Demographic Information

First Name | Last Name

Phone Number | Address

Date of Birth | Pharmacy

Chief Concern:

____

Top two other concerns:

____

Family History (List any health conditions):

Mother: | Father: | Siblings:

MGM: | PGM: | Spouse:

MGF: | PGF: | Children:

PAST MEDICAL HISTORY:

Prior illnesses, injuries, diagnosis and date of occurrence:

List all surgeries and hospitalizations:

Last 3 physicians involved in your most recent

Last blood testing:

Last Medical Imaging:

Rheumatology:

How often does your disease flare? (Circle)

All the time | Few times/month

Several times/year | Few times/year

How much prednisone use? (Circle)

Never | Daily | Weekly

Monthly | Every few months | Few times/year

Other medications used in the past (circle)

Plaquenil/Hydroxychloroquine Rheumatrex/Trexall/Methotrexate Asulfadine /Sulfasalazine

Neoral/Sandimmune/Genegraf /Cyclosporine Cellcept/Mycophenolate Mofitil IVIG

Cytoxan/Cyclophosphamide Avara/Leflunamide Imuran/Azathioprine

Please mark the diagram below indicating the **TYPE** of pain(s)/sensations(s) you are having and the location on your body.

Please use the following symbols:

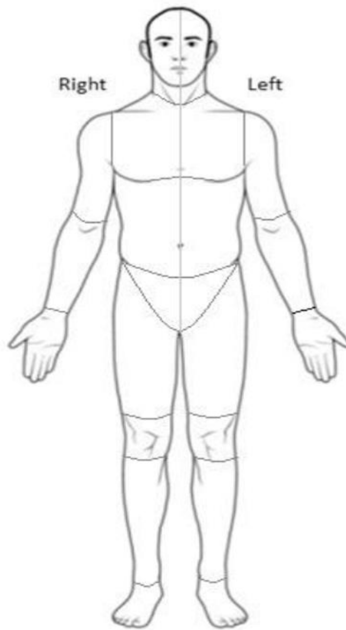
Solid Circles ● for **Stabbing Pain**

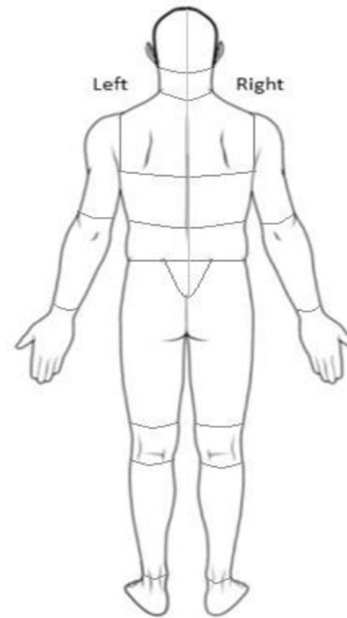
Open Circles ○ for **Pins & Needles**

Circles with X's ⊗ for **Numbness**

X's for **Burning Pain**

Triangles Δ for **Aching Pain**





Any allergies to Drugs or Food? (List triggers and response)

____

Current medications/supplements and dosages (List year you began taking)

____

____

____

____

SOCIAL HISTORY:

Foreign Travel (List ALL locations traveled outside the U.S)

Brief timeline of places you lived throughout your life:

Provide overview your daily routine:

What do you do for a living? Do you enjoy your job? Please list all jobs prior to that.

Hobbies: Spiritual or Religious Practice:

Relationship status (circle)

Single
Married
Separated
Divorced
Widowed

Your support system (Circle)

Strong
Moderate
Limited

Stressors:

Money
Work
Relationship
Home
Other

Describe childhood memories in three words:

History of Tobacco use? Indicate amount and frequency.

Packs per day and number of years: None

Alcohol intake frequency and preference.

Daily
Weekly
Monthly
None

Alcohol preference

Liquor
Wine
Beer
Other

Sleep and Energy:

Your energy levels on a scale of 1-10 (10 best)
At these 4 time points:

Waking:
7:00PM:
11:00AM
3:00PM:

Stimulants, circle and list amount:

Tea:
Energy Drinks:
Coffee:
Other:

Time you have breakfast & time you have dinner

Your routine a few hours prior to bedtime:

Temperature of your sleeping environment:

What time are you in bed?

