Today's Date: __ __ /__ __ /__ __

PATIENT INFORMATION & INTAKE FORM		
Patient Name:	Social Security #:	Birth Date: __ __ / __ __ / __ __ __ __ Sex: Male Female
Address:	City, State, Zip:	Home Phone: Cell Phone: Work Phone: E-Mail:
Employer:	Employer Address:	Occupation:
Marital Status: Married Single Partner	Name of Spouse:	Spouse Employer: Spouse Employer Phone:
Primary Care Physician: Phone #:	Dentist: Phone #:	Landlord (If Renting): Phone #:
Emergency Contact: Relationship to Patient: Phone #: Alternate Phone #:	Nearest Relative Not Living With You: Relationship to Patient: Phone #: Alternative Phone #:	Is your visit due to an injury? Yes No If yes, when did the injury occur? Date Type of Injury: Workers Compensation Automobile Accident Other
Reason for Visit	How did you hear about us?	I will be paying by: Cash Check Credit Card
INSURANCE POLICY HOLDER INFORMATION		
Name of Insured/Responsible Party:	Insured Social Security #:	Insured: Date of Birth: __ __/__ __/__ __ __ __
Home Address: City, State, Zip:	Phone #: Work Phone: Alternate Phone/Cell #:	Employer Name & Address:
Insurance Company:	Insured ID #:	Relationship to Patient: Do you have Secondary Insurance? Yes No

I have completed and reviewed the above information and to the best of my knowledge it is accurate. I authorize the individual physicians to advise me of any necessary procedures, diagnostic studies and treatment. I will notify you of any changes in my status of the above information.

Patient Signature: ____ Date: ____________________

Patient or Parental Signature if Patient is a Minor

Do you currently or have you had:	Please mark all that apply: Current	Past
Sleep Problems		
Disabled		
Nervous Tension		
Irritability		
Mood Swings / Changes		

Do you currently or have you had:	Please mark all that apply: Current	Past
Growing Moles or Lumps		
Wear Glasses or Contacts		
Glaucoma		
Light Bothers Eyes		
Other Eye Problems		
Date of Last Eye Exam: ___________		
Hearing Difficulties		
Ringing in Ears		
Sinus Infection		
Motion Sickness		
Dental Problems		
Date of Last Dental Exam: _________		

Do you currently or have you had:	Please mark all that apply: Current	Past
More Frequent Urination		
Pain or Blood with Urination		
Leaking Urine		
Urinating at Night		
Kidney or Bladder Infection		
Kidney Stones		
Recurrent Abdominal Pain		
Ulcers		
Heartburn		
Swallowing Problems		
Hernia		
Hemorrhoids		
Polyps		
Loss of Smell		

Do you currently or have you had:	Please mark all that apply: Current	Past
Arthritis or Gout		
Bursitis		
Fractured Bones		
Seizures		
Tremor		
Passing Out		
Speech Problems		
Trouble Concentrating		
Diarrhea or Constipation		
Varicose Veins		

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Tempe, AZ 85282

Do you currently or have you had:	Please mark all that apply: Current	Past
Asthma		
Eczema		
Hay Fever		
Sinus Problems		
Diabetes		
High Cholesterol or Triglycerides		
Thyroid Trouble		
Liver Trouble		
Anemia		
Bleeding or Bruising Tendency		

Do you currently or have you had:	Please mark all that apply: Current	Past
Low Blood Pressure		
Racing, Pounding Heart		
Ankle Swelling		
Lung or Breathing Problems		
Pneumonia		

Do you currently or have you had:	Please mark all that apply: Current	Past
History of Trauma		
Infection		
Unexplained Weight Loss		
Unusual Fatigue		
Dizziness / Poor Balance		
Vomited Blood		
Bloody or Black Stools		
Change in Appetite		
Fevers		
Night Sweats		
High Blood Pressure		
Chest Pain		
Shortness of Breath		
Chronic Cough		
Stroke		
Heart Disease or Murmur		
Loss of Bowel or Bladder Control		
Headaches		
Muscle Weakness or Paralysis		
Memory Loss		
Severe Trauma		
Direct Head Trauma		
Lost Consciousness		
Poor Coordination		
Night Pain		
Difficulty Swallowing		
Recent Infection		
History of Osteoporosis		
History of Cancer		
Difficulty Breathing		
Abdominal Pain		
Use of Corticosteroids		
Use of Anticoagulants		
Use of Birth Control Pills		
Numbness in Groin (Saddle Anesthesia)		
Loss of Anal Sphincter Tone, Fecal Incontinence (Bowel Accidents)		
Pain Fails to Improve With Rest		
Pain Greater Than 4 Weeks		
Prolonged Use of Corticosteroids		
Intravenous Drug Use		

ABOUT YOUR FAMLY HISTORY

Please mark relative's current age or age at time of death. Place an X in the boxes that apply to them. Describe "Other" and list cause of death

