

New Patient Intake Forms

Your completed intake paperwork helps our physicians and other providers get to know you and your medical history. We rely on its accuracy and completeness to provide you with the best possible care. If you have questions about any section, please ask at the front desk or call (501) 227-0184.

This form takes about 10–15 minutes to complete. If a section does not apply to you, check the “None” or “NEVER” box and continue to the next section.

Patient Information

First name: _____ Last name: _____
 Date of birth: _____ Age: _____ Email: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Phone: _____ Alternate phone: _____
 Preferred contact: ☐ Phone ☐ Text ☐ Email Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
 May we contact you by text message regarding new treatments or therapies? ☐ Yes ☐ No
 Emergency contact: _____ Phone: _____ Relationship: _____
 Referring physician: _____ Primary care physician: _____
 How did you hear about us? ☐ Family/Friends ☐ Commercial/Ad ☐ Physician ☐ Other: _____

Primary Insurance Information

Insurance company: _____ Phone: _____
 Policy ID number: _____ Group number: _____
 Subscriber name: _____ Relationship to subscriber: _____

Secondary Insurance Information

Insurance company: _____ Phone: _____
 Policy ID number: _____ Group number: _____
 Subscriber name: _____ Relationship to subscriber: _____

Workers' Compensation / Personal Injury Claim Information

Is this visit related to a workers' compensation claim? ☐ Yes ☐ No
 Work comp carrier: _____ Date of injury: _____
 Claim ID: _____ Adjuster's name: _____
 Adjuster's phone: _____ Adjuster's fax: _____
 Is this visit related to an auto or other accident filed under a personal injury claim? ☐ Yes ☐ No
 Attorney's name: _____ Phone: _____
 Attorney's practice (firm) name: _____

Preferred Pharmacy Information

Pharmacy name: _____ Phone: _____
 Street address: _____ City/State/ZIP: _____
 Other pain management physicians you have seen in the past: _____

Patient Name: _____

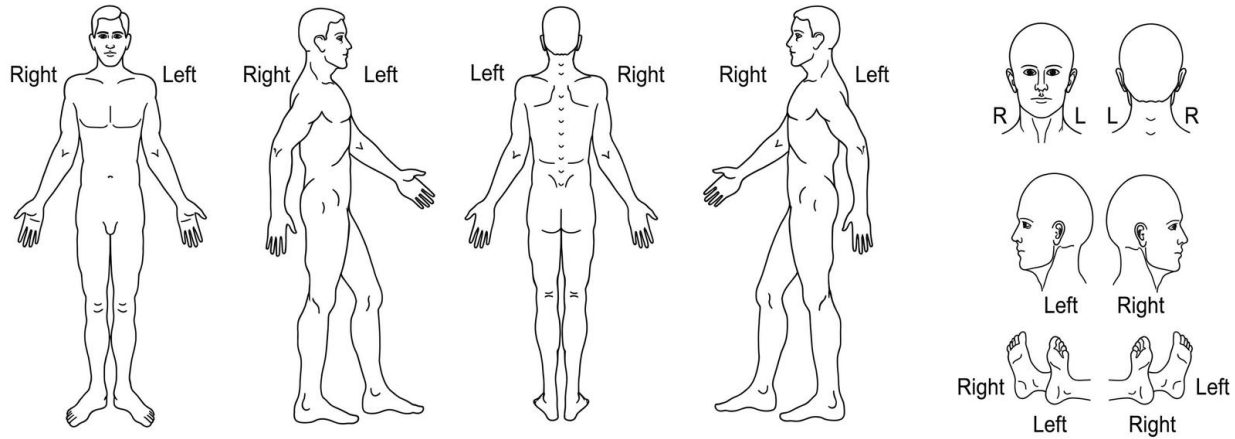
Date of Birth: _____

Pain History

Chief complaint (reason for your visit today): _____

Does this pain radiate (spread)? If so, where? _____

Pain diagram: mark the location(s) of your pain with an "X".



Approximately when did this pain begin? _____

What caused your current pain episode? _____

How did your current pain episode begin? ☐ Gradually ☐ Suddenly

Since your pain began, how has it changed? ☐ Improved ☐ Worsened ☐ Stayed the same

Pain Description

Check all words that describe your pain:

- | | | | | |
|------------------------------------|--------------------------------------|-----------------------------------|------------------------------------|---|
| ☐ Aching | ☐ Burning/Hot | ☐ Dull | ☐ Cramping | ☐ Numbness |
| ☐ Pressure | ☐ Shooting | ☐ Stabbing | ☐ Sharp | ☐ Spasm |
| ☐ Squeezing | ☐ Throbbing | ☐ Tingling | ☐ Tightness | ☐ Pins and needles |

How often does the pain occur?

