Zona Spine and Pain
750 N Estrella Parkway, Suite 60
Goodyear, AZ 85338
(P) 623-321-5079 || (F) 623-321-5083

Patient Intake Forms

Patient Name: ______________________________________ Date of Birth: _______________ Gender : _____________
Address: ____ City:________________________
State: ________________ Zip: _____________ SSN: ____

Cell Phone: __________________________ Home Phone: ________________________ Preferred ❍ Cell ❍ Home
Is it okay to leave messages? ____________

Email Address for Patient Portal: ____
(Patient Portal : Please provide your personal email address. Portal may be used for communication, bill pay, appointments.)

Emergency Contact Name: ______________________________ Relationship: _____________ Phone: __________________

Marital Status: _______________________ Preferred Language: _____________ Occupation: _________________________
Race: ____ Ethnicity: ❍Hisp./Latino ❍ Non Hisp./Latino ❍Decline to Specify

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Primary Insurance: _______________________________________ Policy #: _________________________________
Primary Subscriber Name: _______________________________________ Prim Subscriber DOB: ___________________
Relationship to Prim. Subscriber: ___________________________ Employer: __________________________________

Secondary Insurance: _____________________________________ Policy #: _________________________________
Primary Subscriber Name: _______________________________________ Prim. Subscriber DOB: __________________
Relationship to Prim. Subscriber: ___________________________ Employer: __________________________________

Is your pain related to a Motor Vehicle Accident or any other Personal Injury Claim?__________ *(Skip to next section if NOT)*
Date of Injury: ____________________________________ Was injury the fault of another party? __________________
Do you have an attorney representing you? ______________
*****Please notify staff if your visit is related to an MVA or Personal Injury claim. Additional information will be required.**

Is there an active Workers' Compensation claim related to your pain? ____________ *(Skip to next section if NOT)*
Date of Injury: ______________________ State where work related injury occurred: ____________________________
Employer at time of injury: ____
WC Insurance Carrier Name: ____ Claim #: ________________________
Adjustor Name: ____ Adjustor Phone: ______________________________
Attorney Name: ____ Attorney Phone: ___________________________
*****Please notify he staff if your visit is related to a Workers' Comp claim.**

Primary Care Provider(PCP) Name: _______________________________________ Phone: ________________________
PCP Address/Location: ____ Referred by PCP? _____________________
If referred by physician other than PCP, please provide referring physicians name: ______________________________
If none of the above, how did you hear about Zona Spine and Pain: ____

I acknowledge that all of information above is true to the best of my knowledge:

Patient Signature ____ **Date:** _______________

Patient Name: ____

Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have had the opportunity to review the NOTICE OF PRIVACY PRACTICES, which is displayed for public viewing in the reception area of Zona Spine and Pain and on its website www.zonaspine.com. This notice describes how my protected health information may be used and disclosed and how I may access my health records.

Patient Signature: ____ **Date:** ____________________

Consent to Release Personal Health Information

By signing below, I authorize Zona Spine and Pain to use and disclose any and all of my protected health information of any kind and description to the following parties. This information may be disclosed to and used by the following individuals and organizations.
Name: ____ Relationship: __________________
Name: ____ Relationship: __________________
Name: ____ Relationship: __________________

Patient Signature: ____ **Date:** __________________________

General Consent

1. Consent to Treat: I request and authorize medical treatment as may be deemed medically necessary and appropriate by the physician(s), mid-level practitioner(s), and the practice's designees and assistants participating in my care. This care may include diagnostic, radiology and laboratory procedures, anesthesia, therapeutic procedures, drugs, devices, medical, nursing and durable medical equipment. I will be informed of the nature and purpose of the treatment, and potential common side effects as well as alternative treatment. I understand I will sign a separate informed consent for my injection/surgical procedure and for anesthesia.
2. Consent to Release Information to Insurance: I authorize the release of Protected Health Information to third party payors and other healthcare practitioners. I assign and authorize payment from my insurance company directly to Zona Spine and Pain for any and all services rendered.

