SPINE REHABILITATION ASSOCIATES, INC.
2401 UNIVERSITY PKWY, SUITE 106, SARASOTA, FL 34243
PHONE: 941-923-0999 FAX: 941-923-0090

Dear New Patient:

Welcome to Spine Rehabilitation Associates, Inc. in order to expedite your appointment we are enclosing a set of Patient Admission forms, which should be completely filled out prior to seeing the doctor.

You will also need the following:

- PHOTO IDENTIFICATION
- MEDICAL INSURANCE CARDS-Primary and Secondary if applicable

If applicable, specific information will also be required for your appointment. Please see the following:

- **AUTOMOBILE ACCIDENT CASES**-You will need your automobile insurance card and claim number, which you will have had to have filed with your insurance carrier and received prior to seeing the doctor. We will also need your claims adjustors name and contact information in order to verify your benefits. Please note we do not accept health insurance on automobile accidents.
- **LETTER OF PROTECTION** (also know as LOP)- Should you have any out of pocket responsibility not covered from your insurance; this could be due to deductible or co-insurance responsibility not covered by your insurance, you will be required to provide our office with an LOP. This can be obtained by retaining an attorney (if the accident was not your fault). This letter will ensure that your out of pocket responsibility will be temporarily waived until your case has settled thru your attorney. Ultimately you will still be responsible for any and all charges not paid by your insurance no matter what. The LOP will only ensure you do not have to pay your out of pocket portion every time you see the provider. If you have further questions, please notify the front desk and we will be happy to assist you.
- **WORKERS COMPENSATION**- Workers Compensation patients will have to provide our office with ample information before your appointment. We will need date of accident, caseworkers name and contact information, claim number, name of your employer and their contact information and any attorney information that you may have regarding your case.

PRESCRIPTION REFILLS:

In order to efficiently service our patients, our office policy is to handle any and all prescription refill requests that you may need to have written or refilled during a scheduled office visit with the doctor.
NO EXCEPTIONS WILL BE MADE.

FORM COMPLETION:

There is an additional fee that will be due by the patient should you need at any time forms to be completed during your course of care. This fee is determined by the doctor and based on the type of forms and the time needed to complete them. Please be informed that this charge can range from around $25 and more.
PLEASE NOTIFY THE FRONT DESK UPON ARRIVAL OF THE FORMS YOU WILL NEED.

It is our goal to provide you with the best possible care. Thank you in advance for trusting us for your healthcare needs. If you have any questions, please do not hesitate to notify our staff.

Patient Initials: ____________
Staff Initials: ____________

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PATIENT REGISTRATION FORM

First Name: ________________________ Middle Initial: ________ Last Name: ______________________________

Address: ____ City/State: ______________________ Zip: _____________

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed Date of Birth: _____/_____/_____

AGE: ___________________ SEX: **(Please Circle)** Male Female Other

Home Phone: ______________________Cell Phone: _______________________ Work Phone: ______________________

Social Security Number: **(required)** ______________________ Spouse's Name: __________________________

Spouse's Date of Birth: _____/_____/_____ Employers Name: ____

Employers Address: __________________________________ City/State ____________________ Zip: _______________

Spouse's Employer: _________________________________Spouses Occupation: _______________________________

Nearest Relative not living with you: ____________________ Relation to you: _____________ Phone #: ________________

Guardian or Person Responsible for payment, if other than the patient:

Name: ____ Relation to the Patient: _______________________________

Social Security Number: **(required)** ____________________ Address: ____

City/State: ______________________Zip: __________ Home Phone: ____________________ Cell: _______________

Employers Name: __________________________________ Occupation: _______________________________

PATIENTS INFORMATION: Effective Date: _____/_____/_____

Primary Insurance Name: _____________________________ Insurance Policy Number: ____________________________

Group Number: __________________________ Policy Holders Name: ___________________________________

Policy Holders Date of Birth: _____/_____/_____ Insurance Address: ____

City/State: __________________________ Zip: ______________ Insurance Phone: ___________________________

Secondary Insurance Name: _____________________________ Insurance Policy Number: ____________________________

Group Number: __________________________ Policy Holders Name: ___________________________________

Policy Holders Date of Birth: _____/_____/_____ Insurance Address: ____

City/State: __________________________ Zip: ______________ Insurance Phone: ___________________________

IS THIS INJURY RELATED TO? **(Please Circle the following): Insurance Work Comp Auto Slip & Fall Other**

