DESERT PAIN SPECIALISTS
Interventional Spine Care

PATIENT REGISTRATION

1. First Name: _____ Middle Initial _____ Last Name: _____

Preferred name: _____ Date of Birth: _____ Gender: ○ Female ○ Male

Social Sec. #: _____ Email: _____

Mailing address _____

City: _____ State: _____ Zip Code: _____ Mobile Phone: _____

Home Phone: _____ Ethnicity: ○ Non Hispanic or Latino ○ Hispanic or Latino ○ Decline

Marital Status: ○ Single ○ Married ○ Domestic Partner ○ Separated ○ Divorced ○ Widowed

Race: ○ American Indian ○ African American ○ White ○ Native Hawaiian ○ Asian ○ Other

How did you hear about our clinic? ☐ Referring Physician ☐ Google referral ☐ Patient/ Family referral ☐ Phone book ☐ VA ☐ DPS Employee referral ☐ Radio ☐ News ☐ Other

If yes to Referring Physician, please list name: _____ If other please list: _____

2. EMERGENCY CONTACT *REQUIRED*

Name: _____ Phone #: _____ Relationship: _____

3. RESPONSIBLE PARTY INFORMATION * Minors or Power of Attorney only

Name: _____ Relationship to Patient: _____ Date of Birth: _____ Primary Phone: _____ Social Sec. #: _____

4. Authorization to release health information to: (Example: Spouse/Partner, Parent, Child)

Name(s): _____

Relation to patient: _____

Release the following information:
○ All Records ○ Chart notes
○ Financial Information

Dates of service:
☐ All

Authorization expires:
☐ Never

Date from: _____

Date to: _____

5. INSURANCE INFORMATION *Insurance cards required at time of visit*

Primary Insurance: _____ Policy #: _____ Policy Holder: _____ Date of birth: _____

Secondary Insurance: _____ Policy #: _____ Policy Holder: _____ Date of birth: _____

Is your pain related to the following?
☐ Auto accident ☐ Workers comp

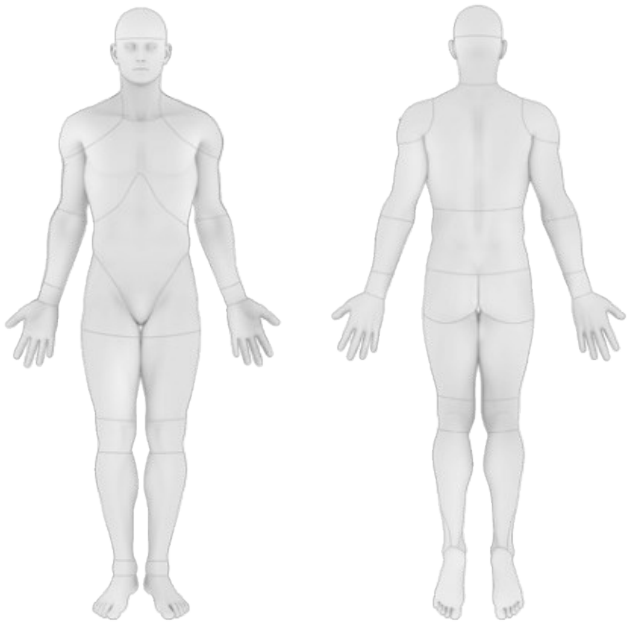
If yes when was the date of injury? _____

Patient or Legal representative

_____
Signature

PAIN DESCRIPTION

6. Please use the diagram below to indicate the area of your pain. Click to highlight



7. What brings you in today? _____ Height: _____ Weight: _____

Briefly describe under what circumstances your pain first began:

_____

8. How long has your current pain problem existed?

_____

How did your current pain problem begin?

○ Acutely ○ Gradually

Does your pain radiate?

○ Yes ○ No

If yes, where?

_____

Since your pain began, how has it changed?

○ Improved ○ Worsened ○ Stayed the same

How often does your pain occur?