Patient Signature: ____ **Date:** _____________________

Missed Appointment Policy

It is the responsibility of the patient to call at least 24 hours in advance of their scheduled appointment if the patient cannot make their appointment. If a patient fails to show for a scheduled appointment without contacting the office staff directly at least 24 hours in advance to cancel, then the patient will be responsible for a Missed Appointment Fee of $25.00 for office visits and $50.00 fee for procedure visits. This fee will be billed to the patient, not their insurance company, and will be due at their next scheduled appointment. It is the responsibility of the patient to keep track of their appointment date and time, and to contact the office if unable to keep the appointment.

I have read the above, understand it fully, and agree to pay the $25.00 fee for any missed appointment for consultations and $50.00 for procedure visits by signing below:

Patient Signature: ____ **Date:** ______________________

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. The collected information is stored in the practice electronic medial record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions. It is important that you and your provider discuss all your medication in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance. Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own man not be included.
I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.
Patient Signature: ____ **Date**: ______________________

Patient Name: ____

Payment Policy

Self-Pay Patients: All cash patients and patients that present without valid insurance information are considered Self-Pay Patients. If your insurance does not pay for services rendered by Zona Spine and Pain, you are considered a Self-Pay Patient. Services are based on our current Self-Pay fee schedule. All Self-Pay Patients are required to pay at the time service. If you are unable to pay for the services in full, we reserve the right to reschedule your appointment until the time you are able to make your payment. We accept Cash and Credit Cards.

Initial: _______________

Patients with Health Insurance: If you have health insurance, you have entered a contract with your insurance carrier. You are ultimately responsible for payment for all medical services provided to you. Unless the network agreement between Zona Spine and Pain and your insurance carrier limits us, any charges not paid by your insurance carrier is your responsibility. The most recent insurance card must be presented at each visit to verify the information on file. It is your responsibility to inform us of any changes to your insurance information. Depending on your specific insurance plan, you may be required to pay copayments, coinsurance, and/or a deductible due at the time of your visit. Some plans have a combination of two or three of the aforementioned items. **Initial:** _______________

Insurance Participation: Zona Spine and Pain is contracted with many insurance carriers and policies but not all. It is your responsibility to contact your insurance carrier and verify our participation in your specific plan. If we are not contracted with your insurance policy, you may have out-of-network benefits with higher copayments and deductible. It is your responsibility to meet these requirements. Out-of-Network payments from your insurance carrier may be paid directly to you. It is your responsibility to forward these payments to Zona Spine and Pain immediately. If your insurance requires a referral to see a specialist, it is your responsibility to obtain this referral prior to your appointment.

Initial: _______________

Services Not Covered by Insurance: Zona Spine and Pain might recommend services your insurance carrier might require a prior authorization for or might exclude. We will make every effort to obtain a prior authorization on your behalf. But it is your responsibility to find out from your carrier whether the services provided to you are covered benefits by your insurance carrier. If the services are not covered, you are ultimately responsible for the charges.

Initial: ________________

Unpaid Accounts: Zona Spine and Pain reserves the right to refuse treatment to those patients with outstanding balances over 90 days. If your balance remains unpaid over 120 days and no payment arrangement has been made, we reserve the right to turn your balance over to a collections agency. **Initial:** ________________

Refunds: If there is an overpayment after all services have been paid for by insurance and the patient's responsible party, you may submit a written request for a refund of the overpayment. **Initial:** _______________

Patient Signature: ____ **Date:** __________________________

Patient Name: ____

PREFERED PHARMACY NAME: ______________________________ Phone #: ____________________
Cross Streets or Address of Preferred Pharmacy: ____________________________________

Primary Care Provider Name: ______________________ Ph: ______________ Fax: ______________
Referring Doctor (if other than PCP): ____________________Ph:_______________Fax:_______________

Reason for Visit: ____

Did your pain begin: ❑ Gradually ❑ Suddenly

When did your pain begin? Exact date or approximate: ________________________________
Was there an event that caused your pain?: _______________________________________