What time do you rise?

How many minutes to fall asleep?

How many times do you wake nightly? Why?

Do you awaken in the morning refreshed?

Have you had a sleep study done?

Do you dream vividly or have nightmares?

Do you snore, grind teeth, or clench you jaw?

Nutrition:

On a scale of (1-10) how willing are you to change your diet?

Times per week takeout is consumed?

Where is your grocery shopping done?

Who prepares your food?

Any specific diet’s you’ve tried? (Vegan, Paleo, Atkins, etc)

Exercise: How many minutes per week and what type

Review of systems:

PLEASE TAKE YOUR TIME WITH THIS SECTION AND GO THROUGH ALL OF THE SYMPTOMS COMPLETELY.

Please mark any symptoms which you've experienced **IN THE LAST MONTH.**
Circle each symptom in each system domain and write a number next to each symptom rating it 1 to 4.

1 = infrequently/past 2 = somewhat frequent 3 = few days weekly 4= constantly

General

Weight Change
Fevers
Night sweats
Weakness
Fatigue
Chills
Appetite Change

Eyes

Wears correct lenses
Blurry Vision
Vision loss
Pain
Discharge
Itchiness
Visual changes
Floaters
Redness
Swelling
Dryness
Watery

Cardiovascular

Chest pain
Arm or Leg soreness
Leg cramps
High Blood Pressure
Dizziness
Murmurs
Palpitations
Varicose Veins
Swelling
Low Blood Pressure
Loss of Consciousness
Strokes

Gastrointestinal

Number of Bowel movements per day:

Bristol Stool Type (circle, if changing circle range):

Gastrointestinal cont…

Nausea
Blood in stool
Gas
Abdominal pain
Heartburn
Fatty meals bothering
Vomiting
Mucus in stool
Bloating
Food sensitivity
Hemorrhoids
Rectal itching/burning/sensitivity

Respiratory

Pain with breathing
Shortness of Breath
Asthma
Emphysema
Cough
Coughing blood
Bronchitis
Pneumoniae

Ears/Nose/Mouth

Ringing
Ear pain
Vertigo
Pressure
Discharge
Ear discharge
Hearing loss

Nose bleeds
Problems smelling
Nasal congestion
Nasal discharge
Nasal polyps
Postnasal drip
Hoarseness
Sore throat

Cavities
Mouth Sores
Tongue pain
Sore jaw
Trouble swallowing
Bleeding gums
Tongue soreness
Trouble chewing
Problems tasting
Dry Mouth

Urinary Tract

Incontinence
Bladder pain
Frequent infections
Trouble urinating
Cola colored urine
Back pain
Blood in urine
Urgency
Frequent urination
Pain with urination
Low urine output
Waking to urinate
Kidney stones
Protein in urine

Musculoskeletal

Weakness
Stiffness
Aching
Stabbing
Cold
Cramps
Myalgias
Soreness
Electrical
Pain

Neurological

Paralysis
Sciatica
Headaches
Numbness/Tingling
Carpal Tunnel
Blackouts
Weakness
Seizures
Migraines
Tremors
Fainting
Dizziness

Skin

Positive Skin Exam
Moles
Acne
Hives
Oily Hair
Losing Hair
Nail changes
Itchy Skin
Eczema
Warts
Color Changes
Dry Skin
Rash
Dandruff
Hair changes
Dry Hair
Psoriasis
Rosacea
Skin cancer

Mood/ME

Anger/Irritability
Eating Disorder
Feeling down
Suicidal thoughts
Anxiety
Fear
Suspicion
Hospitalization

Endocrine

Frequent snacking
Heat intolerance
Increased urine output
Change in glove/shoe size
Rings do not fit
Cold intolerance
Increased thirst
Thyroid disease
Mood swings

Blood:

Easy bruising
Swollen Lymph Nodes
Deep bone pain
Easy bleeding
Circulatory issues
Severe reaction to insect bites

Male:

Last digital rectal exam?

Testicular pain
Hernia
Impotency
Prostate Disease
Difficulty urinating
Incomplete urination
Testicular swelling
Discharge
Poor Libido
Skin Changes
Dribbling
Waking at nigh to urinate

Female

Age of first menses:

Year of last menses (if menopausal):

Day and month of last menses:

Last PAP Smear?

