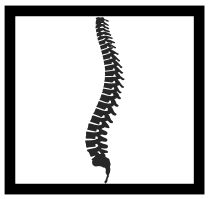

JOSEPHSPINE
INSTITUTE

Samuel A. Joseph, Jr., M.D.
Ron Chatterjee, M.D.
Andrew W. Moulton, M.D.
Thuy M. Nguyen, D.O.

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
- 710 94th Avenue North
  Suite 309
  St. Petersburg, FL 33702

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]

_____
_____
_____
_____
_____

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

BACK PAIN

Relationship to Injury

- ☐ Injury Related
- ☐ Related to repetitive activity
- ☐ Not related to specific injury

Injury Setting

- ☐ At home
- ☐ At work
- ☐ Motor Vehicle Accident

Past Evaluation Setting

- ☐ Primary Care
- ☐ Specialty Provider
- ☐ Emergency Room
- ☐ Hospitalization
- ☐ Urgent Care

Past Evaluation

- ☐ ESR
- ☐ C-reactive protein
- ☐ Spine x-rays
- ☐ Spine CT
- ☐ Spine CT myelogram
- ☐ Spine MRI
- ☐ Bone Scan
- ☐ Electromyography
- ☐ Nerve conduction studies
- ☐ Provocation discography
- ☐ Diagnostic selective nerve block
- ☐ Rheumatology evaluation
- ☐ Neurology evaluation
- ☐ Neurosurgery Evaluation
- ☐ Orthopedic Evaluation

Past Treatment

- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Non-opioid analgesics
- ☐ Opioid analgesics
- ☐ Muscle relaxants
- ☐ Tricyclic antidepressants
- ☐ Anticonvulsants
- ☐ Corticosteroids
- ☐ Physical therapy
- ☐ Chiropractic Therapy
- ☐ Manipulation
- ☐ TENS Unit

Past Treatment Continued

- ☐ Mental health care
- ☐ Laminotomy
- ☐ Laminectomy
- ☐ Discectomy
- ☐ Spinal fusion
- ☐ Vertebroplasty
- ☐ Kyphoplasty
- ☐ Artificial disc replacement

Past Procedures

- ☐ None
- ☐ Nerve block
- ☐ Trigger point injection
- ☐ Epidural injection facet injection
- ☐ Radiofrequency neurolysis
- ☐ Lysis of epidural adhesions
- ☐ Spinal cord stimulation
- ☐ Intrathecal pump

Symptoms

- ☐ Back pain
- ☐ Back stiffness
- ☐ Decrease spine range of motion
- ☐ Decreased flexion
- ☐ Decreased extension
- ☐ Decreased lateral bending
- ☐ Decreased rotation
- ☐ Lower extremity numbness
- ☐ Lower extremity tingling
- ☐ Lower extremity weakness

Pain Location

- ☐ Upper back
- ☐ Mid back
- ☐ Low back
- ☐ Left upper back
- ☐ Left mid back
- ☐ Left low back
- ☐ Left sacroiliac region
- ☐ Right upper back
- ☐ Right mid back
- ☐ Right low back
- ☐ Right sacroiliac region
- ☐ Left side more than the right
- ☐ Right side more than the left

Radiation

- ☐ None
- ☐ Left arm
- ☐ Left flank
- ☐ Left groin
- ☐ Left buttock
- ☐ Left thigh
- ☐ Left calf
- ☐ Left great toe
- ☐ Left lateral foot
- ☐ Right arm
- ☐ Right flank
- ☐ Right groin
- ☐ Right buttock
- ☐ Right thigh
- ☐ Right calf
- ☐ Right great toe
- ☐ Right lateral foot

Pain Quality

- ☐ Sharp
- ☐ Dull
- ☐ Aching
- ☐ Burning
- ☐ Shooting
- ☐ Stinging
- ☐ Stabbing
- ☐ Throbbing

Timing

- ☐ Constant
- ☐ Intermittent
- ☐ Mostly during the day
- ☐ Mostly nocturnal

Progression

- ☐ Worsening
- ☐ Unchanged
- ☐ Improving
- ☐ Resolved

Exacerbating Factors

- ☐ Coughing
- ☐ Lifting
- ☐ Sitting
- ☐ Standing

BACK PAIN

Exacerbating Factors Continued

- ☐ Walking
- ☐ Climbing stairs
- ☐ Side sleeping position
- ☐ Supine sleeping position
- ☐ Prone sleeping position