Your pain has been: ❑Worsening ❑Improving ❑Stayed the same

Weight (lbs.): ______________ Height: ________________

Opioid Risk Tool

Mark each box that applies	**Females** (Mark under this column)	**Males** (Mark under this column)
Family History of Substance Abuse		
• Alcohol	❑	❑
• Illegal Drugs	❑	❑
• Prescription Drug Abuse	❑	❑
Personal history of substance abuse		
• Alcohol	❑	❑
• Illegal Drugs	❑	❑
• Prescription Drug Abuse	❑	❑
Your Age (check box if between 16-45)	❑	❑
Personal History of preadolescent sexual abuse	❑	❑
Personal History of Psychological disease		
• ADD, OCD, Bipolar, Schizophrenia	❑	❑
• Depression	❑	❑

❑ **None of the above apply**

Patient Name: ____

Patient Health Questionnaire 9

Over the past 2 weeks, how often have you been bothered by the following?

0= Not at all
1=Several days over the past 2 weeks
2=More than half the days over the past 2 weeks
3=Nearly every day over the past 2 weeks

1. Little interest or pleasure in doing things ❍0 ❍1 ❍2 ❍3
2. Feeling down, depressed or hopeless ❍0 ❍1 ❍2 ❍3
3. Trouble falling or staying asleep or sleeping too much ❍0 ❍1 ❍2 ❍3
4. Feeling tired or having little energy ❍0 ❍1 ❍2 ❍3
5. Poor appetite or overeating ❍0 ❍1 ❍2 ❍3
6. Feeling bad about yourself, that you are a failure or that you have let yourself or your family down ❍0 ❍1 ❍2 ❍3
7. Trouble concentrating on things, such as reading the newspaper or watching television ❍0 ❍1 ❍2 ❍3
8. Moving or speaking slowly that other people could have noticed. Or the opposite being so fidgety or restless that you have been moving around a lot more than usual ❍0 ❍1 ❍2 ❍3
9. Thoughts that you would be better off dead, or of hurting your self ❍0 ❍1 ❍2 ❍3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people

❍Not difficult at all ❍Somewhat difficult ❍Very difficult ❍Extremely Difficult

Patient Name: ____

PAIN DISABILITY INDEX

The rating scale below helps us to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

A score of 0 means NO disability at all, and a score of 10 signifies (WORST DISABILITY) that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain. (Total 7 sections)

1. Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

   ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

2. Recreation: This disability includes hobbies, sports, and other similar leisure time activities.

   ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

3. Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

   ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

4. Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

   ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

5. Sexual Behavior: This category refers to the frequency and quality of one's sex life.

   ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

6. Self-Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

   ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

7. Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.

   ❒0 ❒1 ❒2 ❒3 ❒4 ❒5 ❒6 ❒7 ❒8 ❒9 ❒10

Patient Name: ____

Past Medical History

____

____

____

Past Surgical History

____

____

____

Prior Consultations

Mark the following physicians or specialists you have consulted for your current pain problem(s):

☐ Acupuncturist ☐ Neurosurgeon ☐ Psychiatrist/Psychologist

☐ Chiropractor ☐ Orthopedic Surgeon ☐ Rheumatologist

☐ Internist ☐ Physical Therapist ☐ Neurologist

☐ Other ____

Family History

Family history of Drug/Alcohol Abuse**:** ❍Yes ❍No Explain: ______________________________________

Relationship	Health Problem
Mother	
Father	
Sibling: Brother or Sister (circle)	
Sibling: Brother or Sister (circle)	
Other significant family history	

Social History

❑Singe ❑Married ❑Divorced ❑Separated ❑Widowed ❑Partnered ❑Other

Do you have children? ❑Yes ❑No How Many? __________________

Do you drink Alcohol? ❑Yes ❑No How Much? ______________________ per _____________

Do you use any Illicit Substances? ❑Yes ❑No Substance: __________________________________

Do you work: ❑Yes ❑No ❑Retired ❑Student Occupation/Prev. Occupation: _____________________________

Do you Smoke? ❑Yes ❑No ❑Former Smoker How Much? __________________________ per _______________

Patient Name: ____

Review of Systems

Are you experiencing any of the following?

