



AZ Integrated Neuro Spine & Pain

623-322-5700 • Fax: 623-337-5305

azintegrated.com

Your completed intake paperwork helps our providers get to know you and your medical history.
We rely on the accuracy and completeness to provide you with the best care possible.

Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices and I have been provided with the opportunity to review it.

Name: _____ **DOB:** _____

Signature: _____

Date: _____

COMMUNICATION AUTHORIZATION

Patient Name: _____

Date of Birth: _____

What numbers may we contact you at?

May we leave a message?

☐ Yes ☐ No

☐ Yes ☐ No

Is there anyone other than yourself that you authorize AZ Integrated to speak with on your behalf of your medical care? If so, please list below:

_____	_____	_____
Name	Phone Number	Relationship

_____	_____	_____
Name	Phone Number	Relationship

Pharmacy Information

Do you authorize AZ Integrated to communicate with your pharmacy?

☐ Yes ☐ No

Local Pharmacy: _____

Phone Number: _____

Address: _____

Fax Number: _____

Mail Order Pharmacy: _____

Phone Number: _____

Address: _____

Fax Number: _____

Email Information

Do you authorize AZ Integrated to communicate with you via email?

☐ Yes ☐ No

Email: _____

Emergency Contact

Name: _____

Phone: _____

Address: _____

Patient Signature: _____

Date: _____

CONFIDENTIAL BILLING INFORMATION

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip: _____

Physical Address same as Mailing? ☐ Yes ☐ No

If not, please list mailing address: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other: _____

Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Referring Provider: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Primary Insurance Plan

Payer: _____ Plan: _____

Policy/ID Number: _____ Group Number: _____

Complete this box if you are not the policy holder for your primary insurance

Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _____ Social Security Number: _____

Secondary Insurance Plan (if any)

Payer: _____ Plan: _____

Policy/ID Number: _____ Group Number: _____

Complete this box if you are not the policy holder for your secondary insurance

Insurance Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Policy Holder Name: _____ Policy Holder Gender: ☐ Female ☐ Male

Date of Birth: _____ Social Security Number: _____

Is this a Workman's Compensation Case? ☐ Yes ☐ No

Is this related to a Motor Vehicle Accident? ☐ Yes ☐ No

PAYMENT POLICY

Address Correspondence to:

AZ Integrated Neuro Spine & Pain
13640 N. 99th Ave
Suite 100
Sun City, AZ 85351
Phone: 623-322-5700 Fax: 623-337-5305

Patient Name: _____ DOB: _____ Date: _____

I hereby authorize my insurance company to make direct payment to:

AZ Integrated Neuro Spine & Pain

Initial: _____

I understand that I am financially responsible for any copayments, deductibles, coinsurance, and all other charges which are considered to not be a covered benefit by my insurance company. I understand that verification of coverage is not a guarantee of benefits. Actual plan coverage and benefit payments are determined when a claim is received.

I understand that I am financially responsible for all charges if it is determined that the insurance information I have provided is no longer in effect.

Please inform staff immediately of any insurance changes.

Payments:

Initial: _____

Payment is expected at the time of service for Copays, coinsurance, and/or deductibles, AZ Integrated accepts cash, checks, VISA, Mastercard, And American Express as forms of payment. If your check is returned for insufficient funds, a \$35 returned check fee will be applied to your outstanding balance.

Delinquent Accounts:**Initial:** _____

Delinquent accounts will be reported to a collection agency following AZ Integrated normal collection procedure of four (4) patient statements being mailed to you. If an account is reported to the collection agency, then a fee of 30% will be added to your outstanding balance. Please inform the billing department if your payment will be late arriving or you need to set up a payment plan.

Forms:**Initial:** _____

Should you request our office to complete forms on your behalf for disability, work status, FMLA, and etc. there will be a fee of \$100. Payment of this charge is expected at the time of completion.

