



To our New and Prospective Patients,

On behalf of the physicians, providers and staff of Desert Pain Institute, welcome to our practice. We are pleased that you have entrusted us with your health and consider it both a privilege and honor to be of service to you. Our primary role at DPI is to ensure that every patient receives quality care and has a favorable experience with every aspect of their care at our facilities and with our team of professional caregivers.

The reputation of our practice and physicians has resulted in an increasingly overwhelming demand for our services. While we want to accommodate every patient who seeks care at DPI, we do not wish to sacrifice the personal service that we take pride in. Instead, we want to make sure that both our staff and patients have clear expectations of what we can all do to ensure a positive experience.

Below are a few pertinent details about your care at DPI:

- **Appointment time:** We respect the fact that you are taking time out of your day to seek treatment with our team of professionals. In order to minimize delays in your appointment/treatment, **please arrive at least 45 minutes before your initial appointment, and 30 minutes before your follow-up appointments** – this will allow our staff the chance to make sure that we have everything we need to render your treatment and properly manage your account.
- **Insurance:** While we appreciate the fact that the cost of healthcare continues to challenge our families, we do not set insurance regulations. We make every effort to understand the terms and extent under which your insurance will cover your services and file your claims as a courtesy to you. Occasionally, insurance carriers supply inaccurate information regarding your coverage. Regardless, **please understand that DPI expects you to be ultimately responsible for payment of services rendered to you.**
- **Your Co-pay/Co-insurance:** Please be aware that **our contractual agreements with insurance carriers require that we collect co-pays/co-insurance on the date of service.** We respectfully ask that you come prepared to pay your carrier-mandated fees while you are here.
- **Missed appointments/no-shows:** Life happens – we understand that. On occasion, things come up that require a change in plans, whether or not it is anticipated. Because of high demand, our treatment, procedure and other appointment times are very limited. Despite this demand, we want to minimize the lead time for appointments – that is, we want to see you as soon as feasible. **Out of respect for other patients who must wait for an open appointment time, please contact us if you are unable to keep (or are running late for) your appointment.** This will give us the chance to make every effort to accommodate your schedule, and/or give another patient the opportunity to receive the treatment they need. **We do reserve the right to charge a missed appointment/procedure fee.**

Thank you for allowing us the opportunity to help *relieve your pain and restore your life*, and for taking the time to consider the above details. Please let us know if we can provide assistance at any stage of your experience here.

Again, welcome to Desert Pain Institute.

The Physicians, Providers and Staff

Patient Name

Date of Birth

PATIENT'S REPRESENTATIVE AUTHORIZATION

In accordance with new federal regulations we are not allowed to discuss or even acknowledge that you are a patient of Desert Pain Institute without your expressed written consent. If there is anyone (i.e.: spouse, parent, child, neighbor, etc.) you think might ever have a need to discuss your medical condition, your treatments, your appointments, or your financial account please list them below. This will prevent us from having to get your written consent each time they call to handle matters on your behalf.

Mark each purpose for which you are authorizing your protected health information to be used and/or disclosed to the person(s) you list below.

Discussion of financial account

Discussion of scheduling appointments

Discussion of medical status

Other: Picking up Prescriptions

1) Name: _____ Relationship to patient: _____

2) Name: _____ Relationship to patient: _____

This authorization will expire when I have been discharged from Desert Pain Institute and all financial matters are settled.

I understand that I may revoke this authorization at any time by giving written notice to the front desk staff. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

Patient's Signature: _____ Today's Date: _____

**ACKNOWLEDGEMENT OF RECEIPT OF DESERT PAIN INSTITUTE'S
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

I have been allowed to review and/or have received Desert Pain Institute's Notice of Privacy Practices.