- **Constitutional/General:**
  ❑None
  ❑Fever
  ❑Chills
- **Cardiovascular**:
  ❑None
  ❑Chest Pain/Angina
- **Respiratory:**
  ❑None
  ❑Shortness of Breath
- **Musculoskeletal**:
  ❑None
  ❑Recent Trauma (less than 2 months ago)
- **Psychological:**
  ❑None
  ❑Depression
  ❑Anxiety
- **Gastrointestinal**:
  ❑None
  ❑Abdominal Pain
- **Genitourinary**:
  ❑None
  ❑Urinary Incontinence
  ❑Bowel Incontinence
- **Skin:**
  ❑None
  ❑Rashes
- **Neurological:**
  ❑None
  ❑Dizziness
  ❑Headaches
- **Endocrine:**
  ❑None
  ❑Weight Changes

Medications

Allergies to Medications: ____

Current Medication List		
Medication	**Dose (mg)**	**Frequency**

****Provide list to staff if available**

Patient Name: ____

Imaging / Nerve Study				
Region of Body	**Imaging Type**	**Approximate Date**	**Facility**	**Other Information**
	❑MRI ❑CT ❑X-ray ❑EMG/NCS Other: ____________			
	❑MRI ❑CT ❑X-ray ❑EMG/NCS Other: ____________			
	❑MRI ❑CT ❑X-ray ❑EMG/NCS Other: ____________			
	❑MRI ❑CT ❑X-ray ❑EMG/NCS Other: ____________			
	❑MRI ❑CT ❑X-ray ❑EMG/NCS Other: ____________			

- Have you had a fall in the last 3 months? ❑Yes ❑No
- If you are on opioids to treat your pain, is your quality of life better on them? ❑ Yes ❑No ❑Not Applicable
- Have you experienced any side effects from opioids? ❑Yes ❑No ❑Not Applicable
- Do you have any bowel or bladder incontinence? ❑Yes ❑No
- Have you experienced any significant upper or lower extremity weakness? ❑Yes ❑No
  Explain: ____

Neck Pain

(Mark "No Neck Pain" if none and skip to next section)

- Neck Pain Status: ❑Getting Worse ❑Getting Better ❑Staying the Same ❑No Neck Pain

- Select all that apply regarding the Neck Pain:
  ❑Right ❑ Left ❑Center → *With radiation to (if applicable)*: ❑Arm ❑Hand ❑Shoulder Blade/Scapula ❑Head
  Other Neck Symptoms: ____

- Average Neck Pain Score: ______________ (scale of 1-10. With 10 being worst)

- Onset/Duration of Neck Pain: ❑Less than 3 months ago ❑More than 3 months ago ❑Other
  Explain: ____

- Timing of Neck Pain: ❑Intermittent ❑Constant

- What causes the neck pain? (select all that apply):
  ❑Movement ❑Bending ❑Lying Down ❑Walking ❑Standing ❑Sitting ❑Other (Explain)
  Additional Information: ____

- Modifying/Relieving Factors (select all that apply)
  ❑Massage ❑Medication ❑Rest ❑Standing ❑Stretching ❑Walking ❑Other (Explain)
  Additional Information: ____

Patient Name: ____

Lower Back Pain

(Mark "No Low Back Pain" in none and skip to next section)

- Low Back Pain Status: ❑Getting Worse ❑Getting Better ❑Staying the Same ❑No Low Back Pain
- Select all that apply regarding the Lower Back Pain:
  ❑ Right ❑Left ❑Center → *With radiation to (if applicable):* ❑Leg ❑Thigh ❑Hip/Buttocks
  Other Low Back Pain Symptoms ____
- Average Low Back Pain Score: ______________________ (scale of 1-10. With 10 being worst)
- Onset/Duration of Low Back Pain: ❑ Onset less than 3 months ago ❑Onset more than 3 months ago
  ❑Other. Explain: ____
- Timing Low Back Pain: ❑Intermittent ❑Constant
- What Causes the Pain? ❑Movement ❑Bending ❑Lying Down ❑Walking ❑Standing ❑Sitting
  ❑Other. Explain: ____
- Modifying/Relieving Factors. (Select all that apply):
  ❑Massage ❑Medication ❑Rest ❑Standing ❑Stretching ❑Walking ❑Other
  Additional Information: ____

