Patient Information Sheets for The Florida Back Institute, CERVICAL

PATIENT'S NAME: _____ DATE: _____ D.O.B.:_____

PLEASE CIRCLE AND/OR FILL IN THE ANSWERS TO THE FOLLOWING QUESTIONS

Who referred you to our office?_____ Who is your primary physician? _____

Other physicians who should receive correspondence about today's visit?

What is your age? What is your gender? Male Female

What do you do for a living?

Main Complaint

What is your main complaint?

Neck Pain Which side? Right Left Center
Arm Pain Which Arm? Right Left Both
Both arms Which arm is worse? Right or Left

If your **Arm pain is worse** than your neck pain, how much percentage % worse?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

If your **Neck pain is worse** than your arm pain, how much percentage % worse?
90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

Have you had **previous Cervical Spinal Surgery**? Yes No

Surgery Type: Laminoplasty Diskectomy Fusion Corpectomy
When? (mo/yr) _____ Surgeon's Name: _____ City/State: _____
Why was it done?: Due to neck pain alone? Yes No
Due to arm pain alone? Yes No
Due to neck and arm pain? Yes No
If arm pain, which arm? Right Left
Did the surgery help? For how long? _____mo. _____yr.

Duration of Symptoms

How long have you had the neck pain?____ years ____months ____weeks ____days
How long have you had the arm pain? ____ years ____months ____weeks ____days

Are the symptoms episodic? Yes No How many episodes per year? _____ episodes/year
The current episode has been present for ____ years ____months ____weeks

Since the onset of the current symptoms, you feel: Better Worse Same
If better, what percentage % better: _____ % better
If worse, how much worse? _____

Does the Arm Pain travel down your arm? Yes No
If yes, **circle** the location(s) where the pain travels to:
Trapezius Scapula Shoulder Upper arm Biceps Triceps Elbow Forearm Wrist Hand Fingers

Injury
Were you injured? Yes No What happened?

Description of Pain (circle):
Arm Pain: Sharp Dull Aching Burning Stabbing Electrical
The Arm Pain: **Comes and goes** or **is constant?**
Is the arm pain excruciating? Yes No Is the arm pain agonizing? Yes No
Arm pain wakes you up at night? Yes No
Is the arm pain: Livable or Not Livable?
Arm symptoms worsen with: Athletic Activity Driving Walking Standing Sitting Lying Down
Arm symptoms are improved with: Lying down Sitting Walking
Pins and Needles Sensation down arm? Yes No
Numbness and Tingling down the arm? Yes No
Arm pain is worse when you cough or sneeze? Yes No
Arm pain improves with placing your arm on top of your head? Yes No
Arm bothers you when reaching overhead? (for example, kitchen cabinet) Yes No
Arm bothers you when reaching behind? Yes No
Do you have difficulty with your handwriting? Yes No
Difficulty picking up small coins off a table? Yes No
Trouble buttoning buttons? Yes No
Do your hands feel clumsy? Yes No
Do you have problems with your balance? Yes No
Any recent falls because of poor balance? Yes No

Neck Pain: Sharp Dull Aching Burning Stabbing
The Neck Pain: **Comes and goes** or **is constant?**
Is the neck pain excruciating? Yes No Is the neck pain agonizing? Yes No
Neck pain wakes you at night? Yes No
Is the neck pain: Livable or Not Livable?
Neck symptoms worsen with: Athletic Activity Driving Walking Standing Sitting Lying Down
Neck symptoms worsen with: Turning head Left Turning head Right Looking up Looking down
Neck symptoms are improved with: Lying down Sitting Walking

Exercise:
Exercise Routine: _____ days per week.
Type of exercise: Treadmill Stationary bike Elliptical machine Swimming Weightlifting
Other types of exercise: Sports: Tennis Golf Other_____ _____ times per week

Walking: How far can you walk comfortably?
Unlimited 1 – 2 blocks Less than ½ block Not able to walk
How far can you walk before you must stop and sit?_____ (distance)
You can get up and continue walking after _____ minutes of rest.
Do you use an assistive device? Cane Walker Wheelchair How long using this? _____

Arm Weakness? Yes No Which arm? Right Left

Bladder Problems:
Incontinent of urine? Yes No Date it started:_____

Treatment for this problem thus far:

What **Medications** have you taken for the **Pain**?

