

Patient Information Sheets for The Florida Back Institute Patients, LUMBAR

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?

Back Pain Which Side? Right Left Both
Leg Pain Which Leg? Right Left Both
Both legs Which leg is worse? Right or Left

If your **Leg pain is worse** than your back pain, how much percentage % worse?

90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

If your **Back pain is worse** than your leg pain, how much percentage % worse?

90 vs. 10 80 vs. 20 70 vs. 30 60 vs. 40 50 vs. 50

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

Surgery Type: _____ Fusion _____ Laminectomy _____ Disectomy _____

When: (mo/yr): _____ Surgeon: _____ City/State: _____

Why was it done? Due to back pain alone? Yes No

Due to leg pain alone? Yes No

Due to back and leg pain? Yes No

If leg pain, which leg? Right Left

Did the surgery help? Yes No For how long? _____ mo. _____ yr.

Duration of Symptoms

How long have you had the back pain? _____ years _____ months _____ weeks _____ days

How long have you had the leg 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 leg pain travel down your leg? Yes No

If yes, circle the location(s) where the pain travels to.

Buttock Back of Thigh Side of Thigh Calf Ankle Foot Toes

Groin Front of Thigh Side of Thigh Knee Shin Foot

Injury

Were you injured? Yes No What happened?

Description of Pain

Leg Pain: Sharp Dull Aching Burning Stabbing Electrical

The Leg Pain: **Comes and goes** or **is constant?**

Is the leg pain excruciating? Yes No Is the leg pain agonizing? Yes No

Leg pain wakes you up at night? Yes No

Is the leg pain: Livable or Not Livable?

Leg symptoms worsen with: Athletic Activity Walking Standing Sitting Lying Down

Leg symptoms worsen with: **Getting in and out of:** Bed Chair Car

Leg symptoms are improved with: Lying down Sitting Walking Standing

Pins and Needles Sensation down leg? Yes No

Numbness and Tingling down the leg? Yes No

Back Pain: Sharp Dull Aching Burning Stabbing

The Back Pain: **Comes and goes** or **is constant?**

Is the back pain excruciating? Yes No Is the back pain agonizing? Yes No

Back pain wakes you at night? Yes No

Is the back pain: Livable or Not Livable?

Back symptoms worsen with: Athletic Activity Walking Standing Sitting Lying Down

Back symptoms worsen with: **Getting in and out of:** Bed Chair Car

Back symptoms are improved with: Lying down Sitting Walking Standing

Restricted in all activities due to the pain? YES NO

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 have you been using this? _____

Does leaning forward on a grocery cart improve your symptoms? Yes No

Weakness? Yes No Which leg? Right Left

Location: Thigh Knee Calf Ankle Foot drop Knee Buckles

Difficulty stair climbing? Yes No

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 **lumbar epidural steroid injections**? Yes No
When? _____ How many? _____ By whom? _____
Did the injections help? Yes No

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

Have you ever had **sacroiliac joint (SI) 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 **back 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?

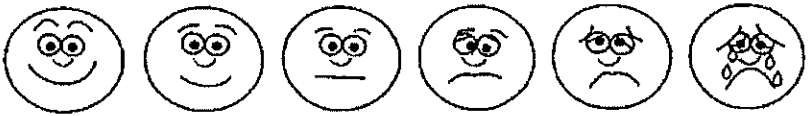
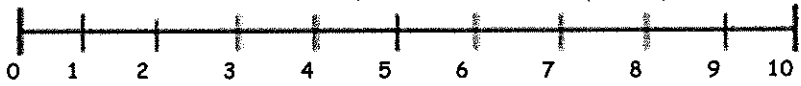
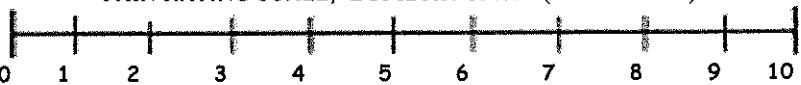
Abnormal Heart Beat? _____	Incontinence of stool? _____	Sore throat? _____
Chest Pain? _____	Incontinence of urine? _____	Sinus problems? _____
Shortness of breath? _____	Problems with urination? _____	Pain in legs? _____
Unexplained weight loss? _____	Blurred vision? _____	Swelling in legs? _____
Heart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

FAMILY HISTORY:

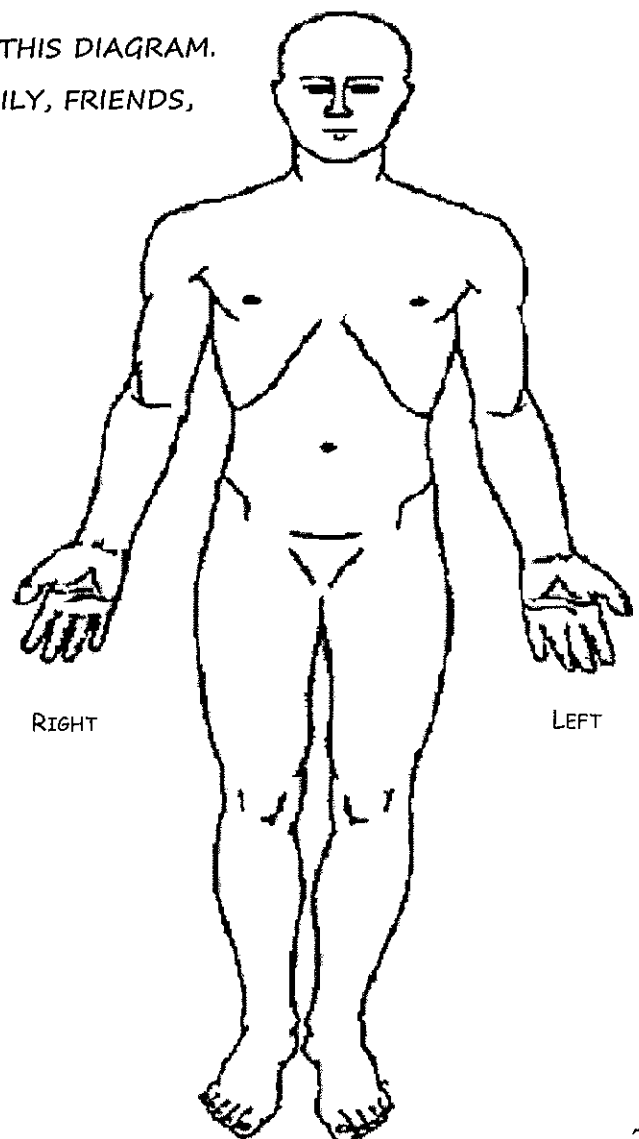
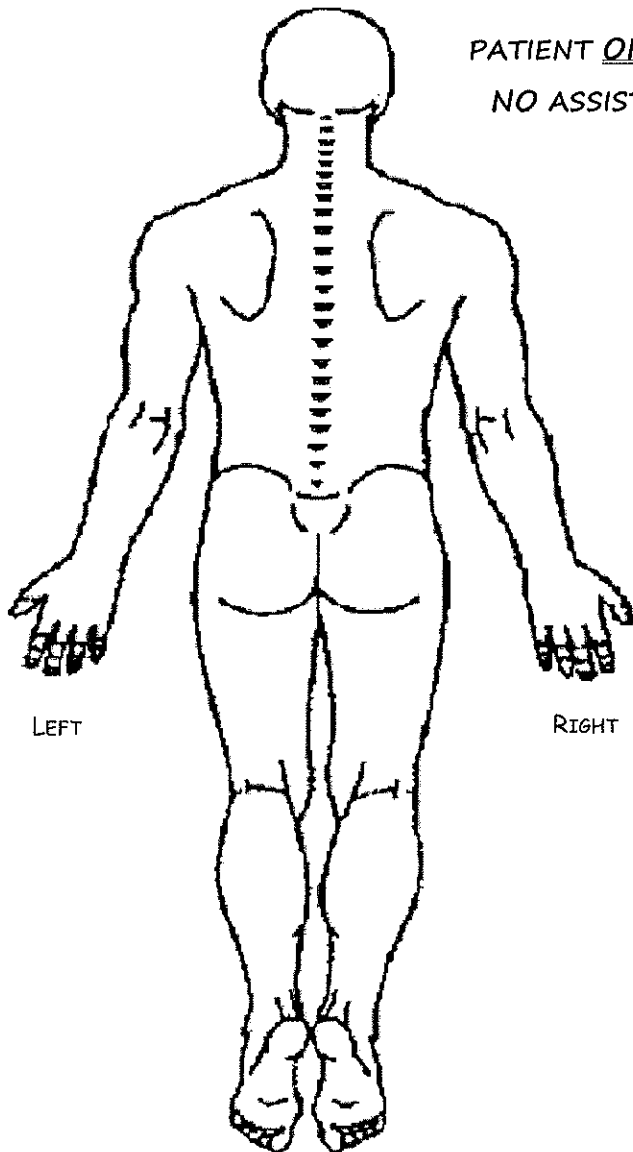
Do you have a positive family history for any of the following?

Scoliosis? _____ Osteoporosis? _____ Spinal stenosis? _____

PATIENT PAIN DIAGRAM

FIRST NAME:	LAST NAME:	DATE:
<p>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.</p> <p>~~~~~ Aching □□□□ Numbness XXXXX Burning ○○○○ Pins & Needles ΔΔΔΔ Stabbing</p>	 <p>0 No pain 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts A Whole Lot 10 Hurts As Much As You Can Imagine</p> <p>PLEASE CIRCLE THE NUMBER BELOW THAT BEST REPRESENTS YOUR PAIN</p> <p>PAIN RATING SCALE, CERVICAL SPINE (NECK)</p>  <p>PAIN RATING SCALE, LUMBAR SPINE (LOW BACK)</p> 	<p>Use the pain scale to select the appropriate number to best fill in the following blanks:</p> <p>Right Arm Pain: ____/10</p> <p>Left Arm Pain: ____/10</p> <p>Right Leg Pain: ____/10</p> <p>Left Leg Pain: ____/10</p>

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



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: _____

A Comprehensive Diagnostic
and Treatment Center for
Spine Disorders

Leaders in Innovative
Minimally Invasive Spine Care

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Board Certified in
Orthopedic Surgery

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**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

MEDICAL RELEASE CONSENT FORM

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**Compression Fractures
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Spinal Stenosis
Spinal Injuries**

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