Last mammogram?

Breast pain
Breast Discharge
Fibroids
Ovarian disease
Breast swelling
Breast masses
Endometriosis
Pelvic Inflammatory Disease

Do you experience the following before or during your menses?

Diarrhea
Constipation
Mood changes
Headaches
Breast pain
Bloating
Food Cravings
Heavy bleeding
Fatigue
Constipation
Mood changes
Cramping
Backache

Age specific Screening:

Last cholesterol test
Last eye exam
Last skin exam
Last blood sugar test
Last dental exam
Last bone density test

DEEPER ETIOLOGIC FACTORS:

There is some redundancy here and I apologize. Please take your time with this section. I gives me some guidance as to what the root cause may be and helps me be economical with the ordering of lab testing.

Medical Devices implanted

I have breast implants	Yes	No
I have artificial joints	Yes	No
Abdominal surgical mesh	Yes	No
Vaginal surgical mesh	Yes	No
Bladder Sling	Yes	No
Pacemaker	Yes	No
Other (if yes indicate)	Yes	No

Detoxification assessment

Bowel movements	1-3 per day	Less than every day	
Sweating	Daily	A few times/wk	I can't sweat
Urination	4+ times per day	<4 times per day	
Caffeine tolerance	1-2 cups/day	2+ cups/day	
Odors bother me	Yes	No	
Multiple drug/food sensitivity	Yes	No	
Headaches	Occasional	Frequent	
I do cleanses	At least once/yr	Never	
I use air filters	HEPA MERV 13	I don't know filter/No	
Mindful of cosmetics (deodorant, soap, etc)	Yes	No	
Job or hobby exposures (past or present)	Yes	No	
I am taking more than 6 meds	Yes	No	
I was exposed to water Damaged building >6month	Yes	No	
I use air fresheners in my Home or car	Yes	No	
My home is less than 5 yrs old	Yes	No	
My home was constructed Prior to 1980	Yes	No	
My home has new carpets	Yes	No	
Imaging studies with contrast, barium, gadolinium or other agents	Yes	No	

Jobs held ***Yes/No and duration

Home improvement
Landscaping
Agriculture
Military
Brick Laying
Painting

Oral Health

I have root canals	Yes	No
I have amalgams (metal tooth fillings)	Yes	No
I have bridges	Yes	No
Recurrent Gum bleeding	Yes	No
Bad breath	Yes	No
Multiple Cavities	Yes	No
Receding gumline	Yes	No
History of Abscess	Yes	No
I brush at least 2times/day	Yes	No
I floss	Yes	No
I use a water pick	Yes	No
I have annual dental visits	Yes	No

Hormone Balance

I have taken a birth control pill for more than 3 years	Yes	No	
I have had an adverse reaction to oral contraceptives	Yes	No	
My disease during pregnancy	Flared	Went into remission	No change
I have an IUD	Yes, if yes, type?	No	
I am on hormone replace therapy	Yes	No	

Autonomic

I get light headed when going from sitting to standing or laying to standing	Frequently	Seldom	No
I cannot sense when my bladder is full	Frequently	Seldom	No
I have difficulty voiding my bladder	Frequently	Seldom	No
I urinate excessively	Yes	No	
I don't digest my food well	Yes	No	
Food just "sits" in my stomach	Yes	No	
I get nauseated just before meals	Yes	No	
I have irritable bowel	Yes	No	
I have diarrhea late at night	Yes	No	
I get dizzy with hot showers	Yes	No	
I cannot tolerate temperature extremes	Yes	No	
I sweat excessively OR not at all	Yes	No	
My joints are extra flexible	Yes	No	
I have regular migraines	Yes	No	
My blood pressure is usually low	Yes	No	
Myself or a family member have ADHD	Yes	No	
My heart races often	Yes	No	
I scare easily or not at all	Yes	No	
I cannot tolerate exercise	Yes	No	
I frequently have sensations as if something is crawling on me	Yes	No	
I have an anxiety that seems "different" from typical anxiety	Yes	No	
My body seems to damage electronics (TV's, computers, phones etc) or drain batteries faster	Yes	No	

