

Prolotherapy AZ



Thank you for taking the time to visit our website. We ask that you complete the New Patient Intake forms legibly and as best you can, so we may better help you. If you come across an item you'd prefer not to answer, just go on to the next question.

Please have these forms completed prior to your arrival. We ask that you arrive at least 15 minutes prior to your scheduled appointment with completed forms so that we can put a chart together and go over a few more questions. We are a "fee for service" practice which means we ask for payment in full at time of service. We submit conventional lab work, so we ask that you bring your insurance card with you. As a courtesy, we can submit to your insurance for covered medical services for your convenience.

We are located just off the Loop 101 on Raintree Drive (exit #39). Go east to 92<sup>nd</sup> Street and turn left. We are at the Northeast corner of Raintree Drive and 92<sup>nd</sup> Street in the **Raintree Office Park** business complex.

We look forward to serving you and assisting you on your path to wellness.

**9200 E. Raintree Dr. Ste 150, Scottsdale, AZ 85260**

**480 451-6161- Office /480 306-5304- Fax**



## New Patient Information

Today's Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email: \_\_\_\_\_  
Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_  
Which is the best phone # for appointment reminders or messages? \_\_\_\_\_  
Marital status: S / M / D / W Name of spouse or significant other: \_\_\_\_\_  
# children \_\_\_\_\_ at home \_\_\_\_\_ names: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insurance name and group #: \_\_\_\_\_  
Primary Cardholder: \_\_\_\_\_

### **Your health care team:**

Primary Care Physician: \_\_\_\_\_ City: \_\_\_\_\_  
Other specialist and therapists (including MD, DC, Physical Therapist, Acupuncturist, ND, etc): \_\_\_\_\_  
\_\_\_\_\_

**How did you hear about us (if referred, by whom):** \_\_\_\_\_

### **Please list and describe your medical problems and health concerns in order of importance:**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

**Most recent lab testing and with what physician:** \_\_\_\_\_

### **List all significant surgeries & hospitalizations with approximate dates:**

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_

### **Please describe most recent imaging and the reason, injury or concern:**

X-Ray/mammogram \_\_\_\_\_

MRI/CT Scans: \_\_\_\_\_

Ultrasounds: \_\_\_\_\_ Bone density: \_\_\_\_\_

## MUSCULOSKELETAL PROBLEMS

Please describe your pain or problem and its history with relevant details of injuries and treatments:

Problem#1: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ X-ray or  
 MRI? \_\_\_\_\_ Results: \_\_\_\_\_

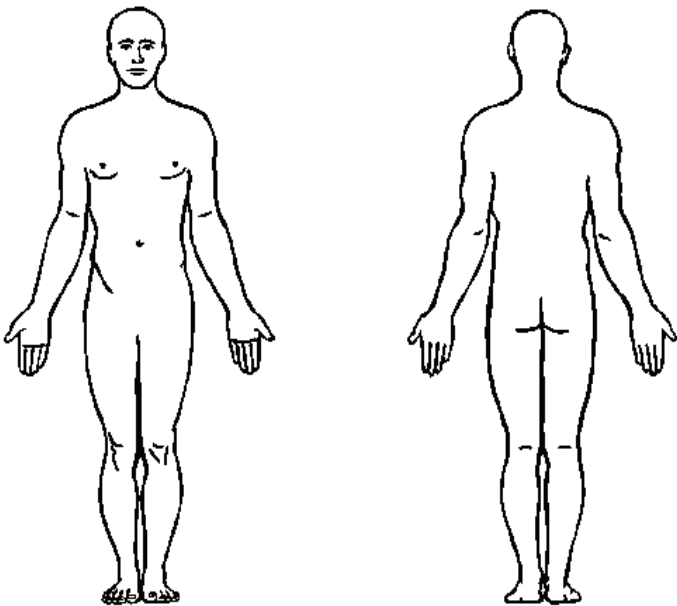
Problem#2: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ X-ray or  
 MRI? \_\_\_\_\_ Results: \_\_\_\_\_

Problem#3: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ X-ray or MRI? \_\_\_\_\_ Results: \_\_\_\_\_

**Do you have any of the following?**  
**Please mark: Y=Yes, current or recent problem; N=No, never a problem; P= Past problem, not current**

- |                |       |                  |       |                   |       |
|----------------|-------|------------------|-------|-------------------|-------|
| Headache:      | Y N P | Migraine         | Y N P | Neck Pain:        | Y N P |
| TMJ Pain:      | Y N P | Upper Back Pain: | Y N P | Middle Back Pain: | Y N P |
| Low Back Pain: | Y N P | Hip Pain:        | Y N P | Sciatica:         | Y N P |
| Shoulder Pain: | Y N P | Elbow Pain:      | Y N P | Wrist Pain:       | Y N P |
| Thumb Pain:    | Y N P | Finger pain      | Y N P | Muscle Spasms     | Y N P |
| Knee Pain:     | Y N P | Ankle Pain:      | Y N P | Foot Pain:        | Y N P |
| Weakness:      | Y N P | Stiffness:       | Y N P | Numbness:         | Y N P |
| Arthritis:     | Y N P | Leg cramps:      | Y N P | Tremors:          | Y N P |

**Circle problem areas below:**



## OVERVIEW OF BODY SYSTEMS

For this section, please circle (Y) for **CURRENTLY**, (N) for **NEVER** and (P) for the **PREVIOUSLY**.

### SKIN

Rash:	Y N P	Color Change:	Y N P	Acne:	Y N P
Hives:	Y N P	Itchy:	Y N P	Eczema:	Y N P
Psoriasis:	Y N P	Skin Cancer:	Y N P		

### HEAD

Headaches:	Y N P	Headache Intensity: 1-10_____	H/A frequency:_____
Head Injury:	Y N P	Hair loss:	Y N P

### NOSE

Frequent colds:	Y N P	Post nasal drip:	Y N P	Congestion:	Y N P
Seasonal allergies:	Y N P	Sinusitis:	Y N P	Nosebleeds:	Y N P

### EYES

Dry eyes:	Y N P	Blurry/dbl vision:	Y N P	Glaucoma:	Y N P
Poor Night Vision:	Y N P	Double vision:	Y N P	Itchy:	Y N P

### MOUTH/THROAT

Dental infections:	Y N P	Mercury fillings:	Y N P	Canker/Cold sore:	Y N P
Sore throats:	Y N P	Gum disease:	Y N P	Loss of taste:	Y N P

### NECK

Pain:	Y N P	Tension:	Y N P	Stiffness:	Y N P
Swollen glands:	Y N P	Goiter:	Y N P	Immobility:	Y N P

### RESPIRATORY

Cough:	Y N P	Bronchitis:	Y N P	Pneumonia:	Y N P
Short of breath:	Y N P	Asthma/wheezing:	Y N P	Emphysema:	Y N P
Valley Fever:	Y N P	Tuberculosis:	Y N P	COPD:	Y N P

### CARDIOVASCULAR

High blood pressure:	Y N P	Arrhythmias:	Y N P	Chest pain:	Y N P
Heart attack/MI:	Y N P	Murmurs:	Y N P	Poor Circulation:	Y N P
Low blood pressure:	Y N P	Leg Swelling/Edema:	Y N P	Rheumatic fever:	Y N P

### URINARY TRACT

Urgent need urinate:	Y N P	Incontinence:	Y N P	Frequent infections:	Y N P
Kidney stones:	Y N P	Pain w/urination:	Y N P	Discharge/blood:	Y N P

### **GASTROINTESTINAL**

Heartburn/GERD: Y N P      Bloating: Y N P      Indigestion: Y N P  
Constipation: Y N P      Diarrhea/loose BM: Y N P      Recent BM change: Y N P  
Nausea: Y N P      Vomiting: Y N P      Change in appetite: Y N P  
Hemorrhoids: Y N P      Gall Bladder disease: Y N P      Liver disease: Y N P

### **DIET & NUTRITION**

3 Meals per day: Y N P      Snack: Y N P      Sit and enjoy: Y N P  
Smoke: Y N P      Caffeine: Y N P      Alcohol: Y N P  
Crave sugar: Y N P      Crave salt: Y N P

### **ENERGY LEVEL**

Energy level on scale 1-10 \_\_\_\_\_ When is energy lowest \_\_\_\_\_  
Chronic Fatigue: Y N P      Good Energy: Y N P