- | | |
|--|--|
| ☐ Constant | ☐ Intermittent (comes and goes) |
| ☐ Infrequent (not often, but lasts a long time) | ☐ Seldom (rare) |

Rate your pain (0 = no pain, 10 = the worst pain you have ever felt). Mark one box on each line.

0 = no pain • 10 = worst	0	1	2	3	4	5	6	7	8	9	10
Pain at its BEST	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pain at its WORST	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
AVERAGE pain	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Patient Name: _____

Date of Birth: _____

Factors Affecting Your Pain

Mark the effect each of the following has on your level of pain:

Factor	Increases	Decreases	No effect
Bending backward	☐	☐	☐
Bending forward	☐	☐	☐
Climbing stairs	☐	☐	☐
Cold	☐	☐	☐
Coughing/Sneezing	☐	☐	☐
Driving	☐	☐	☐
Heat	☐	☐	☐
Lifting objects	☐	☐	☐
Looking upward	☐	☐	☐
Looking downward	☐	☐	☐
Manipulation	☐	☐	☐
Medication	☐	☐	☐
Sitting	☐	☐	☐
Standing straight up	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Weather changes	☐	☐	☐
Other: _____	☐	☐	☐

Past Treatments

Mark all of the following treatments you have used for pain relief:

☐ I have NEVER had any treatments for pain relief

Treatment	Haven't tried	Tried with relief	No relief
Spine surgery	☐	☐	☐
Physical therapy	☐	☐	☐
Chiropractic care	☐	☐	☐
Psychological therapy	☐	☐	☐
Brace support (back/neck)	☐	☐	☐
Acupuncture	☐	☐	☐
Hot/Cold packs	☐	☐	☐
Massage therapy	☐	☐	☐
TENS unit	☐	☐	☐
Other: _____	☐	☐	☐

Diagnostic Tests / Imaging

Mark all tests you have had related to your current pain complaints:

☐ I have NEVER had any diagnostic tests/imaging

☐ MRI of the: _____	Date: _____	Where: _____
☐ CT of the: _____	Date: _____	Where: _____
☐ X-ray of the: _____	Date: _____	Where: _____
☐ EMG/NCS	Date: _____	Where: _____
☐ Bone density test	Date: _____	Where: _____

Interventional Pain Treatment History

Please indicate if you have had any of the following treatments:

☐ I have NEVER had interventional pain treatments

Treatment	When	Where	Relief
☐ Trigger point injections	_____	_____	_____ %
☐ Joint injection	_____	_____	_____ %
☐ Nerve blocks	_____	_____	_____ %
☐ MILD (minimally invasive lumbar decompression)	_____	_____	_____ %
☐ Epidural steroid injection ☐ Cervical ☐ Thoracic ☐ Lumbar	_____	_____	_____ %
☐ Medial branch blocks / facet injections ☐ Cervical ☐ Thoracic ☐ Lumbar	_____	_____	_____ %
☐ Radiofrequency nerve ablation ☐ Cervical ☐ Thoracic ☐ Lumbar	_____	_____	_____ %
☐ Spinal cord stimulator ☐ Trial only ☐ Permanent placement	_____	_____	_____ %
☐ Vertebroplasty / kyphoplasty	_____	_____	_____ %
☐ Other: _____	_____	_____	_____ %

Past Surgical History

List ANY surgical procedures you have had, including the date or year:

☐ I have NEVER had any surgeries or procedures

Surgery / procedure	Date or year
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

Patient Name: _____

Date of Birth: _____

Past Medical History

Mark the conditions/diseases you have been treated for in the past:

☐ I have NEVER had any medical problems

General Medical

☐ Cancer – type: _____

Cardiovascular

- ☐ Atrial fibrillation (AFib)
- ☐ Coronary artery disease
- ☐ Deep vein thrombosis (DVT)
- ☐ Defibrillator
- ☐ Heart attack
- ☐ Heart valve disorder
- ☐ High blood pressure
- ☐ Pacemaker
- ☐ Peripheral vascular disease
- ☐ Stroke/TIA

Hematologic

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Easy bruising
- ☐ HIV/AIDS

Respiratory

- ☐ Asthma
- ☐ Bronchitis/Pneumonia
- ☐ Emphysema/COPD

Endocrine

- ☐ Diabetes – type: _____
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

Gastrointestinal

- ☐ Constipation
- ☐ Gastrointestinal bleeding
- ☐ GERD (acid reflux)
- ☐ Hepatitis – type: _____
- ☐ Nausea/Vomiting