Relieving Factors

- ☐ Ice
- ☐ Heat
- ☐ Rest
- ☐ Lying supine
- ☐ Stretching
- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Non-opioid analgesics
- ☐ Opioid analgesics
- ☐ Physical therapy
- ☐ Back brace
- ☐ Acupuncture
- ☐ Manipulation
- ☐ Injection treatments

Associated Symptoms

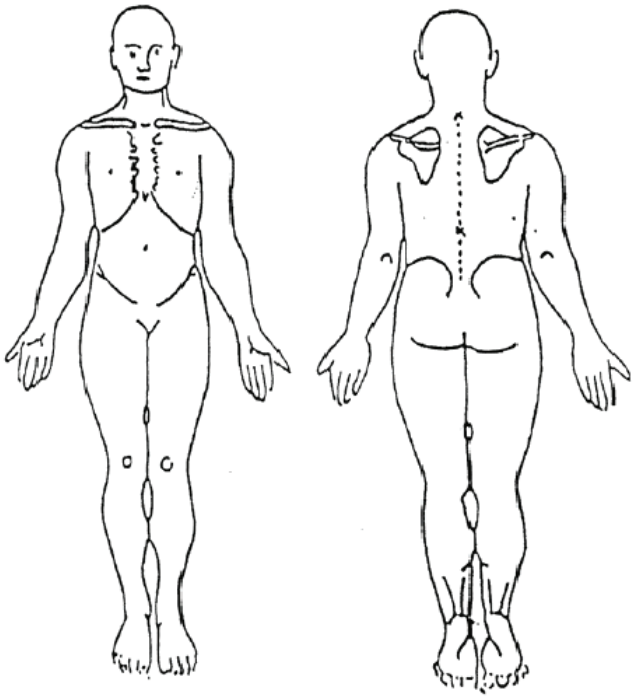
- ☐ Headache
- ☐ Neck pain dizziness
- ☐ Difficulty walking
- ☐ Difficulty Sleeping
- ☐ Urinary incontinence
- ☐ Fecal incontinence
- ☐ Sexual dysfunction
- ☐ Depression
- ☐ Suicidal ideation

Functional Limitations

- ☐ General activity
- ☐ Walking ability
- ☐ Work
- ☐ Housework
- ☐ Activities of daily living
- ☐ Hobbies
- ☐ Social relationships
- ☐ Sleep
- ☐ Enjoyment of life

Current Treatment

- ☐ None
- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Non-opioid analgesics
- ☐ Non-opioid analgesics
- ☐ Muscle relaxants
- ☐ Tricyclic antidepressants
- ☐ Anticonvulsants
- ☐ Corticosteroids
- ☐ Physical therapy
- ☐ Manipulation
- ☐ TENS unit
- ☐ Mental health care



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

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NECK PAIN

Relationship to injury

- ☐ Without any known injury
- ☐ Following a specific injury
- ☐ In association with a new activity
- ☐ In association with a change in activity
- ☐ In association with an established activity

Injury Mechanism

- ☐ Hyperflexion
- ☐ Hyperextension
- ☐ Twisting
- ☐ A motor vehicle accident
- ☐ A fall
- ☐ Blunt force trauma
- ☐ Sleeping position
- ☐ No know event

Symptoms

- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Muscle spasm
- ☐ Crepitus
- ☐ Tenderness
- ☐ Impaired range of motion
- ☐ Shoulder p ain

Location

- ☐ Entire neck
- ☐ Left posterior neck
- ☐ Left anterior neck
- ☐ Left lateral neck
- ☐ Right posterior neck
- ☐ Right anterior neck
- ☐ Right lateral neck

Radiation

- ☐ None
- ☐ Left trapezius
- ☐ Left chest
- ☐ Left shoulder
- ☐ Left arm
- ☐ Left upper arm
- ☐ Left forearm

Radiation Continued

- ☐ Left hand
- ☐ Right trapezius
- ☐ Right chest
- ☐ Right shoulder
- ☐ Right arm
- ☐ Right upper arm
- ☐ Right forearm
- ☐ Right hand

Pain Quality

- ☐ Sharp
- ☐ Dull
- ☐ Arching
- ☐ Burning
- ☐ Stinging
- ☐ Throbbing

Timing

- ☐ Constantly
- ☐ Frequently
- ☐ Intermittently
- ☐ Occasionally
- ☐ Rarely
- ☐ During the day
- ☐ At night

Severity

- ☐ Mild
- ☐ Moderate in severity
- ☐ Severe

Progression

- ☐ Worsening
- ☐ Unchanged
- ☐ Improving
- ☐ Resolved

Exacerbating Factors

- ☐ Turning the head to the right
- ☐ Turning the head to the left
- ☐ Use of the right arm
- ☐ Use of the left arm

Exacerbating Factors Continued

- ☐ Neck flexion
- ☐ Neck extension
- ☐ Neck movement

Relieving Factors

- ☐ Ice
- ☐ Heat
- ☐ Rest
- ☐ Lying supine
- ☐ Stretching
- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Non-opioid analgesics
- ☐ Opioid analgesics
- ☐ Physical therapy
- ☐ Back brace
- ☐ Acupuncture
- ☐ Manipulation
- ☐ Injection treatments

Associated Symptoms

- ☐ Headache
- ☐ Upper extremity paresthesias
- ☐ Upper extremity weakness
- ☐ Tinnitus
- ☐ Impaired hearing
- ☐ Impaired memory
- ☐ Impaired vision

Current Treatment

- ☐ None
- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Acetaminophen
- ☐ Muscle relaxants
- ☐ Non-opioid analgesics
- ☐ Opioid analgesics
- ☐ Ice
- ☐ Heat
- ☐ Massage
- ☐ Physical therapy
- ☐ Manipulation
- ☐ Soft cervical collar
- ☐ Rigid cervical collar
- ☐ TENS Unit

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NECK PAIN

Pertinent Medical History

- ☐ Neck pain
- ☐ Spinal surgery
- ☐ Low back pain
- ☐ Cervical disc herniation
- ☐ Neck injury

Presentation

- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Shoulder pain
- ☐ Headache
- ☐ Arm pain
- ☐ Arm paresthesias
- ☐ Arm numbness

Past Evaluation

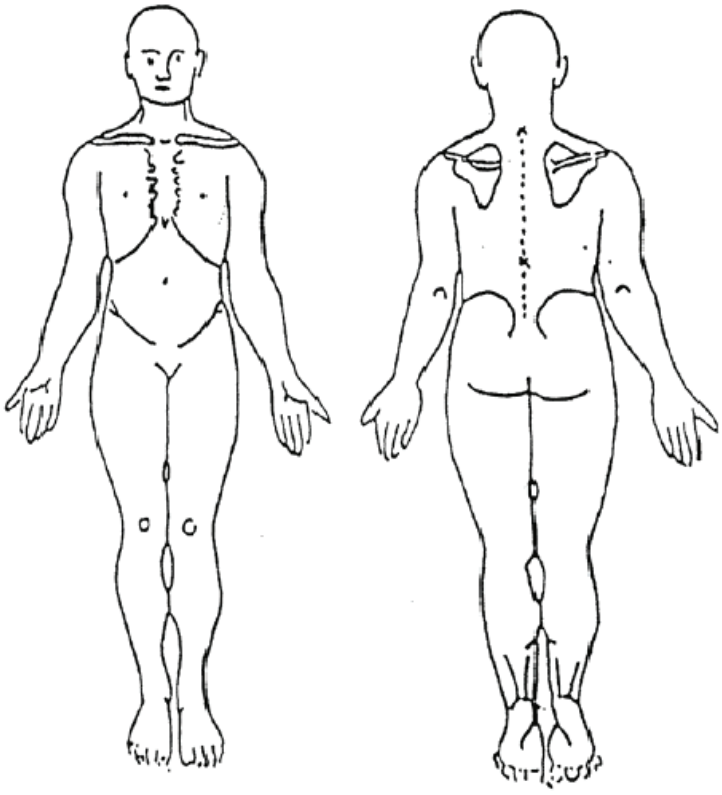
- ☐ None
- ☐ White blood cell count
- ☐ Erythrocyte sedimentation rate
- ☐ Cervical spine x-rays
- ☐ Cervical spine CT
- ☐ Myelogram CT
- ☐ Cervical spine MRI
- ☐ Nerve conduction velocity studies
- ☐ Electromyogram
- ☐ Neurology evaluation
- ☐ Orthopedics evaluation
- ☐ Physical therapy evaluation
- ☐ Chiropractic evaluation

Past Treatment

- ☐ None
- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Acetaminophen
- ☐ Muscle relaxants
- ☐ Non-opioid analgesics
- ☐ Opioid analgesics
- ☐ Ice
- ☐ Heat
- ☐ Massage
- ☐ Physical therapy
- ☐ Manipulation
- ☐ Rigid cervical collar

Past Treatment Continued

- ☐ Soft cervical collar
- ☐ TENS unit
- ☐ Spinal injection
- ☐ Spinal surgery



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

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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		
Prior Accidents:					

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

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

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

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

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

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

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