### **EXERCISE**

Is weight a current concern: Y N      Present Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
Lowest adult weight \_\_\_\_\_ What age \_\_\_\_\_      Maximum adult weight \_\_\_\_\_ What age \_\_\_\_\_  
What type of exercise? Walk/Hike \_\_\_\_\_ Jog/Run \_\_\_\_\_ Bike \_\_\_\_\_ Golf \_\_\_\_\_ Yoga \_\_\_\_\_ Tennis \_\_\_\_\_  
Other \_\_\_\_\_  
Duration of exercise and how often? \_\_\_\_\_  
Hobbies and/or other activities: \_\_\_\_\_

### **SLEEP PATTERNS**

Insomnia: Y N P      Wake refreshed: Y N P      Nightmares: Y N P  
Grind teeth: Y N P      Nap during the day: Y N P      Snore: Y N P  
Do you wake up during the night: Y N P      Why? \_\_\_\_\_  
Bedtime: \_\_\_\_\_ Rise at \_\_\_\_\_ How many hours sleep to be refreshed? \_\_\_\_\_

### **MEN ONLY**

Prostate disease: Y N P      Nighttime urination: Y N P      Hernia: Y N P  
Testicular pain/swelling: Y N P      Erectile Dysfunction: Y N P      S.T.D.: Y N P  
Discharge: Y N P      Sexually active: Y N P

### **NERVOUS SYSTEM**

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

### **MENTAL/EMOTIONAL**

Depression: Y N P      Chronic Sadness: Y N P      Anger/irritability: Y N P  
Anxiety: Y N P      High-strung/tense: Y N P      Fear/Panic: Y N P  
Suicidal: Y N P      Eating disorder: Y N P      Psych hospitalization: Y N P  
Any alcohol addiction or treatment: Y N P      Any drug addiction or treatment: Y N P

## TOXIN EXPOSURE

Did you grow up near any polluted area or near any refinery? \_\_\_\_\_ What sort of pollutions were you exposed to \_\_\_\_\_

Do you now or have you had any jobs where you were exposed to solvents, chemicals, paints, heavy metals, fumes or other toxic materials? \_\_\_\_\_ If so, explain: \_\_\_\_\_

Are you sensitive to perfumes, dry cleaning, gasoline, solvents or other vapors? \_\_\_\_\_  
Which types and what reactions? \_\_\_\_\_

Do you use a pest service, frequent dry cleaning, yard chemicals or other chemicals in or around your home \_\_\_\_\_  
Describe: \_\_\_\_\_

## SOCIAL LIFE

Enjoy job: Y N P      Rate work stress 1-10 \_\_\_\_\_      Hours worked per week: \_\_\_\_\_  
Active religious or spiritual practice: Y N P      Prayer \_\_\_\_\_ Meditation \_\_\_\_\_ Affirmations \_\_\_\_\_  
Quality of significant relationship: 1-10 \_\_\_\_\_  
History of mental, emotional, sexual or physical abuse: Y N P      Explain \_\_\_\_\_

## FAMILY HISTORY

	Father	Mother	Siblings	Grandparents	Spouse
Age if living	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N
Autoimmune/SLE/RF:	Y N	Y N	Y N	Y N	Y N
Cancer:	Y N	Y N	Y N	Y N	Y N
Depression/Mental Dx:	Y N	Y N	Y N	Y N	Y N
Diabetes:	Y N	Y N	Y N	Y N	Y N
Domestic Violence:	Y N	Y N	Y N	Y N	Y N
High Blood Pressure :	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N
Hepatitis/Mono:	Y N	Y N	Y N	Y N	Y N
High Cholesterol:	Y N	Y N	Y N	Y N	Y N
HIV/AIDS:	Y N	Y N	Y N	Y N	Y N
Inherited Birth Dx:	Y N	Y N	Y N	Y N	Y N
Kidney/Bladder Dx:	Y N	Y N	Y N	Y N	Y N
Liver/Gallbladder Dx:	Y N	Y N	Y N	Y N	Y N
Pneumonia:	Y N	Y N	Y N	Y N	Y N
Rheumatic Fever:	Y N	Y N	Y N	Y N	Y N
Thyroid Dx:	Y N	Y N	Y N	Y N	Y N

Circle if you have had the following Disease (D)    Immunization (I)    or Neither (N)

Measles:    D I N      Chicken Pox:    D I N      Mumps:    D I N      Rubella:    D I N

Tetanus:    D I N      Whooping Cough:    D I N      Hepatitis:    D I N      HIV:    D I N

Any reactions: \_\_\_\_\_

