ☐ topamax ☐ imitrex ☐ midrin ☐
maxalt ☐ zomig ☐ frova ☐

Sleep medications:
Lunesta ☐ restoril ☐ ambien ☐ ambien CR ☐ Nortriptyline ☐ amitriptyline (elavil) ☐
tofranil ☐ trazodone ☐ zyprexa ☐ respiradol ☐

Name: _____

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY & LIST DATES.

NOSE/SINUS	**NO**	**YES**	**DATE**	**OTHER**
Nasal Allergies	☐	☐		
Obstructive Sleep Apnea	☐	☐		

HEART/BLOOD VESSELS	**NO**	**YES**	**DATE**	**OTHER**
Irregular Heart Beat	☐	☐		
Congestive Heart Failure	☐	☐		
Heart Attack	☐	☐		
High Cholesterol	☐	☐		
High Blood Pressure	☐	☐		

LUNGS/RESPIRATORY	**NO**	**YES**	**DATE**	**OTHER**
Asthma	☐	☐		
Bronchitis	☐	☐		
COPD	☐	☐		
Tuberculosis	☐	☐		

STOMACH/DIGESTIVE	**NO**	**YES**	**DATE**	**OTHER**
Diverticulitis	☐	☐		
Colitis	☐	☐		
Stomach Ulcer	☐	☐		
Duodenal Ulcer	☐	☐		
GERD (heartburn)	☐	☐		
Hepatitis	☐	☐		
Irritable Bowel Syndrome	☐	☐		

KIDNEY	**NO**	**YES**	**DATE**	**OTHER**
Renal Failure	☐	☐		
Dialysis	☐	☐		
Kidney Stones	☐	☐		

NOSE/SINUS	**NO**	**YES**	**DATE**	**OTHER**
Depression	☐	☐		
Anxiety	☐	☐		
Schizophrenia	☐	☐		
Biploar Disorder	☐	☐		

Name: _____

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY & LIST DATES.

GLADS/HORMONES	**NO**	**YES**	**DATE**	**OTHER**
Insullin Dependent Diabetic	☐	☐		
Non-Insulin Dependent Diabetic	☐	☐		
Under Active Thyroid	☐	☐		
Over Active Thyroid	☐	☐		
Thyroid Surgery	☐	☐		

BLOOD/LYMPH NODE PROBLEMS	**NO**	**YES**	**DATE**	**OTHER**
Anemia	☐	☐		
Bleeding Disorder	☐	☐		
Blood Clots	☐	☐		
Phlebitis	☐	☐		

IMMUNE INFECTIOUS PROBLEMS	**NO**	**YES**	**DATE**	**OTHER**
HIV	☐	☐		
Infectious Mononucleosis	☐	☐		
Shingles	☐	☐		

MUSCULOSKELETAL	**NO**	**YES**	**DATE**	**OTHER**
Fibromyalgia	☐	☐		
Muscle Disease	☐	☐		

CANCER	**NO**	**YES**	**DATE**	**OTHER**
IF YES, PLEASE LIST TYPE & TREATMENT	☐	☐		

NEUROLOGICAL	**NO**	**YES**	**DATE**	**OTHER**
Stroke	☐	☐		
Seizure	☐	☐		
Neuropathy	☐	☐		

FEMALE	**NO**	**YES**	**DATE**	**OTHER**
Last Menstrual Period	☐	☐		
Menopausal	☐	☐		
Pregnant or Possibly?	☐	☐		

REVIEW OF SYSTEMS:

Check all that apply

General Health Problems:

☐ Change in appetite ☐ Unintended weight loss ☐ Sleeping Problems ☐ Fever
☐ Fatigue ☐ Weight Gain

Head/Face/Eye:

☐ Headache ☐ Face Pain ☐ Blurred Vision ☐ Double Vision ☐ Loss of Vision
☐ Wear glasses or contacts

Ear/Mouth/Throat:

☐ Hearing Loss ☐ Ringing in the Ears ☐ Dizziness ☐ Wear hearing aid(s) ☐ Change in Voice
☐ Snoring ☐ Sore Throat ☐ Mouth Ulcers ☐ Dentures: upper/lower

Neck:

☐ Neck lumps or masses ☐ Neck pain ☐ Swollen Glads

Stomach Problems:

☐ Stomach Pain ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Indigestion ☐ Nausea
☐ Vomiting ☐ Hemorrhoids

Urinary Problems:

☐ Urinating more than usual ☐ Kidney Stones ☐ Difficulty or painful urinating
☐ Kidney Dialysis ☐ Blood in urine

Bones/Joints/Muscles:

☐ Back spasms ☐ Back pain ☐ Painful Joints ☐ Stiffness ☐ Swollen Joins
☐ Muscle Cramps ☐ Shoulder pain

Brain/Nervous System:

☐ Change in alertness ☐ Seizures ☐ Stroke ☐ Numbness ☐ Loss of consciousness

Heart/Circulation:

