ADVANCED RELIEF INSTITUTE

New Patient Intake

Date: _____

Demographics

Patient Name: _____

Date of Birth: _____ Phone Number: _____

Email Address: _____

Pharmacy Name: _____ Location: _____

Primary Care Physician: _____ Referring Provider: _____

Reason For Your Visit

- ☐ Ankle Pain
- ☐ Ear Pain
- ☐ Elbow Pain
- ☐ Finger Pain
- ☐ Hand Pain
- ☐ Headaches/Migraines
- ☐ Hip Pain
- ☐ Jaw Pain
- ☐ Knee Pain- Arthritis
- ☐ Knee Pain- General
- ☐ Knee Pain- After Replacement
- ☐ Lower Back Pain- Arthritis
- ☐ Lower Back Pain- Disc Issue
- ☐ Lower Back Pain- Sciatica
- ☐ Mid Back Pain
- ☐ Muscular Pain
- ☐ Neck Pain-Arthritis
- ☐ Neck Pain-Disc Issue
- ☐ PRP
- ☐ Shoulder Pain
- ☐ Stem Cells
- ☐ Pelvic Pain
- ☐ Tailbone Pain
- ☐ Toe Pain
- ☐ Other_____

What caused your current pain episode?
When did this pain begin?
What other factors relieve your pain?
What other factors worsen your pain?
Does your pain radiate? If so, where?

Pain Description -Check all the following that describe your pain

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Numbness ☐ Stabbing/Sharp ☐ Throbbing
☐ Tightness ☐ Cramping ☐ Soreness ☐ Stiffness

If pain "0" is no pain and "10" is the worst pain you can imagine, how would you rate your pain on a scale of 0-10?

Now_____ The Best It Gets_____ The Worst It Gets_____

Have you had any of the following treatments? if so, were they helpful?

Treatment	Helped	Somewhat Helped	No Help
Brace Support	☐	☐	☐
Chiropractic Care	☐	☐	☐
Hot/Cold Packs	☐	☐	☐
Physical Therapy	☐	☐	☐
Spine Surgery	☐	☐	☐

Do you have ANY diagnostic tests for your current pain complaint?

☐ CT of the _____ Date _____
☐MRI of the _____ Date _____
☐X-Ray of the Date

Review of Systems – Check the following symptoms that you currently suffer from.

Constitutional:	☐Chills ☐Fever	☐Weight Gain ☐ Weight Loss
Head:	☐Dizziness ☐ Pain	☐ Fainting ☐ Headaches
Eyes	☐Blurry Vision ☐ Cataracts ☐ Glaucoma	☐ Double Vision ☐Eyeglasses use
Respiratory	☐ Asthma ☐ Bronchitis	☐ Short of Breath ☐ Wheezing
Cardiovascular	☐ Chest Pain ☐ Extremity(s) Cool ☐ Extremity(s) Discolored ☐ Swelling of legs	☐ High Blood Pressure ☐ History of Heart Attack ☐ History of Heart Attack ☐ Palpitations

Gastrointestinal	☐ Antacid Use ☐ Constipation ☐ Heartburn	☐ Hepatitis ☐ Liver Disease
Musculoskeletal	☐Arthritis ☐Back Problems ☐Joint Pain	☐Muscle Stiffness ☐Restricted Motion ☐Joint Stiffness
Psychiatric	☐ Depression ☐ Disturbing Thoughts ☐ Psychiatric Disorders	☐ Memory Loss ☐ Nervousness
Neurological	☐ Memory Loss ☐ Numbness	☐Tingling ☐ Tremors
Endocrine	☐ Fatigue ☐ Neck Pain	☐ Thyroid Trouble ☐ Weakness
Hematologic/Lymph	☐ Anemia ☐ Blood Clots	☐ Bleeding Easily ☐ Radiation Exposure
Allergic/Immunologic	☐Itchy Eyes	☐ Runny Nose

Have you had any injections to treat your pain?

Type of injection	Administered By	How Long Ago

Allergies

Do you have any drug/medication allergies? ☐ YES ☐ NO

If so, please <u>list all the medications to which you are Allergic</u>.

	Describe your reaction
1)	
2)	
3)	

Do you have any Topical Allergies? ☐Latex ☐Iodine ☐Tape ☐IV Contrast

Current Medications

Are you taking any blood thinners or anti-coagulants, if **YES**, which ones?

☐ Aggrenox ☐ Aspirin ☐ Brilinta ☐Coumadin ☐ Pradaxa ☐ Effient ☐ Heparin

☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Xarelto ☐ Eliquis ☐ Other_____

Prescribed by _____

Please list any other current medications

Medication Name	Dose	Frequency
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		

Past Medical History

Cancer/Oncology	☐ Cancer Type _____ ☐ Cancer Type _____ ☐ Cancer Type _____	
Cardiovascular/Hematologic	☐Anemia ☐ Heart Attack ☐ Coronary Artery Disease ☐ High Blood Pressure Disease	☐ Prescence of Stent/pacemaker/defibrillator ☐ Peripheral Vascular ☐ Stroke/TIA ☐ Heart Valve
Gastrointestinal	☐ Gastrointestinal Bleeding ☐IBS/Crohn's Disease	☐ Stomach Ulcer ☐GERD (Acid Reflux)
Urological	☐ Chronic Kidney Disease ☐ Kidney Stones	☐ Urinary Incontinence ☐ Dialysis
Neurological	☐ Multiple Sclerosis ☐ Peripheral Neuropathy ☐ Seizure	☐ Balance Disorder ☐ Migraines ☐ Head Injury ☐ Headaches

ENT	☐ Glaucoma ☐ Vertigo	☐ Hearing Problems ☐ Nosebleeds
Respiratory	☐ Asthma ☐ Bronchitis/ Pneumonia	☐Emphysema/ COPD
Musculoskeletal/Rheumatologic	☐Bursitis ☐Carpal Tunnel Syndrome ☐Fibromyalgia	☐ Osteoarthritis ☐Rheumatoid Arthritis ☐ Chronic Joint Pains ☐Osteoporosis
Psychiatric	☐ Depression ☐ Anxiety ☐ Schizophrenia	☐ Bipolar Disorder ☐ Add/ADHD ☐ PTSD
Endocrinology	☐ Diabetes- Type _____ ☐Hyperthyroidism ☐Hypothyroidism	
Other Diagnosed Conditions	☐ _____ ☐ _____ ☐ _____	

Social History

Do you engage in the following?	Currently	Formerly	Never
Alcohol Use	☐	☐	☐
Tobacco Use	☐	☐	☐
Illegal Drug Use	☐	☐	☐

Are you currently under worker's compensation? ☐ YES ☐ NO

Is there an ongoing lawsuit related to your visit today? ☐ YES ☐ NO

Have you ever abused narcotics or prescription medications? ☐ YES ☐ NO

Surgical History - List any Surgical Procedures you have had in the past.

1) _____ Date _____

2) _____ Date _____

3) _____ Date _____

4) _____ Date _____

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You have the right to restrict how your

Protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes ☐ No ☐

May we leave a message on your answering machine at home or on your cell phone? Yes ☐ No ☐

May we discuss your medical condition with any member of your family? ☐ No ☐

Yes If YES, please name the members allowed:_____

Patient Name: _____ DOB: _____

Signature: _____ Date: _____