Date of Injury: _____/_____/_____

Patient Initials: ___________
Staff Initials: ___________

2401 University Parkway, Suite 106
Sarasota, Fl. 34243
Phone: (941) 923-0999

Assignment of Benefits

I, ________________________________, hereby authorize ________________________________
(Name of Insured Patient) (Name of Insurance Carrier)

To make payment payable to and mailed directly to : **Spine Rehabilitation Associates Inc.**
2401 University Parkway, Suite 106
Sarasota, Fl. 34243

The medical benefits otherwise payable to me for their services, but not to exceed the charges of those services. I hereby IRREVOCABLY ASSIGN to **Spine Rehabilitation Associates Inc.** any benefits under any policy of insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by **Spine Rehabilitation Associates Inc.** In the event that my insurance company does not pay **Spine Rehabilitation Associates Inc.** bills in full and pursuant to the terms of my policy of insurance, I hereby instruct the insurance carrier to set aside all funds in an amount that would be sufficient to pay such bills in full in accordance with the charges submitted. As part of this assignment of benefits, I further instruct the insurance carrier to notify the provider immediately after any dispute as to the payment so that I may preserve and exercise its legal rights. Also, in addition to notifying me and my legal representative, I instruct the insurance carrier to immediately notify the Provider of any scheduled examinations under oath or independent medical examinations. I understand that any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement containing any false, incomplete, or misleading information is guilty of a felony of the third degree. I have read the information herein and it is true to the best of my knowledge and belief.

Initials X__________.

MEDICAL RELEASE: A photocopy of this document shall be sufficient to authorize any person having records of medical treatment, services, or supplies pertaining to me to release true copies of same to the **Spine Rehabilitation Associates Inc.** or any insurers providing coverage to me in connection with the processing of any claim for benefits made by me or by the assignee herein. A photocopy of this document shall be as binding as an original signature page. The undersigned does hereby ratify and confirm and all actions taken by the said attorney in accordance with this special power and which the said attorney shall do or cause to be done by virtue of these presents.

RELEASE OF I NFORMATI ON: I hereby authorize this medical provider to: furnish my insurance company or companies and the patient's attorney with any and all information that may be contained in my medical records; to obtain coverage information telephonically from my insurer; to request a written non-redacted PIP payout sheet from the insurers; and to obtain copies of my medical records, including but not limited to, documents, reports, scans, notes, opinions, x-rays, and MRIs received from any other medical provider or any insurance company. The insurer is directed to keep the patient's medical records private and confidential. The insurer is NOT authorized to provide these medical records to anyone, including but not limited to, third party vendors, without the patient's and the provider's prior expressed written permission.

Initials X__________.

POWER OF ATTORNEY TO ENDORSE CHECKS AND/OR TO SIGN ANY PAPER WHICH WILL ENHANCE OR EXPEDITE PAYMENT TO PROVIDER FOR SERVICES RENDERED, INCLUDING BUT NOT LIMITED TO A RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS/AUTHORIZATION TO PAY. Know by all these present that: The Undersigned has made, constituted and appointed, and by these presents does hereby make, constitute and appoint **Spine Rehabilitation Associates Inc.** and any of its duly authorized agents and employees as and to be the undersigned's true and lawful attorney for and in the undersigned's name, place, and stead to endorse any and all checks, drafts, or money orders which are made payable to the undersigned alone or to the undersigned and said **Spine Rehabilitation Associates Inc** at the request or with the knowledge and approval of the undersigned and/or the maker of the check, draft, or money order. Furthermore, the undersigned allows **Spine Rehabilitation Associates Inc** or any of it's agents to sign any paper that will be necessary to enhance, expedite and/or allow payment to said provider. This may include affidavits of non-ownership of vehicles, insurance forms and other statements. The undersigned by these presents does give and grant the said **Spine Rehabilitation Associates Inc** as attorney to the full power and authority to do and perform all the every act whatsoever requisite and necessary to be done in and about the premises as fully to all intents and purposes as the undersigned might or could do to personally present insofar as

Initials X__________.

IN WITNSS WHEREOF, the undersigned have hereunto set their hands, this_________day of_____________ -20_________.

X____. ____.
Patient's signature Print Patient's Name

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Acknowledgement of Privacy Practice

By signing your name below you acknowledge that you have received or declined a copy of our privacy practice notice as it pertains to your visit in our office. This brochure provides helpful information as it relates to your care in this office and should be read thoroughly to inform you of your rights as a patient. Should you have further questions or concerns, please address our staff and they will help you with any issues you may have.