Mid Back Pain

(Mark "No Mid Back Pain" and skip to next section)

- Mid Back Pain Status: ❑Getting Worse ❑Getting Better ❑Staying the Same ❑No Mid Back Pain
- Select all that apply:
  ❑Right ❑Left ❑Center → *With radiation to (If applicable)*: ❑Ribs
- Other Mid Back symptoms: ____
- Average Mid Back Pain Score: ______________________ (scale of 1-10. With 10 being worst)
- Onset/Duration of Mid Back Pain: ❑Onset Less than 2 months ago ❑Onset More than 3 months ago ❑Other
  Additional Information: ____
- Timing Mid Back Pain ❑Intermittent ❑Constant
- What causes the pain? (select all that apply)
  ❑Movement ❑Bending ❑Lying Down ❑Walking ❑Standing ❑Sitting ❑Other causes
  Additional Information: ____
- Modifying/Relieving Factor (select all that apply)❑Massage ❑Standing ❑Medication ❑Rest
  ❑Stretching ❑Walking ❑Other Additional Information: ______________________

Patient Name: ____

Other Pain

(Mark "No "Other" pain and skip to next section)

- Other Pain Status: ❑Getting Worse ❑Getting Better ❑Staying the Same ❑No "Other" Pain
- Select all that apply:

  ❑Knee: ❑Right ❑Left ❑Abdomen

  ❑Shoulder: ❑Right ❑Left ❑Headache

  ❑Hip: ❑Right ❑Left ❑Fibromyalgia

  ❑Other: ____
- Average Other Pain Score: ____________________ (scale of 1-10. With 10 being worst)
- Onset/Duration of Other Pain: ❑Onset Less than 3 months ago ❑Onset More than 3 months ago ❑Other

  Additional Information: ____
- Timing of Other Pain: ❑Intermittent ❑Constant
- What causes the pain? (Select all that apply)

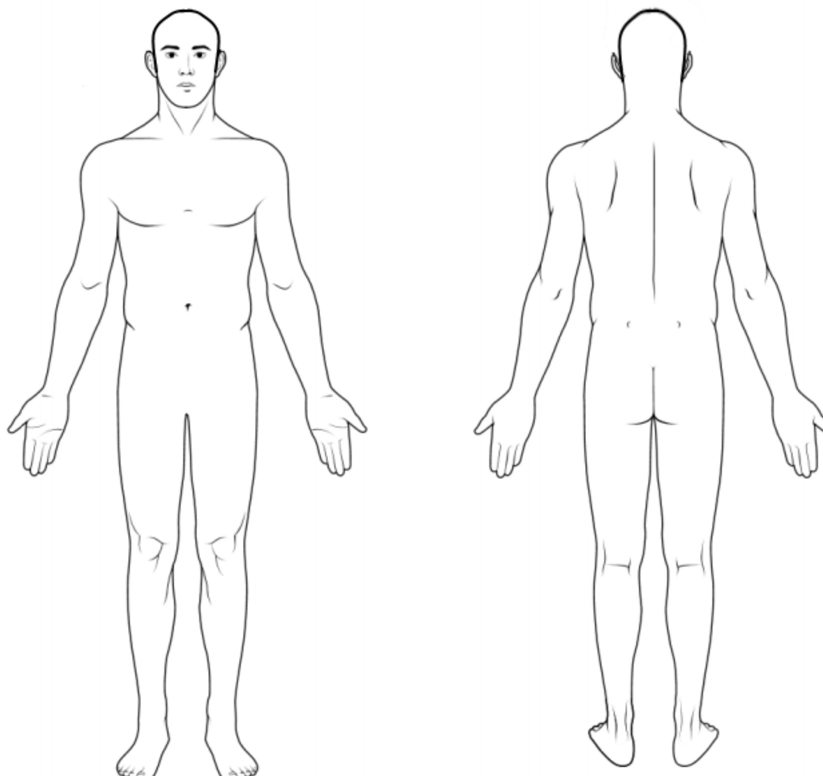
  ❑Movement ❑Bending ❑Lying Down ❑Walking ❑Standing ❑Sitting ❑Other causes