Appointment NO-SHOW:

There is a charge for not canceling/rescheduling your appointment within 24 hours. Regular office visits are \$50, any procedure as in an EEG, AEEG, VNG, CUS, BOTOX, ULTRASOUND and NEUROPSYCH TESTING are \$100, Dr. Alishahi and Dr. Manchanda procedures are \$200. These appointment times could have been given to another patient who needs medical care. We understand that unusual circumstances might arise if that is the case, please contact our office as soon as possible.

Signed: _____**Date:** _____**Release of Information:**

I hereby authorize a release of my medical information to my referring/primary care physician and/or to any other physicians who have been or may become involved in my medical care. I also authorize the release of my information that may be necessary in the processing of any insurance claims.

Signed: _____**Date:** _____

REASON FOR TODAY'S VISIT

What is the main reason you are seeing neurology today?

What symptoms or problems concern you the most?

When did your symptoms begin?

- ☐ Today/recently ☐ Within the past week ☐ Within the past month
☐ 1-6 months ago ☐ 6-12 months ago ☐ 1-5 years ago ☐ More than 5 years ago
☐ Unsure

Was the onset:

- ☐ Sudden ☐ Gradual ☐ Intermittent ☐ Progressive ☐ Unsure

Have your symptoms changed over time?

- ☐ Improved ☐ Worsened ☐ Stayed about the same ☐ Fluctuate

How often do symptoms occur?

How long does a typical episode last?

What makes your symptoms better?

What makes your symptoms worse?

Have you had this problem evaluated previously

- ☐ Yes ☐ No

If yes, by whom and when?

PAST MEDICAL HISTORY (all illnesses diagnosed, controlled or not)

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

SURGICAL/HOSPITALIZATION HISTORY

Have you had any surgeries or hospitalizations? ☐ Yes ☐ No

Procedure/Hospitalization

Date

Reason

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Do you have any know drug allergies? ☐ Yes ☐ No

If so, please list all medications you are allergic to:

Medication Name:

Allergic Reaction Type:

Please check if you are allergic to ☐ Iodine or ☐ Tape

Are you allergic to shellfish? ☐ Yes ☐ No

Are you allergic to latex? ☐ Yes ☐ No

CURRENT MEDICATIONS (include supplements and herbs)

Attach an additional sheet, if required.

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1. _____			6. _____		
2. _____			7. _____		
3. _____			8. _____		
4. _____			9. _____		
5. _____			10. _____		

SOCIAL HISTORY

Are you currently working? ☐ Yes ☐ No

Occupation: _____

If disabled:

Date disability began: _____

Cause of disability: _____

Highest level of education: _____

Tabacco/Nicotine:

☐ Never ☐ Former ☐ Current

If current/former, type and amount: _____

Alcohol Use:

☐ None ☐ Occasional ☐ Weekly ☐ Daily

Recreational/illicit drug use:

☐ None ☐ Current ☐ Former

Caffeine:

☐ None ☐ 1 serving/day ☐ 2-3 servings/day ☐ 4+ servings/day

Living Situation

☐ Alone ☐ With spouse/partner ☐ With family ☐ Assisted living ☐ Other: _____

Do you currently drive? ☐ Yes ☐ No

Have you had any driving restrictions related to your neurological condition? ☐ Yes ☐ No

FAMILY HISTORY

Age	Living	Medical issues (if deceased please state cause)
Mother: _____	☐	_____
Father: _____	☐	_____

☐ I have no significant Family Medical History

☐ I am Adopted (No medical history available)

NEUROLOGIC SYMPTOM CHECKLIST

Check all symptoms you currently have or have had recently.

Headache / Migraine

- ☐ Headaches
- ☐ Migraine
- ☐ Visual aura
- ☐ Light sensitivity
- ☐ Sound sensitivity
- ☐ Nausea/vomiting with headache
- ☐ Dizziness with headache
- ☐ New or changing headache pattern
- ☐ Headache that wakes me from sleep
- ☐ Sudden/severe "worst headache"
- ☐ Head injury associated with headache

Strength / Sensation

- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Burning Sensation
- ☐ Loss of Sensation
- ☐ Facial weakness
- ☐ Arm weakness
- ☐ Leg weakness
- ☐ Symptoms on one side of body
- ☐ Symptoms on both sides
- ☐ Electric/shooting pain