	Age	Allergy - Asthma	Alcohol Abuse	Arthritis	Bleeding Disorder	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	Heart Disease	High Blood Pressure	Kidney Disease	Psychiatric Problems	Spine or Back Disorder	Stroke	Tuberculosis	Chronic Pain	Other	If deceased, cause of death
Mother's Mother																				
Mother's Father																				
Father's Mother																				
Father's Father																				
Father																				
Mother																				
Brother's & Sisters # 1																				
# 2																				
# 3																				
# 4																				
# 5																				
Spouse																				
Children # 1																				
# 2																				
# 3																				
# 4																				
# 5																				

HOSPITALIZATIONS, OPERATIONS,
AUTO ACCIDENT or WORK INJURIES
(Please be as specific as possible)

AREAS INVOLVED INDICATED
EVALUATIONS & TREATMENTS
(Year)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

SERIOUS ILLNESS: List current and past illnesses not mentioned above. (Include cancer, diabetes, etc.)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

Patient Name: ______________________________

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TESTS: Please list the MOST recent date:

Chest X-Ray: __________ EKG: __________ Other X-Ray: __________ MRI/Ct Scans: ___________ Height: _________ Weight: _________

HABITS:	YES	NO	If yes, please describe:
Smoking			Packs Per Day: 0 – ½ ½ - 1 2 or more Duration: __________
Alcohol Consumption			# Drinks Per Day: ________ # Drinks Per Week: ________ Cups Per Day: _______
Coffee or Tea Consumption			Daily Weekly Monthly
Other Drug Use (Street Drugs)			Type: ___________________________
Exercise			

HOBBIES OR INTEREST: ____

____

____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, and herbs.

____

____

____

ALLERGIES: Please list all known allergies, especially to medicines.

____

TREATMENT: What treatment are you receiving or have received:

Medical Care Chiropractic Other ____

____

Do you currently or in the past have:	Please mark all that apply Currently	Past (When, # Episodes)
Back Pain or Stiffness		
Neck Pain or Stiffness		
Shoulder Pains		
Hip Pain		
Foot Pain or Trouble		
Swollen or Painful Joints		
Cold Hands or Feet		
Numbness or Pain in the Arms, Hands or Fingers		
Numbness or Pain in the Legs Feet or Toes		

FEMALES ONLY

Do you have:

- Menstrual Problems
- Abnormal Bleeding
- Breast Lump or Pain
- Problems Getting Pregnant
- Vaginal Discharge
- Tubal Infections
- Sex Concerns

Age Periods Began: __________

Number of Pregnancies: __________

Number of Miscarriages or Abortions: __________

Number of Cesarean Sections: __________

Type of Birth Control: _________

Date of Last Gynecological Exam: __________

Date Last Period Began: __________

Are You Currently or Possible Pregnant? __________

In general, how would you rate your health?

Excellent Average Poor

Do you feel depressed or have trouble falling asleep, poor appetite, lack of interest in normally enjoyable activities, relationship problems?

No Yes If Yes, Please Explain: ___________________________

____

MEN ONLY

Do you have:

- Changes in Urine Stream
- Lumps in testicles
- Prostate Trouble
- Sex Concerns

Date of Last Prostate Exam: ____________________________

DOCTOR'S NOTES: ____

____

____

PATIENT'S NAME: ____

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Dr. Robb D. Bird N.M.D.
CONSENT/FINANCIAL AGREEMENT

I voluntarily consent to outpatient care at Triad Pain Management, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), and administration of injections & medications prescribed by the doctor. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff. I understand that some treatments are considered experimental and that some treatment suggestions provided are NOT accepted by the United States FDA. I therefore, hereby release Dr. Robb D. Bird from any liability arriving out of the status of the approval or lack of approval of these therapeutic processes.

It is very important therefore that you inform Dr. Bird immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise Dr. Bird immediately.

There are some health risks to treatment. These include but are not limited to:
- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, dizziness, or injury from venipuncture, acupuncture or injections.
- Fainting or puncturing of an organ with injection therapy needles.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____
Initials

I understand that the Naturopathic Medical Doctor will answer any questions that I have to the best of his ability. I understand that treatment instructions/procedures and any possible side effects will be explained to me. I do not expect the doctor to be able to anticipate and explain all risks and complications.

_____
Initials

I understand that charges are to be paid at the time of the visit. Payments for all dispensary items (supplements/pharmaceuticals/hormones) are due at the time of the visit. Exceptions exist in lien cases only!

_____
Initials

HCG Patients only
I understand that HCG does not cure or eradicate obesity. The FDA has not approved HCG for use as a weight loss aid. I also understand that results are individual and not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I am also aware that there are no refunds for this program.

_____
Initials

As the patient, you are responsible for the total charges incurred for each visit including costs of supplements. I understand that most insurance companies do not cover the cost of some injection therapies or supplements. If possible, the doctor will bill insurance for patient reimbursement which will remain as a credit on the patient's account. The doctor cannot guarantee that the insurance company will reimburse 100% of the fees charged to the patient. Patients must also understand that not all treatments are covered by insurance. I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) ____

Signature of Patient or Guardian: ____________________________________ Date: ___________________