Gut Health

Recurrent antibiotics	Yes/past	No
Multiple food intolerances	Yes	No
My diet is restricted	Yes	No
The form of my poop is Often changing	Yes	No
Frequent flatulence/burping	Yes	No
After I eat a meal	Yes	No
I sometimes look pregnant soon after eating	Yes	No
I have low energy after	Yes	No

eating		
I have rashes	Yes	No
There are certain vegetables that upset me	Yes	No
I have recurrent UTIs	Yes	No
I have recurrent vaginitis/prostatitis	Yes	No
I crave sugar/bread like crazy!	Yes	No
I have rashes in skinfold areas	Yes	No
I have dandruff	Yes	No
I am sensitive to fruit	Yes	No
Sugar makes my symptoms worse	Yes	No
I have used multiple rounds of Steroid/prednisone	Yes	No
I have taken antibiotics more than 3x	Yes	No
I have taken an oral contraceptive Longer than 3 years	Yes	No

<u>Histamine/Oxalates</u>

I have migrating joint pains	Yes	No
History of kidney stones	Yes	No
Heart races often	Yes	No
I am intolerant of nuts, seeds Leafy greens, chocolate, Peanuts	Yes	No
I am intolerant of fermented Food (beer, yogurt, cheese, Sauerkraut, etc)	Yes	No

<u>Circadian Rhythms/HPA Axis</u>

I get regular sunlight exposure (few times per week)	Yes	No
I have a regular schedule	Yes	No
I eat at the same times daily	Yes	No
I'm in bed at the same time nightly	Yes	No
I fall asleep quickly	Yes	No
I have energy crashes in the afternoon	Yes	No
I get bursts of energy at night	Yes	No

<u>Community/Interpersonal/Spirituality/Emotional Assessment</u>

I have a sense of purpose	Yes	No
I feel accomplished	Yes	No
I have friends I see regularly	Yes	No
My own spiritual practice or organized setting	Yes	No
I have problems giving	Yes	No
I have problems receiving	Yes	No

I do things right	Yes	No
I have a sense of humor (that I express frequently)	Yes	No
I make time for fun	Yes	No
I am kind to myself	Yes	No
I get into arguments often	Yes	No
Everyone around me seems to be an ass	Yes	No
I feel like things always go wrong	Yes	No
I dwell on the past	Yes	No
I compare myself to others	Yes	No
I watch the news and am	Yes	No
On social media frequently	Yes	No
I am a perfectionist	Yes	No
I feel other peoples pain and problems	Yes	No
I have been betrayed	Yes	No
I have resentments	Yes	No
I am estranged from family	Yes	No
There is someone I am frequently speaking poorly of	Yes	No

Housed emotions/feelings:

Guilt	Yes	No
Shame	Yes	No
Inauthenticity	Yes`	No
Anger	Yes	No
Fear	Yes	No
Worry	Yes	No
Sadness	Yes	No
Abandonment	Yes	No

CDC-Kaiser Study Adverse Childhood Events Assessment

Finding Your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often or very often**...
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?

   Yes No If yes enter 1 ________

2. Did a parent or other adult in the household **often or very often**...
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?

   Yes No If yes enter 1 ________

3. Did an adult or person at least 5 years older than you **ever**...
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Attempt or actually have oral, anal, or vaginal intercourse with you?

   Yes No If yes enter 1 ________

4. Did you **often or very often** feel that ...
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes enter 1 ________

5. Did you **often or very often** feel that ...
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes No If yes enter 1 ________

6. Were your parents **ever** separated or divorced?

   Yes No If yes enter 1 ________

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit at least a few minutes or threatened with a gun or knife?

   Yes No If yes enter 1 ________

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   Yes No If yes enter 1 ________

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes No If yes enter 1 ________

10. Did a household member go to prison?

    Yes No If yes enter 1 _______

Now add up your "Yes" answers: _______ This is your ACE Score.

Adapted from: http://www.acestudy.org/files/ACE_Score_Calculator.pdf, 092406RA4CR

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To:
____

Doctor/Hospital

Address:
____

Office #: ________________________________
Fax #: __________________________________

I hereby authorize and request you to release to:

AZ Integrative Rheumatology   Attn: Dr. Mitchell
9097 E Desert Cove Ave # 100
Scottsdale, AZ 85260

Phone: (480) 609 4200   Fax: (480) 609 4233

The following information:

______ **Lab Only**
______ **Imaging Only**
X   Complete Medical Records

Concerning my illness and/or treatment from ______ to ______.

