AZ INTEGRATIVE
RHEUMATOLOGY

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:

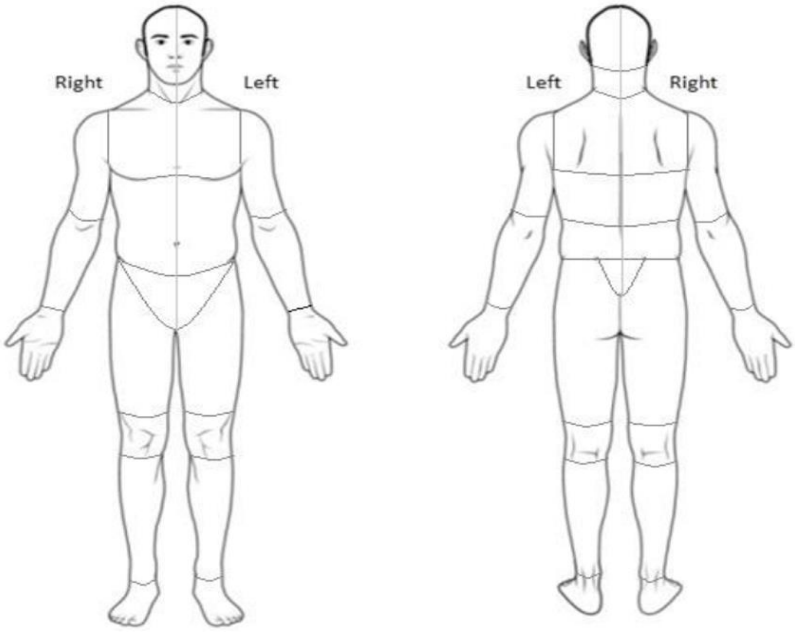
Solid Circles ● for **Stabbing Pain**

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.

Relationship status (circle)

Single Married
Separated Divorced
Widowed

Stressors:

Money Work
Relationship Home
Other

Your support system (Circle)

Strong Moderate Limited

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:

Stimulants, circle and list amount:

Waking: 7:00PM: Tea: Energy Drinks:

11:00AM 3:00PM: 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

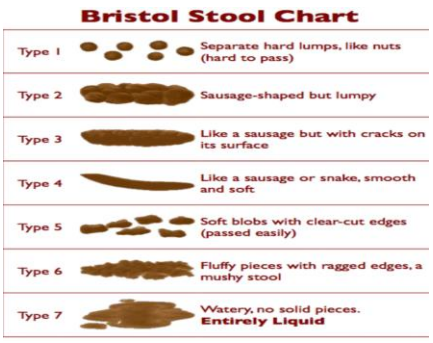
Cardiovascular

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

Mood/ME

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

Endocrine

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

Blood:

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

Male:

Last digital rectal exam?

Testicular pain	Testicular swelling
Hernia	Discharge
Impotency	Poor Libido
Prostate Disease	Skin Changes
Difficulty urinating	Dribbling
Incomplete urination	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 swelling
Breast Discharge	Breast masses
Fibroids	Endometriosis
Ovarian disease	Pelvic Inflammatory Disease

Do you experience the following before or during your menses?

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

Age specific Screening:

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

History of:

Traumatic Head Injury	Yes	No
Motor vehicle accidents	Yes	No
Broken bones	Yes	No
Significant Falls	Yes	No
Organ removal	Yes	No
Severe burns	Yes	No
Spinal Cord Injury	Yes	No
Puncture Wounds	Yes	No
Electrical Injury	Yes	No
Chemical Injury	Yes	No
Shock	Yes	No

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

Infectious

Food poisoning in my life	>3 times	Once or never
I have had pneumoniae	Yes	No
I own a cat	Yes	No
I own a dog	Yes	No
I own an exotic pet (turtle, birds, reptiles)	Yes	No
I have recurrent urinary tract infections	Yes	No
I have recurrent ear infections	Yes	No
Sinus congestion year round	Yes	No
I have been bitten by ticks	Yes	No
Unexplained fevers	Yes	No
I have had severe mono	Yes	No
I have had Parvo B19	Yes	No
History of hand/foot/mouth Disease	Yes	No
I have had staph infections	Yes	No
I have had meningitis (brain infection)	Yes	No
My present issues Improve with antibiotics or antivirals	Yes	No/Don't know

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

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

Vasoactive Amines

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

Brain feeding/Social

World events and TV news stations	Frequently	Infrequently
Facebook	Frequently	Infrequently
Instagram	Frequently	Infrequently
Tik Tok	Frequently	Infrequently
Researching my health	Frequently	Infrequently
Make time for play	Frequently	Infrequently
(play = enjoyable books, crafts, art, music, games, sports, etc)		
Spend time with yourself	Frequently	Infrequently
Practice some form of spirituality	Frequently	Infrequently
Contact family member(s)	Frequently	Infrequently
Contact friend(s)	Frequently	Infrequently
Spend time around drama starters or people who put others down	Frequently	Infrequently

How would you define who you are in three sentences?

Housed emotions/feelings:

Guilt	Yes	No
Regret	Yes	No
Shame	Yes	No
Inauthenticity	Yes`	No
Anger	Yes	No
Fear	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. However

please carefully review below

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.
(Please initial consent option below)
Email Communications:
_____Yes, I have read this consent to E-Mail communication and want to communicate with my doctor/staff electronically.

_____Yes, I have read this consent to E-mail communications and am comfortable receiving imaging and test, lab orders results by email.
_____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/scheduling 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.

There is much grey area here in what is appropriate level of communication. It is not uncommon I communicate with patients via email in between visits for plan adjustment as it is my belief this allows for provision of a higher level of care. I will let you know if this is necessary on your written treatment plans.

E-mail Address:

_____

Name:

_____

Signature:

_____