Today's Date: _____

Patient's Signature or legally authorized individual

For Office Use Only

Desert Pain Institute could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

Individual refused to sign

An emergency situation prevented us

Communication barriers prohibited it

Other (please specify)

Employee Signature

Date

PATIENT DEMOGRAPHIC INFORMATION
PLEASE PRINT CLEARLY

Patient Name: _____ **Date of Birth:** _____

Local Address: _____
Street City State Zip

Summer Address: _____
Street City State Zip

Phone (Local): _____ **(Work/Cell):** _____ **(Summer):** _____

Sex: [] Male [] Female **Social Security:** _____

Marital Status: [] Married [] Single **Spouse's Name:** _____

Referring Physician: _____ **Primary Care Physician:** _____

How Did You First Hear About Us: _____

Responsible Party
(if other than patient): _____ **Relation:** _____

_____ **Phone:** _____
Street City State Zip

In case of Emergency Who Should We Contact

Name: _____ **Relation:** _____

Phone: _____ **Alternate Phone:** _____

Primary Insurance: _____

Insured's Name: _____ **Relation to Patient:** _____

Insured's SS#: _____ **Date of Birth:** _____

Secondary Insurance: _____

Insured's Name: _____ **Relation to Patient:** _____

Insured's SS#: _____ **Date of Birth:** _____

I authorize Baywood Medical Associates, PLLC dba Desert Pain Institute (DPI) to release any information necessary to my insurance carrier and/or their agents in order to determine benefits payable for related services. I authorize the payment of medical benefits for these services to be paid directly to DPI. I authorize the release of all clinical information to my other health care providers so that he/she can be updated on my condition and the care I receive here.

Patient's Signature: _____ **Today's Date:** _____

New Patient Questionnaire



Desert Pain Institute

Relieving pain...restoring lives.

Patient Label

Office use only

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It is recommended you use a No.2 pencil to fill out this form. Please completely erase any mistakes you make. If you have any additional comments, please record them in the comment box provided on page 16. Note that this questionnaire is read by the computer, so any comments recorded outside of the designated area will not be scanned into the medical record nor seen by the medical staff.

Shade Circles Like This--> 

Not Like This-->  

A circle means that only one option can be selected as a response. A square means that multiple answers are allowed.

For optimum accuracy, please print in capital letters and avoid contact with the edge of the box.

The following will serve as an example:

A	B	C	D	E	F	G	H	I	J	K	L	M
N	O	P	Q	R	S	T	U	V	W	X	Y	Z



Today's Date

□□□□ / □□□□ / □□□□□□

First Name

□□□□□□□□□□□□□□□□

Last Name

□□□□□□□□□□□□□□□□

Date of birth (mm/dd/yyyy)

□□□□ / □□□□ / □□□□□□

Referring Physician

□□□□□□□□□□□□□□□□

Primary physician

□□□□□□□□□□□□□□□□

Where is your most bothersome pain located? This is the focus of your visit. I have pain in my: (Choose only one)

- all over body pain
- multiple joints
- multi-level pain
- generalized headaches
- face
- back of head
- right shoulder
- left shoulder
- right arm
- left arm
- both arms
- right arm and neck
- left arm and neck
- both arms and neck
- right hand
- left hand
- neck
- chest
- upper back
- mid back
- abdomen
- low back
- low back and right leg
- low back and left leg
- lowback and both legs
- tailbone
- right groin
- left groin
- pelvis
- right hip
- left hip
- buttocks
- right knee
- left knee
- right leg
- left leg
- both legs
- right foot
- left foot
- other





The precipitating cause for my pain was:
(Choose only one)

- motor vehicle accident
- fall
- skin rash
- surgery
- lifting an object
- illness
- injury
- unsure
- other

The onset of my pain was:

- sudden
- gradual
- gradually increasing episodes
- unsure

My pain began on:

- patient is unsure

- a specific date

Specific date
[][] / [][] / [][][][]



My pain feels like:
(Select all that apply)

- | | |
|------------------------------------|--|
| <input type="checkbox"/> burning | <input type="checkbox"/> stabbing |
| <input type="checkbox"/> shooting | <input type="checkbox"/> sharp |
| <input type="checkbox"/> throbbing | <input type="checkbox"/> dull |
| <input type="checkbox"/> aching | <input type="checkbox"/> electric-shock-like |

Please answer the following questions about your sleep pattern.

My pain keeps me awake at night

yes no unsure

I have trouble sleeping unrelated to pain

yes no unsure



The following symptoms are associated with my pain:
(check all that apply)

- muscle spasms in the painful part
- numbness in the painful part
- tingling in the painful part
- weakness in the painful part
- swelling of the painful part
- sensitive skin in the painful part
- color changes in the painful part

Below is a list of common pain treatments. Please specify if the treatments for your pain were helpful, somewhat helpful, or not helpful. Also record the month(1-12) and year you received that treatment. If you have not tried a treatment, leave that line blank.

Mo. / Yr.

Acupuncture helpful somewhat helpful not helpful /

Biofeedback helpful somewhat helpful not helpful /

Chiropractic treatment helpful somewhat helpful not helpful /

Injections helpful somewhat helpful not helpful /

Physical therapy helpful somewhat helpful not helpful /

TENS unit helpful somewhat helpful not helpful /



Please rate your pain (1=no pain 10=most severe pain)

	1	2	3	4	5	6	7	8	9	10
Currently	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Best	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Worst	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At rest	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
With activity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please note how the following activities affect your pain:

Sitting

increase decrease no effect variable effect

Standing

increase decrease no effect variable effect

Walking

increase decrease no effect variable effect

Lying down

increase decrease no effect variable effect

Leaning forward

increase decrease no effect variable effect

Leaning back

increase decrease no effect variable effect

Emotional stress

increase decrease no effect variable effect

Urination

increase decrease no effect variable effect

Sexual activity

increase decrease no effect variable effect



From the medications listed below, please indicate if the ones you tried were helpful or not helpful.

If you have NOT tried a particular medication, leave that line blank.

Darvon/Darvocet helpful not helpful unsure
Demerol helpful not helpful unsure
Dilaudid helpful not helpful unsure
Fiorinal helpful not helpful unsure
Morphine helpful not helpful unsure
Percocet helpful not helpful unsure
Lortab helpful not helpful unsure
Tylenol 3 helpful not helpful unsure
Vicodin helpful not helpful unsure

MS Contin helpful not helpful unsure
Methadone helpful not helpful unsure
Duragesic Patch helpful not helpful unsure
Oxycontin helpful not helpful unsure

Neurontin helpful not helpful unsure
Topomax helpful not helpful unsure
Tegretol helpful not helpful unsure
Trileptal helpful not helpful unsure
Zonegran helpful not helpful unsure



Baclofen helpful not helpful unsure
Flexeril helpful not helpful unsure
Norflex helpful not helpful unsure
Robaxin helpful not helpful unsure
Skelaxin helpful not helpful unsure
Soma helpful not helpful unsure
Valium helpful not helpful unsure
Xanax helpful not helpful unsure
Zanaflex helpful not helpful unsure

Celexa helpful not helpful unsure
Lexapro helpful not helpful unsure
Paxil helpful not helpful unsure
Prozac helpful not helpful unsure
Zoloft helpful not helpful unsure
Amitriptyline helpful not helpful unsure
Nortriptyline helpful not helpful unsure

Trazodone helpful not helpful unsure
Wellbutrin helpful not helpful unsure

Aspirin helpful not helpful unsure

Celebrex helpful not helpful unsure
Ibuprofen (Motrin) helpful not helpful unsure
Naprosyn (Aleve) helpful not helpful unsure
Relafen helpful not helpful unsure
Toradol helpful not helpful unsure

Lidoderm patches helpful not helpful unsure
Tylenol helpful not helpful unsure
Ultram helpful not helpful unsure



I have the following chronic conditions:
(select all that apply)

- | | |
|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> irritable bowel syndrome |
| <input type="checkbox"/> chronic anxiety | <input type="checkbox"/> history of cancer |
| <input type="checkbox"/> bleeding disorder | <input type="checkbox"/> multiple sclerosis |
| <input type="checkbox"/> blood clotting | <input type="checkbox"/> osteoarthritis |
| <input type="checkbox"/> lung disease | <input type="checkbox"/> osteoporosis/ osteopenia |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> post-polio syndrome |
| <input type="checkbox"/> depression | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> renal failure |
| <input type="checkbox"/> hepatitis | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> HIV | <input type="checkbox"/> ulcer disease |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> vascular disease |
| <input type="checkbox"/> insomnia unrelated to pain | |

I have had the following surgeries:
(Please indicate month and/or year if you know it)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> neck surgery | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> hysterectomy | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> mid back surgery | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> pace maker | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> low back surgery | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> pelvic laproscopy | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> abdominal surgery | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> thyroid surgery | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> appendectomy | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> tonsillectomy | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> breast surgery | <input type="text" value=""/> / <input type="text" value=""/> | | |
| <input type="checkbox"/> cardiac valve surgery | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> rotator cuff repair | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> coronary artery bypass | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> total hip replacement | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> carpal tunnel release | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> hip surgery | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> gallbladder surgery | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> total knee replacement | <input type="text" value=""/> / <input type="text" value=""/> |
| <input type="checkbox"/> hernia repair | <input type="text" value=""/> / <input type="text" value=""/> | <input type="checkbox"/> knee surgery | <input type="text" value=""/> / <input type="text" value=""/> |