Anti-Inflammatories:

Motrin / Advil / ibuprofen, Aleve, Naprosyn, Mobic / meloxicam, Celebrex, Voltaren / diclofenac

Opioid Medications:

Percocet / oxycodone, Vicodin / Norco / hydrocodone, Tylenol #3 / codeine, OxyContin, Oxy-IR, Duragesic / Fentanyl patch.

Steroids:

Medrol Dosepak, Sterapred Dosepak, prednisone

Nerve Modulators:

Gabapentin / Neurontin, Lyrica, Cymbalta

Pain medications:

Tramadol / Ultram, Tylenol

Muscle relaxers:

Flexeril / cyclobenzaprine, Soma, Valium, Skelaxin, tizanidine / Zanaflex

Pain Patches:

Duragesic / Fentanyl patch, Lidoderm patch, Flector patch, Voltaren gel patch

Alternative Medicine:

Medical marijuana / THC, CBD

What Medications are you taking **currently** for the **pain**? **What dose and how often**?

1. 4.
2. 5.
3. 6.

Have you ever had **cervical facet blocks?** Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

Have you ever had **cervical epidural steroid injections?** Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

Have you ever had **radiofrequency ablation (RFA) / rhizotomy?** Yes No
When? _____ By whom? _____ Did it help? Yes No

Have you ever had **trigger point injections?** Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

Have you had any **physical therapy?** Yes No
How many times per week? _____ How many weeks? _____
Did the physical therapy help? Yes No
When was your last session of physical therapy? _____ (Date)

Have you used a **neck brace?** Yes No Did it help? Yes No

What **other treatments** have you had? Massage. TENS unit. Acupuncture. Laser. Chiropractic.

Other? _____

PAST MEDICAL HISTORY: Please circle all that you have.

Diabetes	Hepatitis A -- B -- C	Gastritis	Panic/anxiety attacks
Stroke	Lung disease	GERD	Depression
Heart attack	Bronchitis	Hiatal hernia	Insomnia
Heart disease	Asthma	High cholesterol	TMJ
Atrial fibrillation	Rheumatoid arthritis	Thyroid problems	HIV/AIDS
Coronary artery dis.	Prostate problems	Osteoporosis	Shingles
Hypertension	Fibromyalgia	Osteopenia	Bone marrow cancer
Liver disease	Stomach ulcers	Osteoarthritis	Bone marrow abnormalities
Kidney disease	Irritable bowel synd.	Psoriasis	Platelet abnormalities
Parkinson's disease	Crohn's disease	Ulcerative colitis	Migraine headaches

Unexplained Wt. Loss? Yes No _____ pounds lost

Cancer: Yes No

Type _____ Year _____
Type _____ Year _____
Type _____ Year _____

Other:

PAST SURGICAL HISTORY:

Pacemaker	Kidney surgery	Tonsillectomy
Defibrillator implant	Hysterectomy	Appendectomy
Stents – cardiac	Gallbladder	Gastric Bypass
Stents – aortic	Knee arthroscopy	Fracture surgery _____Bone?
Stents – legs	Knee replacement	Colon cancer surgery
Coronary artery bypass graft	Hip replacement	Breast cancer surgery
Carotid surgery	Shoulder surgery	Lung cancer surgery

Cancer surgery: Yes No

Type _____ Year _____
Type _____ Year _____
Type _____ Year _____

Spine surgery: Yes No Type _____Year _____

Other surgery:

SOCIAL HISTORY:

Do you smoke? No Yes _____ How many packs per day?
Do you drink alcohol ? No Yes _____How much per day?
Married Single Live alone? In an Assisted Living Facility? In your own home?

MEDICATIONS: Please list.

1. 6.
2. 7.
3. 8.
4. 9.
5. 10.

Others:

Are you currently taking any of the following anticoagulants or anti-platelet medications: (Circle)

Eliquis? Xarelto? Plavix / clopidogrel? Aspirin? Baby aspirin? Ecotrin? Coumadin? Pradaxa? Aggrenox? Effient? Lovenox? Brilinta?