Head/Eyes/Ears/Nose/Throat

- ☐ Glaucoma
- ☐ Headaches
- ☐ Head injury

Psychological

- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Depression
- ☐ Schizophrenia
- ☐ Sleeping difficulty

Musculoskeletal/Rheumatologic

- ☐ Bursitis
- ☐ Carpal tunnel syndrome
- ☐ Chronic joint pain
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis

Neurological

- ☐ Multiple sclerosis
- ☐ Parkinson's
- ☐ Peripheral neuropathy
- ☐ Restless leg syndrome
- ☐ Seizures/Epilepsy

Urological/Kidney

- ☐ Blood in urine
- ☐ Chronic kidney disease
- ☐ Dialysis
- ☐ Kidney stones
- ☐ Urinary incontinence

Other diagnosed conditions: _____

Review of Systems

Mark the symptoms you CURRENTLY have:

☐ I do not currently have any of these symptoms

Constitutional

- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Fatigue
- ☐ Weakness
- ☐ Unexplained weight gain
- ☐ Unexplained weight loss
- ☐ Low sex drive

Cardiovascular

- ☐ Chest pain
- ☐ Palpitations
- ☐ Fainting
- ☐ Swelling in feet
- ☐ Blood clots

Musculoskeletal

- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle spasms

Ears/Nose/Throat/Neck

- ☐ Sinus problems
- ☐ Nosebleeds
- ☐ Earaches
- ☐ Hearing problems
- ☐ Dental problems
- ☐ Changes in sense of smell

Neurological

- ☐ Blackouts
- ☐ Dizziness
- ☐ Memory loss

Psychiatric

- ☐ Depressed mood
- ☐ Suicidal thoughts
- ☐ Thoughts of harming others
- ☐ Anxiousness

Patient Name: _____

Date of Birth: _____

Current Medications

List ALL medications you are currently taking. Attach an additional sheet if necessary.

Include all current medications, including narcotics prescribed by your primary care doctor. Your medication list and dosages may change based on your treatment plan, clinical assessments, or updated orders from your healthcare team.

☐ I am not currently taking any medications

Medication name	Dose	How often

PAST pain medications prescribed for your current pain — mark whether each one helped:

☐ I have NEVER taken pain medication

1. _____

☐ Helped☐ Didn't help

2. _____

☐ Helped☐ Didn't help

3. _____

☐ Helped☐ Didn't help

4. _____

☐ Helped☐ Didn't help

5. _____

☐ Helped☐ Didn't help

Are you currently taking any blood thinners (anticoagulants)? ☐ Yes ☐ No

If yes, which one? ☐ Aspirin ☐ Plavix ☐ Coumadin ☐ Lovenox ☐ Other: _____

Allergies

List any medications you are allergic to:

☐ No known drug allergies

Medication	Reaction
1.	
2.	
3.	
4.	
5.	

Other allergies: ☐ Latex ☐ Iodine ☐ Tape/Adhesive ☐ IV contrast

Patient Name: _____

Date of Birth: _____

Family History

Mark all diagnoses that apply to your immediate relatives (parents, siblings, children):

☐ No known/significant family history

☐ Alzheimer's/Dementia

☐ Anxiety

☐ Arthritis

☐ Depression

☐ Cancer

☐ Diabetes

☐ Heart attack

☐ Headaches/Migraines

☐ High blood pressure

☐ Kidney problems

☐ Liver problems

☐ Osteoporosis

☐ Rheumatoid arthritis

☐ Seizures/Epilepsy

☐ Stroke

☐ Thyroid problems

Other medical problems: _____

Social History

Your answers in this section are kept confidential and are used only to help your care team plan safe, effective treatment.

Occupational status: ☐ Employed ☐ Unemployed ☐ Retired

If employed, what is your current occupation? _____

Disability: ☐ Not disabled ☐ Applying for disability ☐ Temporary disability ☐ Permanent disability

Alcohol use

☐ Never ☐ Social use ☐ Daily use ☐ Current alcoholism ☐ History of alcoholism

If history of alcoholism, how long have you been sober? _____

If you drink daily, how much do you drink per day? _____

Tobacco use

☐ Never ☐ Former smoker ☐ Current smoker

If current smoker, how many packs per day? _____ For how many years? _____

If former smoker, when did you quit? _____

Illegal drug use

☐ Never ☐ Currently using ☐ Formerly used

If currently using, how often? _____ Which drug(s)? _____

If formerly used, when did you quit? _____ Which drug(s)? _____

Prescription drug use

Have you ever misused narcotic or prescription medications? ☐ Yes ☐ No

If yes, was the medication prescribed to you? ☐ Yes ☐ No

What was the medication? _____ How long ago? _____

Patient Acknowledgment

I certify that the information provided on this form is accurate and complete to the best of my knowledge. I will notify Arkansas Spine and Pain of any changes to my medical history, medications, or insurance information.