I authorize the release of photocopies of the following medical records and/or x-ray files. Records or files shall include all confidential communicable disease-related information (as defined in ARS 36-661), confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information.

DOB:

____

Patient Name:

____

Patient Signature:

____

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment in your home or any satellite location where Dr. Mitchell is able to render services. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, I encourage you to ask questions.

I voluntarily request a physician to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

____

Signature of Patient or Personal Representative

____

Date:

____

Printed Name of Patient or Personal Representative

____

Relationship to Patient

RAPID3

ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. PLEASE CHECK THE **ONE** BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT **ANY** DIFFICULTY	WITH **SOME** DIFFICULTY	WITH **MUCH** DIFFICULTY	**UNABLE** TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	___ 0	___ 1	___ 2	___ 3
b. Get in and out of bed?	___ 0	___ 1	___ 2	___ 3
c. Lift a full cup or glass to your mouth?	___ 0	___ 1	___ 2	___ 3
d. Walk outdoors on flat ground?	___ 0	___ 1	___ 2	___ 3
e. Wash and dry your entire body?	___ 0	___ 1	___ 2	___ 3
f. Bend down to pick up clothing from the floor?	___ 0	___ 1	___ 2	___ 3
g. Turn regular faucets on and off?	___ 0	___ 1	___ 2	___ 3
h. Get in and out of a car, bus, train, or airplane?	___ 0	___ 1	___ 2	___ 3
i. Walk two miles or three kilometers, if you wish?	___ 0	___ 1	___ 2	___ 3
j. Participate in recreational activities and sports as you would like, if you wish?	___ 0	___ 1	___ 2	___ 3
k. Get a good night's sleep?	___ 0	___ 1.1	___ 2.2	___ 3.3
l. Deal with feelings of anxiety or being nervous?	___ 0	___ 1.1	___ 2.2	___ 3.3
m. Deal with feelings of depression or feeling blue?	___ 0	___ 1.1	___ 2.2	___ 3.3

1. a-j FN (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION **OVER THE PAST WEEK**? PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

ELECTRONIC COMMUNICATION CONSENT

Electronic communication such as email offers an easy and convenient way for patients and doctors to communicate. In many circumstances, it has advantages over office visits or telephone calls, but here are important differences.
Below are our rules for contacting us using e-mail.

E-mail is never, ever, appropriate for urgent or emergency problems! Please use the telephone or go to the Emergency Department for emergencies.
E-mail is great for asking those little questions that don't require a lot of discussion. Appropriate uses of e-mail also include prescription refill requests, referral and appointment scheduling requests and billing/insurance questions.
E-mails should not be used to communicate sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. You may request labs be sent by email.
E-mail is not confidential. It is like sending a postcard through the mail. Our staff may read your e-mails to handle routine, nonclinical matters. You should also know that if sending e-mails from work, your employer has a legal right to read your e-mail.
E-mail may become a part of the medical record when we use it; a copy may be printed and put in your chart.
E-mail is not a substitute for seeing us. If you think that you might need to be seen, please call and book an appointment!
E-mails may be forwarded to our staff for handling, if appropriate. Finally, either one of us can revoke permission to use e-mail electronic communications at any time, which will impact future and not past communications.
I have read the above information and understand the limitations of security on information transmitted. I understand that my doctor may not be able to communicate with me electronically about my specific condition if I live outside of the state in which my doctor is licensed.

(Please initial consent option below)
Email Communications:

_____Yes, I have read this consent to E-Mail communication and want to communicate with my doctor/student/staff electronically.
_____No, I do not consent E-mail communication and do not want to communicate with my doctor electronically.
E-mail Reminders: _____Yes, I authorize appointment reminders electronically via E-mail to the e-mail address(s) listed below.
I understand that my contact information will not be sold to third parties.
_____No, I do not authorize Dr. Mitchell to send appointment reminders electronically via E-mail. (continued on reverse)

AZ Integrative Rheumatology Newsletter. Health tips, literature reviews, medical news

_____ Yes (OPT IN), please notify me of health content and event notification via email.
_____ No (OPT OUT), Please do not notify me of health programs and event notifications via email.

E-mail Address:

____

Name:

____

Signature:

____