ALLERGIES to medications: Penicillin Sulfa Codeine Aspirin.
Others: Please list any other antibiotics, narcotics, etc. that you are allergic to.

1. 3.
2. 4.

HEIGHT: _____ **WEIGHT:** _____

REVIEW OF SYSTEMS:
Do you have any of the following?

Abnormal Heart Beat? _____
Chest Pain? _____
Shortness of breath? _____
Unexplained weight loss?____
Heart attack? _____
Diarrhea? _____
Blood in Stool? _____
Vomiting? _____
Nausea? _____
Incontinence of stool? _____
Incontinence of urine? _____
Problems with urination? _____
Blurred vision? _____
Abdominal pain? _____
Constipation? _____
Decreased hearing? _____
Thyroid problems? _____
Fatigue? ____
Sore throat? _____
Sinus problems?_____
Pain in legs? _____
Swelling in legs? ____
Poor circulation in legs?___
High cholesterol? _____
Depression? _____
Anxiety? _____

FAMILY HISTORY:
Do you have a positive family history for any of the following?
Scoliosis? _____ Osteoporosis? _____ Spinal stenosis? _____

PATIENT PAIN DIAGRAM

FIRST NAME:	LAST NAME:	DATE:

Use the appropriate symbol(s) to mark the affected areas on the chart below to show where you feel the described sensations and areas of radiation.

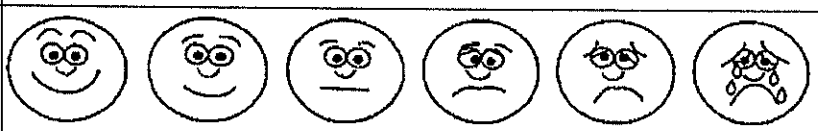
≈≈≈≈≈ Aching

□□□□ Numbness

XXXXX Burning

○○○ Pins & Needles

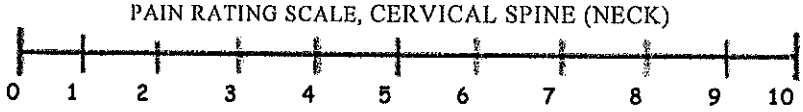
ΔΔΔΔ Stabbing



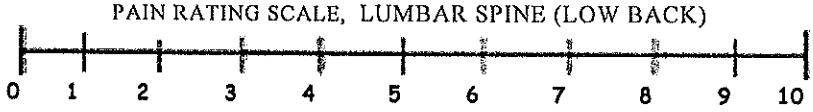
0	2	4	6	8	10
No pain	**Hurts Little Bit**	**Hurts Little More**	**Hurts Even More**	**Hurts A Whole Lot**	**Hurts As Much As You Can Imagine**

PLEASE CIRCLE THE NUMBER BELOW
THAT BEST REPRESENTS YOUR PAIN

PAIN RATING SCALE, CERVICAL SPINE (NECK)



PAIN RATING SCALE, LUMBAR SPINE (LOW BACK)



Use the pain scale to select the appropriate number to best fill in the following blanks:

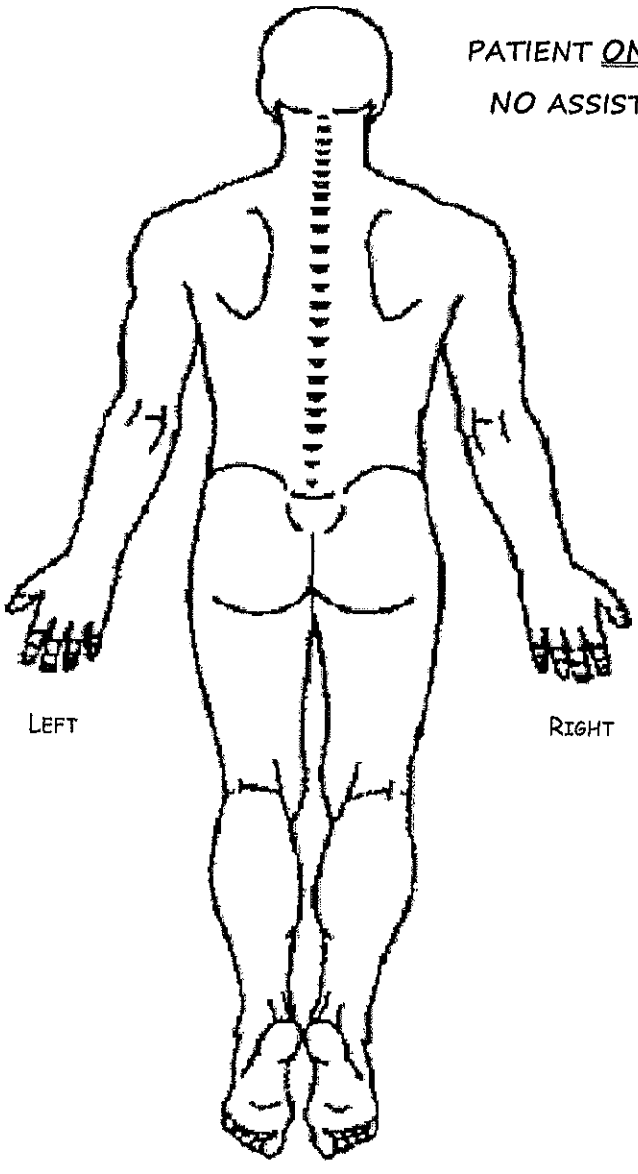
Right Arm Pain: _____/10

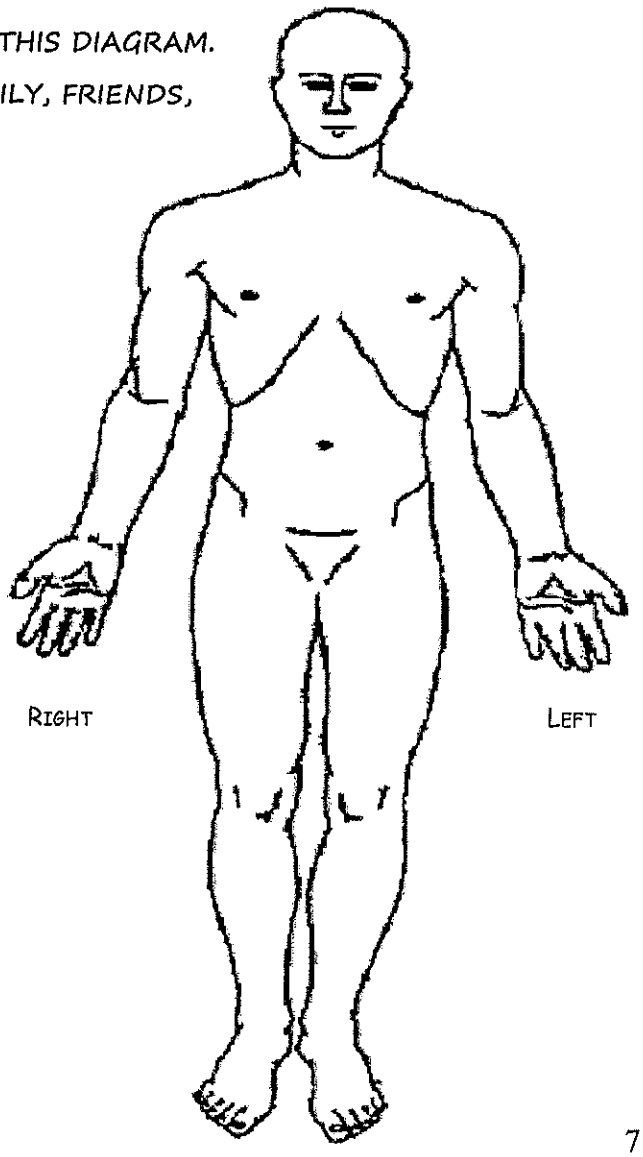
Left Arm Pain: _____/10

Right Leg Pain: _____/10

Left Leg Pain: _____/10

PATIENT <u>ONLY</u> TO FILL OUT THIS DIAGRAM.
NO ASSISTANCE FROM FAMILY, FRIENDS, AIDE'S, ETC





FLORIDA BACK INSTITUTE

Jeffrey C. Fernyhough, M.D.
Nathaniel A. Lowen, M.D.