○ Constantly (100 % of the time) ○ Frequently (75 % of the time) ○ Intermittently (50 % of the time)
○ Occasionally (25 % of the time)

What time of day is your pain at its WORST?

○ Morning ○ Afternoon ○ Evening ○ Night

If "0" is no pain and "10" is the most severe pain imaginable, how would you rate your pain?

Right now:

_____

9. How would you describe your pain (choose as many adjectives as apply)?

☐ Aching ☐ Burning ☐ Cramping ☐ Deep ☐ Dull ☐ Pinching ☐ Sharp ☐ Shooting ☐ Stabbing
☐ Throbbing ☐ Tight ☐ Tingling

10. Has your pain been associated with any of the following factors?

☐ Chills ☐ Fever ☐ Numbness ☐ Tingling
☐ Muscle Weakness ☐ Muscle Cramps
☐ None that are listed

11. Which of the following factors seem to AGGRAVATE pain?

☐ Bending ☐ Caring for others ☐ Coughing ☐ Driving ☐ Exercise ☐ Household Chores ☐ Laying Down
☐ Lifting ☐ Personal Care ☐ Pulling ☐ Pushing ☐ Sitting ☐ Sneezing ☐ Standing ☐ Stress ☐ Touch
☐ Transitioning from sitting to standing ☐ Twisting ☐ Walking ☐ Weather ☐ Yardwork
☐ None that are listed

12. Which of the following ALLEVIATE your pain?

☐ Heat ☐ Ice ☐ Stretching ☐ Lying Down ☐ Position Change ☐ Walking ☐ Relaxation ☐ Sitting
☐ Standing ☐ Tylenol/Ibuprofen ☐ Pain Medications

Other:

_____

13. What areas of your life have been affected by your pain?

☐ Appetite ☐ Finances ☐ Intimacy ☐ Mood ☐ Personal Care ☐ Physical activity ☐ Relationships ☐ Sleep ☐ Travel ☐ Work

14. Please list the providers name the following doctors you have seen.

Primary care provider _____

Orthopedic Surgeon _____

Neurologist _____

Rheumatologist _____

Cardiologist _____

15. Have YOU had any of the following diagnostic studies in the last 5 years PERTAINING to your pain?

Yes ☐

No recent imaging ☐

What facility was imaging completed at? (if applicable)

☐ Intermountain Health Care ☐ Revere Health ☐ Taylor med ☐ Other

16. Are you currently taking any blood thinners or anti-coagulants?

○ Yes

○ No

17. If YES, which ones?

☐ Aspirin ☐ Warfarin ☐ Plavix ☐ Xaralto ☐ Eliquis

Other:

_____

SURGICAL HISTORY **SPECIFIC TO CURRENT PAIN**

18.

	Type of Surgery	Approximate Year/Date
1		
2		
3		

ALLERGIES

19. Have you ever had an allergic reaction to any of the following?

☐ Adhesive tape ☐ Anesthesia ☐ Aspirin

☐ Latex ☐ Contrast Dye ☐ NONE LISTED

20. Do you have any history of MEDICATION allergies?

- ○ No known allergies
- ○ Yes

If yes, please specify:

_____

21. Which of the following treatments have you tried for your current pain?

	Approximate Date	Excellent Relief	Moderate Relief	No Relief
Anti-Inflammatory/NSAIDS				
Back Brace				
Chiropractic care				
Heat/Ice				
Epidural / Radionfrequency Injections				
Pain Medication				
Physical Therapy				
Surgery				
Medical Cannabis				
Acupucture				
Activity Modification				
Massage				
Tens Unit				

Other:

_____

PRESENT MEDICATIONS

22. Please list all prescription, OTC, herbal and/or vitamin (nutritional) supplements you are currently taking.

	Name of Medication, OTC, herbal and/or vitamin	Dosage	Frequency
1			
2			
3			
4			
5			
6			