Printed name: _____

Patient/Guardian signature: _____ Date: _____

Patient Name: _____

Date of Birth: _____

Opioid Therapy Statement

Welcome to Arkansas Spine and Pain. This section contains the **Opioid Therapy Statement** and the **Opioid and Controlled Substances Provider-Patient Agreement and Consent for Treatment**. If you plan to ask for an opioid or other controlled substance for the treatment of your pain, please read both documents carefully and sign where indicated. If you have any questions, please ask a provider or staff member.

Arkansas Spine and Pain is a comprehensive pain clinic that provides medication management and the full range of interventional procedures. To ensure patient safety and optimize outcomes, we require our patients to receive their pain care from only one pain practice. Therefore, if we are providing medication management, we also require patients to undergo interventional procedures with us.

At Arkansas Spine and Pain, the goal of our physicians and staff is to help give you your life back by reducing your pain and improving your daily functioning. We accomplish these goals with customized, safe, comprehensive, and effective treatment plans that reduce risks and maximize benefits.

To protect our patients from the significant risks associated with opioid therapy, including addiction, we follow the recommendations and applicable guidelines of the Drug Enforcement Administration (DEA), Arkansas state regulatory agencies, and the Arkansas State Medical Board regarding the safe and responsible prescribing of these medications. We first try non-opioid medications and other treatments before progressing to treating pain with opioids. Furthermore, we prescribe opioid medications only if, after thorough screening, risk stratification based on the forms you complete, and a thorough history and physical examination, we determine that a patient's condition warrants their use, the patient meets specific criteria, and other treatment options, including non-opioid pain medications, have failed to achieve satisfactory results.

The Opioid Therapy Statement and Patient Agreement document that you and your clinician agree on a care plan so that controlled substances are used in a way that is safe and effective in treating your pain.

Arkansas Spine and Pain takes a conservative approach to opioid therapy. Depending on a patient's specific situation, these medications may not be prescribed at all, may be prescribed at a lower dose, or may be changed to a safer, more appropriate alternative. Research continues to show conflicting evidence for the long-term use of opioid medications for chronic non-cancer pain. High or ever-escalating doses can result in a greater risk of physical dependence, tolerance, addiction, and increased pain (opioid-induced hyperalgesia). The lowest effective dose of opioids, used together with non-opioid medications, pain management procedures, physical therapy, mental health therapy, and other conservative treatments, has been shown to produce the best long-term results.

We track our treatment outcomes to help ensure that our patients are benefiting from their care. We are proud of our results and believe that if you suffer from chronic pain, we can help you. We provide a multidisciplinary approach to pain management that is safe, minimally invasive, and clinically proven to be effective.

Side Effects of Opioid Medications

I understand that the medication I will be taking may cause side effects including, but not limited to: sleepiness or drowsiness, constipation, inability to urinate, nausea, vomiting, dizziness, allergic reaction, immune suppression, hormone deficiencies, sexual problems, lack of coordination, kidney or liver disease, and bone thinning/weakness. The medication may also slow my reflexes and reaction time. Finally, the medication may cause my breathing to become shallow and slow, leading to decreased oxygen supply to my body, which may lead to permanent neurological, mental, cognitive, and physical deficits and possibly death.

I have read, understand, and acknowledge the Arkansas Spine and Pain Opioid Therapy Statement.

Patient printed name: _____

Patient signature: _____ Date: _____

Opioid and Controlled Substances Provider-Patient Agreement and Consent for Treatment

I, _____, understand and voluntarily agree that:

1. **Identification of alternative treatment options:** I am aware that my physician and staff have discussed the possible benefits and risks of other treatments that do not include opioid therapy. These treatments include, but are not limited to, non-opioid medications, injections, physical therapy, mental health therapy, and surgery.
2. I understand my condition, and I voluntarily request that my physician/provider and their staff treat my condition. I authorize my provider to administer or prescribe controlled substances/opioids ("pain killers") to me for the purpose of treating my chronic pain. I agree to take these medications, and my provider did not require or pressure me to take them.
3. **I understand that all controlled substances can be addictive and can lead to death.**
4. I understand the side effects of opioids listed in the Opioid Therapy Statement and will ask questions if needed. I will participate, within reason, in all other types of treatment that I am asked to participate in.
5. I will be responsible for my medicines and will keep them safe, secure, locked, and out of the reach of children.
6. I will not sell my medicine or share it with others. I understand that if I do, my treatment will be stopped and authorities may be called.
7. If my medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.
8. I will not take anyone else's medicine.
9. I will not increase my medicine until I speak with my doctor or Arkansas Spine and Pain clinical staff.
10. I will bring the pill bottles with any remaining pills of this medicine if requested, and I authorize Arkansas Spine and Pain staff to count my pills if necessary.
11. I will take my medication as instructed and will not change the way I take it without first talking to my doctor or another member of the treatment team.
12. If I see another doctor who gives me a controlled substance (for example, a dentist, an emergency room doctor, or a doctor at another hospital), I must bring this medicine to Arkansas Spine and Pain in the original bottle, even if there are no pills left.
13. I will keep, and be on time for, all my scheduled appointments with the doctor and other members of the treatment team.
14. I will not call between appointments, at night, or on weekends looking for refills, and I understand that no early or emergency refills may be made.
15. I understand that prescriptions will be filled only during scheduled office visits with the treatment team.
16. I will make sure I have an appointment for refills.
17. I will treat the office staff respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped.
18. I will tell my doctor about all other medicines that I take and let them know right away if I receive a prescription for a new medicine.
19. I will not obtain any non-opioid pain medicines or other prescription medicines for the treatment of anxiety or pain from other providers without permission from my Arkansas Spine and Pain provider. I understand that if taken with opioids, drugs such as benzodiazepines (Klonopin/clonazepam, Xanax/alprazolam, Valium/diazepam) or stimulants (Ritalin, amphetamine) can be addictive, dangerous to my health, or even cause death.
20. I will not use illegal drugs such as kratom, heroin, cocaine, or amphetamines. I understand that if I do, my treatment may be stopped.
21. I will come in for drug testing and pill counts within 24 hours of being called (random testing). I understand that I must make sure the office has my current contact information in order to reach me, and that any missed test will be considered positive for drugs.
22. I will keep up to date with any bills from the office and tell the doctor or a member of the treatment team immediately if I lose my insurance or can no longer pay for treatment. I understand that I may lose my right to treatment in this office if I break any part of this agreement.
23. **Provider communication consent:** I authorize my provider to talk with my other providers, pharmacists, and attorneys when appropriate for my care, and I give them permission to discuss my opioid use as it pertains to my care. I understand that my provider or Arkansas Spine and Pain staff will review the Arkansas Prescription Drug Monitoring Program (PDMP), and I will sign a release form allowing the doctor to speak with all other doctors or providers that I see.

Patient Name: _____

Date of Birth: _____

24. I will use only one pharmacy to get all of my medicines, and I will notify Arkansas Spine and Pain in writing if I wish to change pharmacies.

Right to Discontinue Treatment or Medication

I understand that I may stop using my medication at any time, and I agree to notify the physician and/or staff immediately if I do. I understand that, if needed, my physician and/or staff may provide supervision when I choose to discontinue my medication. In this situation, alternative care by other pain or addiction providers will be suggested, and I will then be released from this agreement.

I understand that Arkansas Spine and Pain providers will stop my opioid and controlled medications if any of the following occurs:

- I trade, sell, give away, misuse, or abuse these medications.
- Arkansas Spine and Pain finds that I have broken any part of this agreement.
- I do not present immediately for a urine or saliva test, or pill count, when requested by Arkansas Spine and Pain.
- My urine or saliva tests show controlled or non-controlled medications not previously reported to Arkansas Spine and Pain, show illegal drugs or alcohol, or fail to show the opioid and other controlled medications prescribed to me by Arkansas Spine and Pain.
- I receive prescriptions for opioid or controlled medications from sources other than Arkansas Spine and Pain, unless previously arranged and discussed with my Arkansas Spine and Pain physician or provider.
- Any member of the professional staff at Arkansas Spine and Pain believes it is in my best interest, from a safety or accountability standpoint, that opioid and controlled medication treatment be discontinued.
- I demonstrate ANY aggressive, belligerent, or unacceptable behavior toward any physician, provider, patient, or staff member at Arkansas Spine and Pain.
- I consistently miss scheduled appointments, including office visits and procedures scheduled at Arkansas Spine and Pain or any other facility used by Arkansas Spine and Pain.
- I use illicit drugs (e.g., cocaine, methamphetamine, heroin, kratom).
- I misrepresent or lie about my medical history, including not disclosing risk factors for addiction such as a family history of substance abuse, prior abuse of drugs or alcohol, or prior military experience.

My signature indicates that I understand and agree to abide by each item in this agreement, and that if I fail to abide by any item, I may be discharged from this clinic.

Patient printed name: _____

Patient signature: _____ Date: _____