PATIENT INFORMATION SHEET

Patient Name: Last: First: MI: Date:

Full Address: Street Address City State Zip Code

Sex: Date of Birth: Age: SS#: Employer: Work Phone:

Home Phone: Cell Phone: Cell Phone (spouse):

E-Mail address: Second E-Mail address:

Contact Name (family member/relationship to patient) Cell Phone: Home Phone:

Is the reason for your visit:

	Yes	No	
Auto Related	____	____	**Date of Onset of Symptoms:** _____

INSURANCE INFORMATION

☐ Medicare ☐ Private ☐ HMO ☐ PPO ☐ Work Comp ☐ Auto

Primary Insurance:	Secondary Insurance:
Address (only complete below if we did not make a copy of your card)	Address (only complete below if we did not make a copy of your card)
City: State: Zip:	City: State: Zip:
Insurance ID#: Group #:	Insurance ID#: Group #:
(If Work Comp or Auto, please complete the following): Date of Accident:	
Adjuster's Name and Phone #:	
Attorney's Name and Phone #:	

PATIENT SIGNATURE: _____ DATE: _____

FLORIDA BACK INSTITUTE
THE SPINE SPECIALISTS

A Comprehensive Diagnostic and Treatment Center for Spine Disorders

Leaders in Innovative Minimally Invasive Spine Care

Jeffrey C. Fernyhough, M.D.
Board Certified in Orthopedic Surgery

Nathaniel A. Lowen, M.D.
Board Certified in Orthopedic Surgery

Scott W. Howell, PA-C
Physician Assistant Certified

Caroline E Rangel, PA-C
Physician Assistant Certified

Compression Fractures
Back & Neck Pain
Herniated Discs
Spinal Stenosis
Spinal Injuries

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Insurance Assignment of Benefits and Instruction for Direct Payment

I, _____, hereby instruct and direct my insurance company pursuant to F.S. 627.422 to pay by check or draft made out to and mailed directly to Florida Back Institute for professional or medical services. And any reimbursements otherwise payable to me under my current insurance policy as payment toward total charges for professional services rendered by them. The payment is not to exceed my indebtedness to the above-named provider.

I hereby assign all rights and benefits that I have under any Group Health, HMO plan, Individual Health, PIP, Disability, or any other Health or Medical plan or policy or reimbursement plan that may pay patient benefits for service and treatment that I have received or will receive from the above-named provider.

If my current policy prohibits direct payment to the doctor, then I hereby instruct and direct you to make out the check payable to me and mail it to the office indicated above.

This assignment includes, but is not limited to, all rights to collect benefits directly from my insurance company or HMO for those services and treatments that I have received and all rights to proceed against my insurance company or HMO in any action including legal suit if for any reason my insurance company or HMO fails to make payments of benefits that are due to the above-named provider. This assignment also includes the right to recover any attorney fees and costs for such action brought by the provider as my assignee.

I also agree that the above-mentioned provider be given Power of Attorney to endorse/sign my name on any and all checks for the payment of services provided by them.

I understand that I am financially responsible for any balance not covered by my insurance company. All self-pay patients are expected to pay for services in full at the time services are rendered. Ultimately, payment responsibility rests with you, the patient.

I also authorize the release of any information pertinent to my case or claim to the above-named provider or any attorney involved in this case. A photocopy of this assignment shall be considered as effective and valid as the original.

I hereby authorize the above-named provider to file any informal complaints that are necessary to the Insurance Commissioner's Office or agency or court they deem appropriate on my behalf.

_____ _____
Signature of Patient Date

_____ _____
Witness (if minor) Date

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MEDICAL RELEASE CONSENT FORM

I, _____, authorize Florida Back Institute to discuss my medical treatment with the following:

1. _____
2. _____
3. _____
4. _____
5. _____

This authorization is all inclusive for the duration of my medical treatment with any physician at the Florida Back Institute.

_____

Patient Signature Date