



**AZ INTEGRATIVE
RHEUMATOLOGY**

Legal Name
Date of Birth
How should Dr. Mitchell address you?

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)

How much prednisone use? (Circle)

All the time

Few times/month

Never

Daily

Weekly

Several times/year

Few times/year

Monthly

Every few months

Few times/year

Other medications used in the past (circle)

Plaquenil/Hydroxychloroquine

Rheumatrex/Trexall/Methotrexate

Asulfadine /Sulfasalazine

Neoral/Sandimmune/Genegra /Cyclosporine

Cellcept/Mycophenolate Mofetil

IVIG

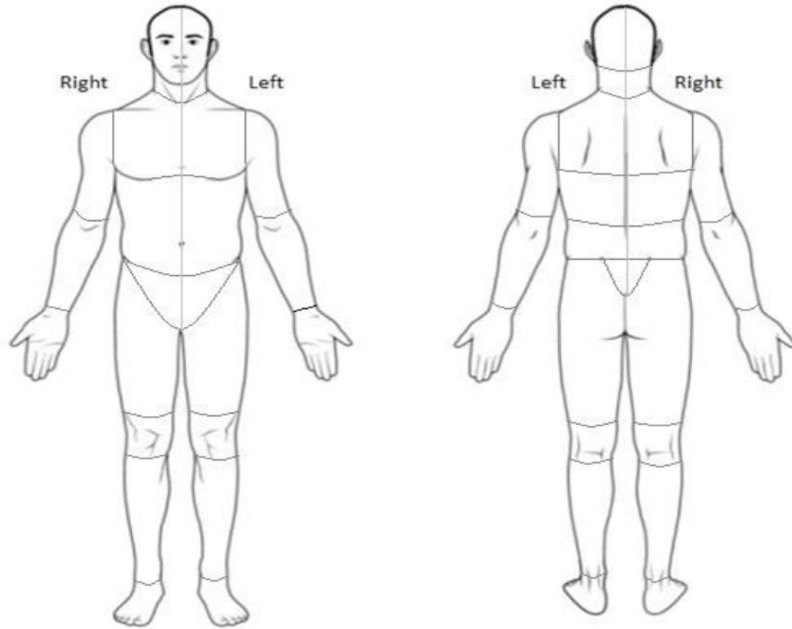
Cytoxan/Cyclophosphamide

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)

Current Pharmacy:

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

Stressors:

Money Work
Relationship Home
Other

Your support system (Circle)

Strong Moderate Limited

Describe childhood memories in three words:

History of abuse?

Mental Sexual
Physical Emotional

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)

How many meals per day?

How many ounces of water consumed per day?

Exercise:

How many days per week? Minutes per session?

Most frequent activity chosen?

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

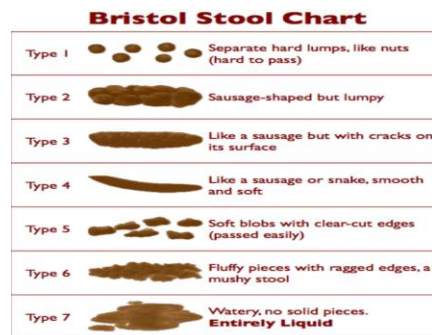
Chest pain
Arm or Leg soreness
Leg cramps
High Blood Pressure
Dizziness
Murmurs

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 night 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

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.

Physical Assessment:

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

Nutrient Status Assessment

I eat 3 servings of vegetables or fruit daily	Yes	No
I eat takeout more than I have taken a birth control pill for more than 3 years 3 days per week	Yes	No
Night vision	good	poor
Skin	normal	dry/flakey
Nails	normal	white spots
Stools	normal	loose
Sore throats	Occasional	always
Cold frequency	<2 year	>3 times per year
Libido	Normal	poor
Hair loss	Normal	Excessive
Hair/eye color change (before age 40)	Yes	No
Smell/Taste	Normal	Poor
Eating ice, nonedibles	Yes	No
Wound healing	Normal	Slow
Bruising	Normal	Excessive
Energy	Normal	Poor
Gum bleeding	Present	Absent
Cholesterol	High	Normal Low
Blood Sugar	High	Normal Low
Blood pressure	High/low	Normal Low
Mood	Normal	Depressed/Anxious/Irritable
Sense of humor	Present	Absent
Bone density	Normal/unknown	Osteopenia/Osteoporosis
Cold intolerance	Present	Absent
Anemia (ever)	Yes	No
Alcoholism	Yes	No
Smoking (ever)	Yes	No
Muscle cramps	Yes	No/Occasional

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 Medications	Yes	No
I was exposed to water Damaged building >6month	Yes	No
I have amalgams (metal tooth fillings)	Yes	No
I have breast implants	Yes	No
I have artificial joints	Yes	No
I have an IUD	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

Infectious

Food poisoning in my life	>3 times	Once or never
I have had pneumoniae	Yes	No
I have root canals	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 been or am quite promiscuous	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 pains/aches/other symptoms Improve with antibiotics or antivirals	Yes	No/Don't know

Gut Health

Recurrent antibiotics	Yes/past	No
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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

Community/Spirituality/Emotional Assessment

I have a sense of purpose	Yes	No
I have no problems giving or receiving	Yes	No
I have friends I see regularly	Yes	No
My own spiritual practice or Organized setting	Yes	No
I dwell on the past	Yes	No
I feel accomplished	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 compare myself to others frequently	Yes	No
I get into arguments often	Yes	No
I am estranged from family	Yes	No
Everyone around me seems to be an ass	Yes	No
I feel like things always go wrong	Yes	No
I do things right	Yes	No
I watch the news and am On social media frequently	Yes	No

Circadian Rhythms/HPA Axis

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

Please fill out the bottom of the record release form on the next page, I may request records from your primary care or specialists if I think they will be helpful.

AUTHORIZATION TO RELEASE MEDICAL RECORDS

To:

Doctor/Hospital

Address:

Office #: _____

Fax #: _____

I hereby authorize and request you to release to:

AZ Integrative Rheumatology
9097 E Desert Cove Ave # 100
Scottsdale, AZ 85260

Attn: Dr. Mitchell

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):

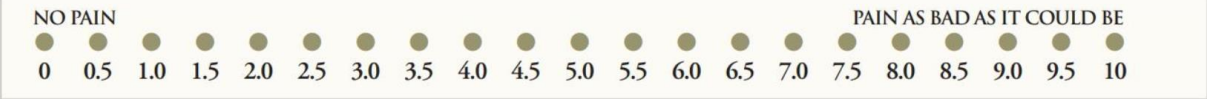
1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. PN (0-10):

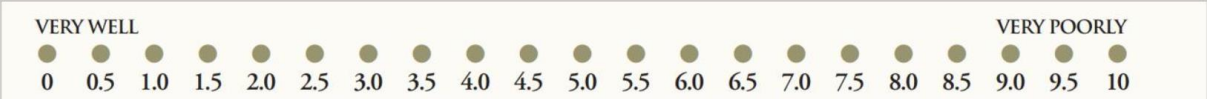
3. PTGE (0-10):

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:



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



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.

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:
