JOSEPHSPINE
INSTITUTE

Ron Chatterjee, M.D.

Your appointment has been scheduled: _____

Your appointment time is: _____

Please arrive at: _____

- 2727 West Dr. Martin Luther King Jr. Blvd.
  Suite 590
  Tampa, FL 33607

- 514 Eichenfeld Drive
  Suite 202
  Brandon, FL 33511

- 1840 Mease Drive (Medical Arts Building)
  Suite 309
  Safety Harbor, FL 34695

You must bring the following to your appointment:

- ✓ New Patient Packet completed
- ✓ MRI films, CT films, X-Ray films and reports for all films. _____
- ✓ Photo ID
- ✓ Insurance ID

If you have any questions related to your MRI films, CT, X-Ray, or reports, please call (813) 534-6269.

Thank you,

Joseph Spine Institute

JOSEPHSPINE
INSTITUTE

NEW PATIENT INFORMATION

Chart: _____ Date: _____

Patient Name: _____ DOB: _____ Age:_____

Primary Care Physician: _____

Emergency Contact: _____ Phone Number: _____

Male / Female (circle one) ( ) Right Handed ( ) Left Handed

Is your problem related to:

Auto Accident: [ ] Yes [ ] No Date: _____

Job Injury: [ ] Yes [ ] No Date: _____

Other: [ ] Yes [ ] No Date: _____

Which physician can we thank for your referral?_____

Briefly describe your main complaint/problem. Also, describe the injury that caused these symptoms, if applicable:

_____
_____
_____
_____
_____

How long have you had this problem? _____

[For physician use only. History of present illness. (Preliminary notes: refer to dictation for more details]

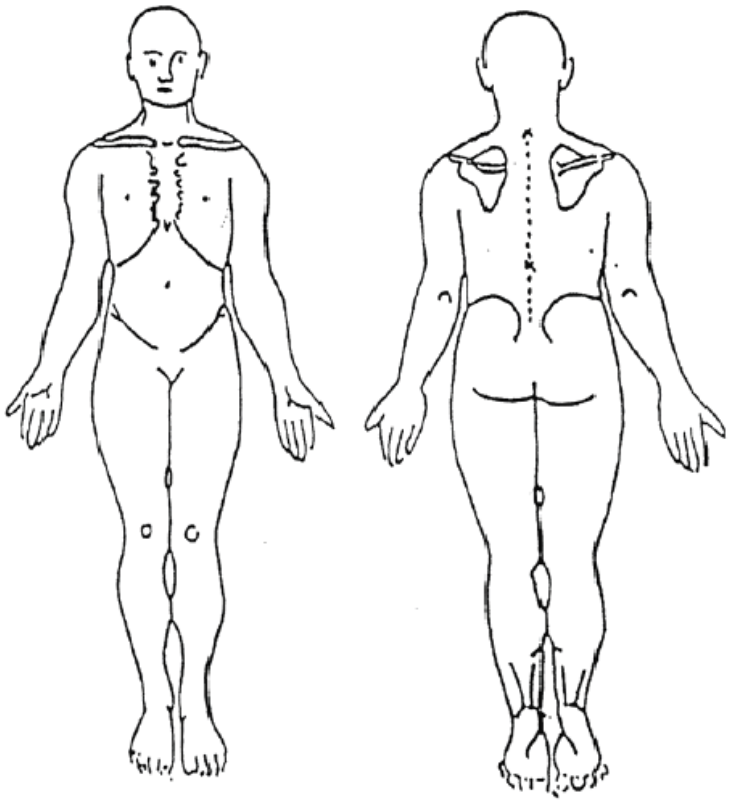
_____
_____
_____
_____
_____

2727 W. Dr. Martin Luther King Jr. Blvd., Suite 590 • Tampa, Florida 33607
1840 Mease Drive, Suite 309 • Safety Harbor, Florida 34695
514 Eichenfeld Drive, Suite 202 • Brandon, Florida 33511

Phone: 813-534-6269 • Fax: 813-870-0008

Using the symbols below, please draw in the location of your symptoms on the diagrams.

X = Pain 0 = Numbness / = Aching * = Pins & Needles



If you have NECK PAIN, what percentage of your pain is _____% Neck and _____% Arm (Total 100%)

If you have BACK PAIN, what percentage of your pain is _____% Back and _____% Leg (Total 100%)

Mark an X on the line indicating the usual degree of the pain :

(0 = no pain and 10 = the worst pain)

---

0 1 2 3 4 5 6 7 8 9 10

Least Pain Worst Pain

2727 W. Dr. Martin Luther King Jr. Blvd., Suite 590 • Tampa, Florida 33607
1840 Mease Drive, Suite 309 • Safety Harbor, Florida 34695
514 Eichenfeld Drive, Suite 202 • Brandon, Florida 33511
Phone: 813-534-6269 • Fax: 813-870-0008

What position/activity makes the pain worse/better?

	Better	**Worse**	**Comments**
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			

Please check which **TREATMENTS** you have had for your main problem/complaint and indicate whether they were helpful.

Treatment	✓	Helpful?	Treatment	✓	Helpful?	Treatment	✓	Helpful?
Electric Stimulation			Massage			Whirlpool		
T.E.N.S.			Pool Exercises			Injections		
Ultrasound			Home Exercises			Acupuncture		
Hot Packs			Manipulation			Cold		
Other:			Botox					

How long can you **STAND** with no or minimal pain? _____ minutes.

WALKING DISTANCE with no or minimal pain:
[ ] 0-50 ft [ ] 50-200 ft [ ] 200-500 ft [ ] 500+ ft [ ] ½ mile +

Do you need SUPPORT to help you walk? [ ] Y [ ] N
If yes, what kind of brace?_____

List below the PREVIOUS PHYSICIANS (MD, DO, Chiropractor) you have seen for your main complaint/problem.

Physician	Specialty	Dates	Treatment

Indicate which **DIAGNOSTIC STUDIES** you have had in evaluation of your main complaint/problem. (include dates)

Test	Date	Test	Date	Test	Date
X- Ray		EMG/NVC/SSEP		CT Scan	
Bone Scan		Arthogram		Dexa Scan	
Myelogram		MRI		Diskogram	
Other:					

PAST MEDICAL HISTORY Check below if you have had any of the following:

	✓	Comments		✓	Comments
Bowel disorders			Osteoporosis		
Cancer-where			Pacemaker		
Depression			Polio		
Diabetes			Psoriasis		
Heart disease			Rheumatoid arthritis		
High blood pressure			Seizures		
High cholesterol			Serious infection		
Kidney disease			Stroke		
Lung disease			Thyroid condition		
Multiple myeloma			Ulcers		
Other:					

List any **SURGERY OR SURGERIES** you have had:

Type	Date	Outcome

List any **DRUG ALLERGIES** you have:

Drug	Type of Reaction

List **ALL CURRENT MEDICATIONS** as follows:

Name	Dose (Milligrams, grams)	How Often – (per day)	How Long

SOCIAL HISTORY & HABITS

Occupation: _____

Marital Status: | | Single | | Married | | Separated | | Divorced | | Widowed

Highest Level of Education: | | Less than high school | | High school graduate
| | Some college | | College Graduate | | Postgraduate | | Unknown

WORK STATUS

[ ] Full duty [ ] Light duty [ ] Off duty per physician [ ] Unemployed [ ] Retired

If you are **NOT** working a full day, how long have you been off work?

Have you had a work capacity assessment? [ ] Yes [ ] No

Are you disabled through Social Security? [ ] Yes [ ] No

TOBACCO USE

Do you currently use tobacco products? [ ] Yes [ ] No Start Age/Year:____Stopped_____

If yes, indicate quantity per day: Cigarettes_____ Cigars_____ Chewing Tobacco (snuff)_____

ALCOHOL USE

Do you currently consume alcoholic beverages? [ ] Yes [ ] No

If yes, indicate quantity per day: Beer _____ Wine _____ Distilled Spirits_____

FAMILY HISTORY

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	Mother	Father's Parents	Mother's Parents	Brother(s)	Sister(s)
Anemia	_____	_____	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____	_____	_____
Bleeding Disorder	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Coronary Artery Disease	_____	_____	_____	_____	_____	_____
Diabetes Mellitus	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____
Hypertension	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Seizures	_____	_____	_____	_____	_____	_____
Sickle Cell Disorder	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____

VITALS: Weight: _____ Height: _____ (Females only) LMP: _____

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: | **Normal**
- ❑ Weight Gain – Last 6 Months
- ❑ Weight Loss – Last 6 Months
- ❑ Poor Appetite
- ❑ Night Sweats
- ❑ Chills
- ❑ Fever

Skin: | **Normal**
- ❑ Rash

HEENT: | **Normal**
- ❑ Recent Changes in Vision
- ❑ Recent Changes in Hearing
- ❑ Recent Changes in Smell
- ❑ Recent Changes in Taste

Respiratory: | **Normal**
- ❑ Short of Breath
- ❑ Cough
- ❑ Sputum
- ❑ History of Tuberculosis
- ❑ Wheezing

Cardiovascular: | **Normal**
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Shortness of Breath with Exercise
- ❑ Murmur
- ❑ Feet Edema

Gastrointestinal: | **Normal**
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Indigestion
- ❑ Abdominal Pain
- ❑ Bloody or Dark Stools
- ❑ Unable to Control Bowel

Genitourinary: | **Normal**
- ❑ Blood in Urine
- ❑ Urinary Tract Infections
- ❑ Unable to Control Bladder
- ❑ Rushing to go
- ❑ Need to go Frequently

Musculoskeletal: | **Normal**
- ❑ Cramps
- ❑ Muscle Weakness
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Morning Stiffness

Neurological: | **Normal**
- ❑ Numbness/Tingling Feet
- ❑ Numbness/Tingling Hands
- ❑ Convulsions
- ❑ Dizziness

Psychiatric: | **Normal**
- ❑ Problem Sleeping
- ❑ Crying Spells

Hematology: | **Normal**
- ❑ Easy Bleeding
- ❑ Easy Bruising

The preceding patient information packet has been reviewed and discussed with my patient.