Headache frequency: _____ days/month

Typical severity: ☐ Mild ☐ Moderate ☐ Severe

Typical location: _____

Typical duration: _____

Seizure / Spell / Loss of Awareness

- ☐ Seizures
- ☐ Convulsions/shaking
- ☐ Loss of consciousness
- ☐ Blackouts
- ☐ Staring spells
- ☐ Episodes of confusion
- ☐ Memory gaps
- ☐ Loss of awareness
- ☐ Tongue biting
- ☐ Loss of bladder control
- ☐ Unexplained injuries
- ☐ Episode during sleep

Vision / Speech / Swallowing

- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision loss
- ☐ Flashing lights
- ☐ Difficulty speaking
- ☐ Slurred speech
- ☐ Word-finding difficulty
- ☐ Difficulty understanding speech
- ☐ Difficulty swallowing
- ☐ Choking
- ☐ Voice changes

Date of most recent episode: _____

Movement

- ☐ Tremor
- ☐ Shaking
- ☐ Slowness
- ☐ Stiffness
- ☐ Muscle spasms
- ☐ Jerking movements
- ☐ Abnormal involuntary movements
- ☐ Difficulty walking
- ☐ Balance problems
- ☐ Falls
- ☐ Coordination problems
- ☐ Change in handwriting
- ☐ Difficulty with fine motor tasks

Cognition / Memory

- ☐ Forgetfulness
- ☐ Short-term memory problems
- ☐ Long-term memory problems
- ☐ Difficulty concentrating
- ☐ Difficulty finding words
- ☐ Getting lost/disoriented
- ☐ Difficulty managing medications
- ☐ Difficulty managing finances
- ☐ Difficulty performing familiar tasks
- ☐ Personality/behavior changes

CONTINUED ON PAGE 10.

Sleep

- ☐ Insomnia
- ☐ Excessive daytime sleepiness
- ☐ Snoring
- ☐ Witnessed pauses in breathing
- ☐ Acting out dreams
- ☐ Sleepwalking
- ☐ Restless legs
- ☐ Frequent nighttime awakenings
- ☐ Unusual movements during sleep

Autonomic

- ☐ Fainting
- ☐ Lightheadedness when standing
- ☐ Abnormal sweating
- ☐ Bowel control problems
- ☐ Bladder control problems
- ☐ Sexual dysfunction
- ☐ Temperature regulation problems
- ☐ Chronic fatigue

Other Neurological Symptoms:

REVIEW OF SYMPTOMS

Mark the following symptoms that you currently suffer from. Note: Diagnosed conditions/diseases should be noted under Past Medical History

• Musculoskeletal:

- ☐ Neck pain ☐ Back pain ☐ Sore muscles ☐ Cramps

• Neurological:

- ☐ Memory Loss ☐ Headache ☐ Numbness/Tingling ☐ Tremor
- ☐ Seizure ☐ Balance Difficulty

PRIOR NEUROLOGICAL TESTING

Check any testing you have had:

- | | |
|---|---|
| ☐ MRI Brain | ☐ Sleep study |
| ☐ MRI Spine | ☐ Lumbar puncture/spinal tap |
| ☐ CT head | ☐ Carotid ultrasound |
| ☐ CT Angiogram | ☐ Echocardiogram |
| ☐ EEG | ☐ Genetic testing |
| ☐ EMG/ NCS | ☐ Blood/urine neurologic testing |
| ☐ Neuropsychological testing | ☐ Other: _____ |

Approximate dates and locations:

-
- ☐ I have brought copies of relevant reports/images.
- ☐ Please request my outside records.

PRIOR NEUROLOGIC TREATMENT

Have you previously seen a neurologist? ☐ Yes ☐ No

Neurologist/Practice: _____

Approximate date(s): _____

Previous diagnosis: _____

Treatments tried:

Did treatment help?

- ☐ Yes ☐ No ☐ Partially ☐ Unsure

Any treatment side effects?