MEDICAL HISTORY

23. Do YOU have a history of any of the following?

- ☐ Alcohol abuse
- ☐ Liver disease
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Depression
- ☐ Asthma
- ☐ Bleeding problems
- ☐ Kidney disease
- ☐ Type 2 Diabetes
- ☐ Seizures
- ☐ NONE LISTED
- ☐ Cancer
- ☐ Hay Fever
- ☐ Anemia
- ☐ Neuropathy
- ☐ Hypertention
- ☐ HIV or AIDS
- ☐ Drug abuse
- ☐ CAD coronary artery disease
- ☐ Type 1 Diabetes
- ☐ COPD
- ☐ Headaches/ Migraines
- ☐ Chest pain
- ☐ CHF congestive heart failure
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Shortness of breath
- ☐ Infection problems
- ☐ Fibromyalgia
- ☐ A-Fib
- ☐ Pacemaker

FAMILY HISTORY

24. Is there a history of any of the following in your immediate family?

- ☐ Anesthesia problems
- ☐ Arthritis
- ☐ Bleeding disorders
- ☐ Cancer
- ☐ Kidney disease
- ☐ Headache/Migraines
- ☐ Heart disease
- ☐ High Blood Pressure
- ☐ Substance abuse
- ☐ NONE THAT ARE LISTED
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Diabetes

SOCIAL HISTORY

25. Occupation/previous occupation: _____

○ Retired ○ Disabled ○ Employed

Do you use tobacco?
○ Yes ○ No

If yes, select one below
☐ Smoke ☐ Chew
☐ Quit Smoking

Date: _____

Do you drink alcohol?
○ Daily ○ Weekly ○ Seldom ○ Never
○ Recovering Alcoholic

Have you ever had a history of substance abuse?
○ Yes ○ No

REVIEW OF SYSTEMS (ROS)

26. **Please mark any of the following that you are CURRENTLY experiencing**

Constitutional:
☐ Body aches ☐ Difficulty sleeping ☐ Fatigue
☐ Chronic pain

Head/Ears/Nose/ Throat (HENT):
☐ Difficulty hearing ☐ Sleep apnea ☐ Vertigo
☐ Recent head injury

Respiratory
☐ Asthma ☐ Shortness of breath

Genitourinary
☐ Urinary incontinence ☐ Vaginal pain
☐ Scrotal pain ☐ Kidney Dialysis

Musculoskeletal
☐ Back pain ☐ Joint pain ☐ Muscle cramps
☐ Muscle weakness ☐ Neck pain ☐ Feet pain

Psychiatric
☐ Anxiety ☐ Depression ☐ Memory Disturbance
☐ Suicidal thoughts

Eyes:
☐ Blurred vision ☐ Sensitivity to light
☐ Use of glasses/contacts

Cardiovascular:
☐ Blood clots ☐ Chest pain
☐ High blood pressure ☐ Swelling in feet or legs

Gastrointestinal
☐ Abdominal pain ☐ Bowel incontinence
☐ Constipation ☐ Nausea

Neurological
☐ Dizziness ☐ Headaches/Migraines
☐ Numbness and tingling ☐ Seizures

Endocrine
☐ Diabetes ☐ Increased fatigue

Hematologic/Lymphatic
☐ Bleeding disorder ☐ Easy bruising
☐ Excessive bleeding

DESERT PAIN SPECIALISTS
Interventional Spine Care

Policy, Authorizations and Financial Agreement

Patient Name: _____ Patient DOB: _____

AUTHORIZATION AND CONSENT:

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH) and Omnibus Rule. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out any and all of the following:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
2. Obtaining payment from third party payers (e.g., my insurance company);
3. The day-to-day healthcare operations of Desert Pain Specialists.
4. Any other non-public personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits for me and/or my dependent(s).

I have also been informed of and given the right to review and secure a copy of your Notice or Privacy Practices, which contains a more complete description of uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I certify that I understand the privacy risks of mail, email and phone calls. I hereby authorize a Desert Pain Specialists representative or my physician to mail, email or call me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements and laboratory results.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to this requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I have the right to revoke this consent at any time by notifying Desert Pain Specialists to that effect in writing. However, if you do agree, you are then bound to comply with this restriction.

