

New Patient General Intake Form

Scottsdale Pain Rehabilitation & Wellness

Fred G. Arnold, N.M.D.
7595 East McDonald Drive, Suite 100
Scottsdale, AZ 85250
(O) 602 292-2978 Fax: 480-219-8132
www.prolotherapyphoenix.com

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: _____

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Supplements: _____ **Dosage** _____ **Frequency/How Often** _____ **Purpose** _____

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

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

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

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

Stiffness: Y N P
Full movement: Y N P

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

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

Head:

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

Eyes:

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

Nose:

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

Mouth/Throat:

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

Neck:

Swollen glands: Y N P
Tension: Y N P

Respiratory:

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

Cardiovascular:

Murmurs: Y N P
Palpitations: Y N P
Chest pain: 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	Pain with urination:	Y N P
Frequent infections:	Y N P	Kidney stones:	Y N P
Urgency:	Y N P	Discharge/blood:	Y N P

Male Genitalia: (Male Only)

Testicular pain/swelling:	Y N P	Sexually active:	Y N P
Hernia:	Y N P	Sexually transmitted disease:	Y N P
Discharge:	Y N P	Prostate disease/symptoms:	Y N P
Impotency:	Y N P		

Female Genitalia: (Female Only)

Age periods began: _____	How often periods occur: _____
How long periods last: _____	Menopausal since what age: _____
Date of last period: _____	
Periods:	Times Pregnant: _____
Heavy Bleeding: Y N P	How many births: _____
Cramping: Y N P	Miscarriages: _____
Pain: Y N P	Abortions: _____
PMS: Y N P	Sexual Active: Y N P
Food Cravings: Y N P	Healthy Libido: Y N P
Last Pap Smear: _____	Pain With Intercourse: Y N P
Diagnosis: _____	Dry Vagina: Y N P
Any abnormal paps: Y N P	Vaginitis: 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	Arthritis: Y N P
Stiffness: Y N P	Leg cramps: Y N P
Tremors: Y N P	Pain: Y N P

Nervous:

Paralysis: Y N P	Sciatica: Y N P
Tingling/numbness: Y N P	Carpal tunnel syndrome: Y N P
Seizures: Y N P	Fainting: Y N P

Mental/Emotional:

Depression: Y N P	Anger/irritability: Y N P
Suicidal: Y N P	High Stress: Y N P
Anxiety: 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: _____

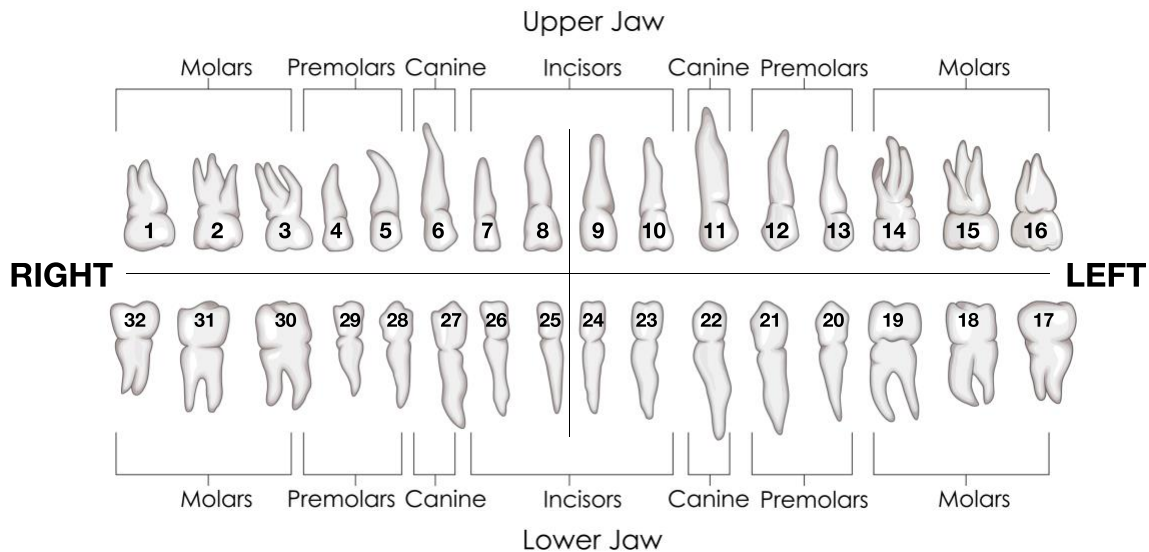
Foods Dislike: _____

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)



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 _____