In the past year I have been hospitalized:

- multiple times for reasons unrelated to pain
- multiple times for pain and other medical reasons
- I have not been hospitalized in the past year

The following best describes my tobacco use:

- recent use
- quit more than a year ago
- never used

The following best describes my current alcohol use:

- no use
- (0-2 drinks per week)
- (3-5 drinks per week)
- (5 or more drinks week)

The following best describes my recreational drug use:

- recent use
- quit more than a year ago
- never used

Currently I have a substance abuse problem.

- yes alcohol prescriptions drugs street drugs
- no
- unsure

I have in the past had a substance abuse problem.

- yes alcohol prescription drugs street drugs
- no
- unsure

I have completed a substance abuse treatment program.

- yes Treatment year
- no

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I have significant family history for the following chronic illness: (Choose all that apply)

- alcohol abuse /chemical dependency
- chronic back pain
- chronic neck pain
- fibromyalgia
- malignancy
- osteoporosis/ osteoporotic fracture
- psychiatric illness
- rheumatoid arthritis
- spinal degeneration

My marital status is:

- single
- married
- divorced
- widowed
- separated
- in a long term relationship

Children living in my home:

- none
- one
- two
- three
- four
- five
- more than five

The following best describes my place of residence:

- I own a home
- I rent an apartment
- I live with extended family
- I live in an extended care facility
- I live with friends
- I am homeless
- I own a condo



Review of System

Please indicate below whether or not you experience the following symptoms:

Constitutional

- yes no fevers
 yes no weight loss
 yes no generalized weakness
 yes no chronic fatigue
 yes no general sick feeling

Genitourinary

- yes no loss of bladder control
 yes no urinary hesitancy
 yes no bloody urine
 yes no retention of urine
 yes no pain with urination

Neurological

- yes no increasing weakness and numbness in the arms
 yes no increasing weakness and numbness in the legs
 yes no loss of bladder control
 yes no incontinence of bowel

Psychological

- yes no anxiety
 yes no depression
 yes no suicidal thoughts

Head/ Eyes

- yes no headaches
 yes no recent head trauma
 yes no visual disturbance

Muscles

- yes no generalized muscle pain
 yes no swelling of joints
 yes no generalized muscle weakness
 yes no muscle spasms in area of pain

Allergic/ Immunologic

- yes no history of hepatitis
 yes no active chronic hepatitis
 yes no anaphylactic shock in the past
 yes no HIV

Skin

- yes no shingles rash
 yes no skin rash in area of pain
 yes no discoloration in area of pain

ENT

- yes no frequent nose bleeding
 yes no difficulty swallowing
 yes no difficulty hearing

Hematologic/ Lymphatic

- yes no abnormal bleeding tendency
 yes no abnormal clotting
 yes no generalized swelling

Pulmonary

- yes no chronic cough
 yes no shortness of breath
 yes no wheezing

Gastrointestinal

- yes no constipation
 yes no diarrhea
 yes no rectal bleeding
 yes no vomiting
 yes no nausea
 yes no Abdominal pain
 yes no Stomach bleeding
 yes no Black, bloody and/or tarry stool

Cardiovascular

- yes no chest pain with exertion
 yes no swelling of legs and feet
 yes no palpitations
 yes no irregular heart beat

GYN

- yes no post menopausal
 yes no early menopause (before age 45)
 yes no history of sexually transmitted disease

Please answer all of the following questions:

Are you allergic to iodine skin prep? yes no

Are you allergic to x-ray dye? yes no

Do you have a latex allergy? yes no

Are you diabetic? yes no

Do you have a bleeding disorder? yes no

Do you have a tape allergy? yes no

Are you taking blood thinners like Coumadin or Plavix? yes no

Medication

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Any chance you might be pregnant? pregnant
 not pregnant
 unsure
 not applicable

Do you have a lawsuit pending? yes no

Are you planning a lawsuit? yes no

Are you receiving Worker's Compensation? yes no

Do you have formal work restrictions in place? yes no