I hereby consent to evaluation, testing and treatment (including but not limited to, medication history, use of x-ray and other non-invasive procedures such as diagnostic testing) to be performed as directed by my Desert Pain Specialists physician or his or her designee. I realize that if a medical procedure is required, I will be given additional information.

FINANCIAL AGREEMENT:

I hereby authorize direct payment of my insurance benefits to Desert Pain Specialists, or the physician individually, for services rendered to me or my dependents by the physician or under his/her supervision and agree to pay any balance that is due. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

I understand that I may receive a separate bill if my medical care includes lab, x-ray and/or other diagnostic services. I understand and agree that I will be financially responsible for any co-pay or balance due that Desert Pain Specialists is unable to collect from my insurance carrier for whatever reason. I understand that I will be responsible for any additional fees incurred from the following:

• Returned Checks • Missed Appointments • Copies of Medical Records • Non-payment of co-pays/deductibles at time of service

In the event any balance is not paid as agreed upon and/or my account is referred to a collection agency, I agree to pay all collection fees. I further agree to pay court costs and reasonable attorney's fees in addition to the collection fee. I hereby authorize the facility, Desert Pain Specialists, or any other collection or servicing agency or agencies retained by the facility (together referred to hereafter as "collectors") to contact me by telephone or text message at any number given by me or otherwise associated with my account, including but not limited to, mobile/cellular, wireless or similar devices for any lawful purpose. I agree to pay any fee(s) and/or charge(s) that I may incur for incoming calls from collectors, and/or outgoing calls to collectors, to or from any such number and understand I will not be reimbursed.

APPOINTMENT POLICY:

Because your appointment has been reserved for you and/or your family member(s), you are required to provide at least 24 hours advanced notice if you are unable to keep your scheduled appointment. This allows us to offer another patient that time spot and prevents a cancellation fee from being applied to your account. The **No Show fee** for all appointments is **$50.00**. It is important to note that our No Show fees are not payable by your insurance carrier(s) and will be your responsibility. Repeated missed appointments may result in termination of your physician's care. There may be a time when your physician may need to cancel your appointment for an emergency; we will make every effort to reschedule you in an appropriate time frame.

PRESCRIPTION REFILL REQUESTS:

With any long-term medications, we require regular office visits. We request a 48 hour notice if you are requesting a refill to be called into your pharmacy.
I give Desert Pain Specialists consent to import and export my medication/medical history as provided by SureScripts. This will be performed through the Health Information Exchange.
By signing the line below you are stating that you have read and agree to all portions of this contract.

_____ _____

Signature of patient or patient's representative Date

Depression Questionnaire 2025

Over the **LAST 2 WEEKS,** how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1.Little interest or pleasure in doing things	☐	☐	☐	☐
2.Feeling down depressed or hopeless	☐	☐	☐	☐
3.Poor appetite or over eating	☐	☐	☐	☐
4.Feeling tired or having little Energy	☐	☐	☐	☐
5.Trouble falling or staying asleep or sleeping too much	☐	☐	☐	☐
6.Feeling bad about yourself or that you are a failure or have let your family down	☐	☐	☐	☐
7.Trouble concentrating on things, such as reading or television	☐	☐	☐	☐
8.Moving or speaking slowly that others may have noticed or the opposite being fidgety more than usual	☐	☐	☐	☐
9.Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

Do you have a history of falling in the last year?	YES ☐	NO ☐
Do you use crutches, cane or a walker?	YES ☐	NO ☐
Do you have an advanced care plan?	YES ☐	NO ☐
If you answered yes to having an advanced care plan- Do you have a surrogate decision maker?	YES ☐	NO ☐

If you answered yes to having a surrogate decision maker Please list their name and relationship to you _____

Names and DOB (Patient's) _____