NEUROLOGICAL SYMPTOM QUESTIONNAIRES

Please complete only the questionnaire section(s) that apply to your reason for referral or current concerns. Leave sections that do not apply blank

HEADACHE QUESTIONNAIRE

Complete if headaches are one of your reasons for referral.

How many headache days do you have per month? _____

How many are severe? _____

How many days per month do you take medication for headache? _____

Headache location:

- ☐ One side ☐ Both sides ☐ Behind eye ☐ Forehead ☐ Temples
☐ Back of head ☐ Neck ☐ Other: _____

Pain quality:

- ☐ Throbbing ☐ Pressure ☐ Sharp ☐ Burning ☐ Stabbing ☐ Other

Associated symptoms:

- ☐ Nausea ☐ Vomiting ☐ Light sensitivity ☐ Sound sensitivity ☐ Smell sensitivity
☐ Visual symptoms ☐ Dizziness ☐ Neck pain

Possible triggers:

- ☐ Stress ☐ Sleep deprivation ☐ Missed meals ☐ Dehydration ☐ Menstrual cycle
☐ Certain foods ☐ Alcohol ☐ Caffeine ☐ Weather changes ☐ Exercise
☐ Other: _____

Medications tried: _____

Most effective treatment: _____

SEIZURE/SPELL QUESTIONNAIRE

Complete if seizures, blackouts, or unexplained episodes are a concern.

Describe what happens during a typical event:

How often do events occur? _____

Date of most recent event: _____

CONTINUED ON PAGE 13.

Before the event, do you experience:

- ☐ Warning/aura ☐ Strange smell/taste ☐ Deja vu ☐ Fear/anxiety
☐ Visual changes ☐ Dizziness ☐ Numbness/tingling ☐ No warning
☐ Other: _____

During the event:

- ☐ Loss of awareness ☐ Staring ☐ Stiffening ☐ Rhythmic shaking ☐ Jerking
☐ Wandering ☐ Speech difficulty ☐ Unusual behavior ☐ Other: _____

After the event:

- ☐ Confusion ☐ Sleepiness ☐ Headache ☐ Muscle soreness ☐ Memory loss
☐ No symptoms

Has anyone witnessed an event? ☐ Yes ☐ No

Do you have a video of an event? ☐ Yes ☐ No

Current seizure medication(s): _____

MEMORY/COGNITIVE CONCERN QUESTIONNAIRE

Complete if memory or thinking is a concern.

Primary concern:

- ☐ Forgetfulness ☐ Word finding ☐ Attention ☐ Planning/organization
☐ Getting lost ☐ Judgment ☐ Personality changes ☐ Other: _____

When did this begin?

Is it getting worse?

- ☐ No ☐ Slowly ☐ Rapidly ☐ Fluctuates

Do you manage your own medication? ☐ Yes ☐ No

Do you manage your own finances? ☐ Yes ☐ No

Do you drive? ☐ Yes ☐ No

Have you gotten lost in familiar places? ☐ Yes ☐ No

Who has noticed the changes? _____

DIZZINESS/BALANCE QUESTIONNAIRE

Complete if dizziness, vertigo, or falls are a concern.

Describe the sensation:

- ☐ Room spinning ☐ Lightheadedness ☐ Imbalance ☐ Feeling faint
☐ Floating/rocking ☐ Other: _____

When does it occur?

- ☐ Standing ☐ Walking ☐ Turning head ☐ Rolling in bed ☐ With exertion
☐ Randomly ☐ Other: _____

When did your main symptoms begin?

- ☐ Today/recently ☐ Within the past week ☐ Within the past month ☐ 1-6 months ago
☐ 6-12 months ago ☐ 1-5 years ago ☐ More than 5 years ago ☐ Unsure

Was the onset:

- ☐ Sudden ☐ Gradual ☐ Intermittent ☐ Progressive ☐ Unsure

Have your symptoms changed over time?

- ☐ Improved ☐ Worsened ☐ Stayed about the same ☐ Fluctuate

How often do symptoms occur? _____

How long does a typical episode last? _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

Have you had this problem evaluated previously?

- ☐ Yes ☐ No

If yes, by whom and when?