☐ Blacking out or fainting ☐ Leg Cramps ☐ Irregular Heartbeat ☐ Chest Pain
☐ Swelling of the feel/ankles ☐ Heart Murmurs ☐ Bluish lips/fingernails

Problems with Glands/Hormones:

☐ Feel cold all the time ☐ Increased appetite ☐ Feel uncomfortably hot ☐ Increased thirst
☐ Increased fatigue ☐ Neck has enlarged ☐ Unwanted weight change

Problems with Allergies:

☐ Food intolerances ☐ Frequesnt sneezing ☐ Post nasal drainage ☐ Hives
☐ Reaction to insect bites/stings

Mental/Psychiatric:

☐ Anxiety ☐ Depression ☐ Compulsive behavior(s) ☐ Hallucinations ☐ Suicidal thoughts/tendencies

Lung or Respiratory Problems:

☐ Shortness of breath ☐ Wheezing ☐ Non-Productive Cough ☐ Productive Cough

Problems with Blood/Lymph Nodes:

☐ Bleed heavily after injury ☐ Bruise easily ☐ Enlarged Lymph Nodes

Skin:

☐ Rash ☐ Itching ☐ Psoriasis ☐ Eczema ☐ Dry flaking skin

PAST SURGICAL HISTORY & HOSPITALIZATIONS:

Do you have a cardiac pacemaker? ☐ NO ☐ YES

Have you ever had NECK or BACK surgery? ☐ NO ☐ YES
If yes, list...

Surgery _____ Location _____ Date _____ Surgeon_____
Surgery _____ Location _____ Date _____ Surgeon_____
Surgery _____ Location _____ Date _____ Surgeon_____
Surgery _____ Location _____ Date _____ Surgeon_____

Do you have any metal implants? ☐ NO ☐ YES *If yes, are you able to have an MRI if needed?* ☐ NO ☐ YES

Do you have any cardiac stents in place? ☐ NO ☐ YES
Have you ever had any other surgeries? ☐ NO ☐ YES *If yes, list surgery & date done.

Surgery_____ Date _____
Surgery_____ Date _____
Surgery_____ Date _____
Surgery_____ Date _____
Surgery_____ Date _____
Surgery_____ Date _____

MEDICATIONS:

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING OVER THE COUNTER & HERBAL MEDICATIONS.
EXAMPLES: TYLENOL, ASPIRIN/BAYER, ADVIL/ALEVE/IBUPROFEN/MOTRIN, APPETITE SUPPRESSANTS, SLEEPING AIDS, LAXATIVES, DECONGESTANTS/NASAL SPRAYS, CALCIUM, HERBS/VITAMINS/SUPPLEMENTS

DRUG NAME	DOSAGE	FREQUENCY	PRESCRIBING PHYSICIAN	REASON FOR TAKING

ALLERGIES:
PLEASE LIST ALL ALLERGIEST & REACTIONS, INCLUDING-LATEX, FOOD, DYE, & ENVIRONMENTAL.

DRUG	
DRUG NAME	REACTION

FOOD	
NAME	REACTION

ENVIRONMENTAL	
NAME	REACTION

FAMILY HISTORY:

	MOTHER	FATHER	BROTHER	SISTER	OTHER
HEART DISEASE					
HIGH BLOOD PRESSURE					
ASTHMA					
LUNG CANCER					
BONE CANCER					
ARTHRITIS					
DIABETES					
STROKE					
BLEEDING/CLOTHING PROBLEMS					

FEMALE HEALTH: BREAST CANCER ☐ MOTHER ☐ SISTER OTHER: _____

MALE HEALTH: PROSTATE CANCER ☐ FATHER ☐ BROTHER OTHER: _____

SOCIAL HISTORY:

Have you ever used Tobacco in any form? ☐ NO ☐ YES
If yes, what type of Tobacco: _____, How much:_____, How often: _____
From: _____ to _____ (year)

Do you drink Alcoholic bevereages? ☐ NO ☐ YES
If yes, what type of Alcohol: _____, How much:_____, How often: _____
From: _____ to _____ (year)

Do you now, or have you ever taken illegal drugs? ☐ NO ☐ YES
If yes, please list: _____

Do you drink Caffeinated bevereages? ☐ NO ☐ YES
If yes, please list: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Living with Partner ☐ Widowed

List individuals living with you & relationship to you:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Do you have children? ☐ NO ☐ YES If yes, how many? _____

Are you independent in all personal activities such as:

☐ Dressing yourself ☐ Bathing ☐ Toilet ☐ Cooking ☐ Walking ☐ Getting out of bed

*If the answer is NO to any or all of these, please explain limitations:
_____

Working Status:

☐ Full-time employed ☐ Part-time employed ☐ Homemaker ☐ Retired ☐ Disabled

Occupation: _____

I certify that the above information is correct to teh best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion fo this form.

Signature:_____ Date: _____