  Additional Information: ____
- Modifying/Relieving Factors: (Select all that apply)

  ❑Massage ❑Standing ❑Medication ❑Rest ❑Stretching ❑Walking ❑Other

  Additional Information: ____

Please mark your areas of pain:



CONTROLLED SUBSTANCE (OPIOID) AGREEMENT

Alternatives to a prescribed opioid will be explained to me, however, if my consultation today results in the doctor prescribing any controlled substance/opioid for my pain/condition, I promise to the following for my current visit and for all future visits:

1. I understand that there are risks associated with the use of prescribed controlled substance medications, such as dependence, addiction, personality change, sleep disorder, constipation, appetite changes, loss of coordination and changes in sexual desire and performance.
2. I will not receive replacements for lost or stolen medications.
3. I will not loan, trade, sell, or give my medications to anyone else under **ANY** circumstance.
4. Making appointments monthly or as directed for medication refills is my responsibility and I understand that **NO REFILLS WILL BE GIVEN AFTER HOURS, ON WEEKENDS OR HOLIDAYS.**
5. I understand that drug testing and/or pill counts are part of my treatment. I agree to submit to Urine, Oral, and/or Blood drug testing to detect the use of my prescribed and non-prescribed medications and/or potential illicit substances. Testing may be done randomly or on demand.
6. I will receive controlled substances ONLY from Zona Spine and Pain unless arrangements have been made with my other physician/provider and Zona Spine and Pain is aware of these arrangements. I understand that my status will be verified that I am receiving my controlled substance medication through the Arizona Board of Pharmacy Prescription Monitoring Program (AZPMP).
7. I will not expect to receive additional medications before my next scheduled refill, even if my prescription runs out.
8. I understand that running out of my medications early is considered self-adjustment of my dose and is not allowed without prior approval by my physician/provider at Zona Spine and Pain.
9. If it appears to the physician/provider that my daily functioning and quality of life are not benefiting from the treatment with the controlled substance(s), I will be tapered off my medication(s) as directed by my physician/provider. I will not hold any member of Zona Spine and Pain liable for the problems caused by the discontinuance of controlled substances.
10. I will refrain from using illicit substances.
11. I understand that there are potential risks, adverse outcomes, complications and even death associated with the concurrent use of an opioid and benzodiazepine or other sedative-hypnotic medications if I am prescribed such medications even from another medical provider.
12. I understand that I must make sure the office has current contact information in order to reach me. It is my responsibility to ensure that my contact information is up to date.
13. I recognize that my pain may represent a complex problem that may benefit from physical therapy, psychotherapy, injection therapy, and behavioral modifications. My participation in a multimodal approach to treat my symptoms is extremely important and I agree to this treatment plan to maximize my level of functioning and to increase my ability to cope with my condition.
14. I understand that I may be prescribed potentially dangerous medications and that, if taken improperly, it may lead to excess sedation, respiratory depression and DEATH.
15. If I am pregnant or become pregnant while receiving Opioid medications or other mind-altering substances, I will notify the provider immediately.
16. I will review and follow the instructions provided with my medications and by my pharmacist. I understand that my medication may impair my ability to perform certain activities, such as driving and operating equipment, and that I should avoid such activities, if impaired.
17. **If I do not adhere to any of these above conditions, my treatment program at Zona Spine and Pain may be terminated and I will be discharged from receiving care from the practice.**

I have read and understand the above and agree to abide to this Controlled Substance Agreement.

Patients Name (Printed) ____ **DOB:** ___________________

Patient Signature: ____ **Today's Date:** _______________