Below are the names of the people or family members I would like to have my information released to:

Name: ______________________________ Date of Birth (required): ________________

Name: ______________________________ Date of Birth (required): ________________

I give Spine Rehabilitation Assocaites, Inc permission to call me at home and/or cell phone number and leave a message on my answering machine or voicemail system as it pertains to my appointment if necessary.

☐ Yes, I give you permission to leave a message

☐ No, I do not permit you to leave a message

I give Spine Rehabilitation Associates, Inc permission to leave test results on my home and/or cell phone number voicemail. Confidential information will not be left on your designated contact number. You will be required to see the doctor for a follow up appointment.

☐ Yes, I give you permission to leave a message

☐ No, I do not permit you to leave a message

☐ I would like to keep a copy of my privacy notice

☐ I declined to keep my copy of the privacy notice

______________________________ ______________________________
Patient Name: (Printed) Signature of Patient

______________________________ ______________________________
Print Name of Patient Representative Relationship to Patient

____
Date

Staff Initials:__________

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REQUEST FOR MEDICAL RECORDS

I, ________________________________, said patient hereby request that the above named provider be able to request on my behalf for the purposes of my medical treatment any and all information as it relates to the treatment or diagnosis for which I am seeing the following provider. Should I request that only a portion of my records be received, please check off the records to be obtained:

- ☐ Medical Records; should include: any and all physician notes, labs, x-rays
- ☐ Radiology Reports; should include: MRI, CT, US, PET SCANS
- ☐ Hospital Records; complete records
- ☐ Laboratory Results; complete records
- ☐ Psychiatry Reports (to be put in a confidential place in the file)

Should there be any information for which I specifically would not like this provider to receive, please list the following:

1) ____

2) ____

3) ____

Signature of Patient: ______________________________ Date: ________________________

Print Name: ____________________________________ Date of Birth: __________________

Witnesses By: __________________________________ Date: ________________________

Patient Initials: __________
Staff Initials: __________

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PROVIDER'S LIEN: PATIENT'S LETTER OF PROTECTION; AUTHORIZATION FOR RELEASE OF INFORMATION; SPECIAL POWER OF ATTORNEY AND ASSIGNMENT OF RIGHTS & BENEFITS WITHIN THE MEANING OF § 627.736, FLORIDA STATUTES

This agreement allows me, ________________________________, to be treated by Spine Rehabilitation Associates, Inc without paying for my care and treatment in advance. Spine Rehabilitation Associates, Inc will be paid within (35) days of submission of claims for my care directly by my personal injury protection insurance carrier. The parties agree that this is good and sufficient mutual consideration.

I hereby guarantee full payment to Spine Rehabilitation Associates, Inc and agree that I will remain personally responsible for any unpaid charges. I also grant Spine Rehabilitation Associates, Inc a lien against any recovery which I may have now or in the future against any tort-feasor or any responsible insurance carrier. I promise to sign a letter of protection in favor of Spine Rehabilitation Associates, Inc and I hereby direct that any attorney representing me now or in the future execute a letter of protection in favor of Spine Rehabilitation Associates, Inc.

I hereby authorize and direct my personal injury protection insurance company or group health insurance companies to pay directly to Spine Rehabilitation Associates, Inc my personal injury protection benefits for care and treatment rendered to me by Spine Rehabilitation Associates, Inc.

I hereby assign my personal injury protection rights <u>and</u> benefits to Spine Rehabilitation Associates, Inc. If any portion of this document is deemed to be inconsistent with an assignment of rights <u>and</u> benefits within the meaning of Florida Statutes § 627.736, said portion shall be rewritten in order to conform with Florida law to give full effect to the intended purpose of this agreement, said intended purpose being to create an assignment of rights and benefits from ________________________ to Spine Rehabilitation Associates, Inc.

I hereby grant Spine Rehabilitation Associates, Inc a limited Power of Attorney to endorse checks made payable to me for PIP benefits. I grant to Spine Rehabilitation Associates, Inc full power and authority to endorse and sign checks or drafts for payment of bills submitted by Spine Rehabilitation Associates, Inc.

I authorize and direct my present or future attorneys and my personal injury protection insurance carrier, or carriers, to release medical and legal information about me to Spine Rehabilitation Associates, Inc.

DATED THIS _________ DAY OF _________, 20___.

SIGNATURE: ____ **DATE:** ______________

WITNESSED BY : ____________________________________ **DATE:** ______________

Patient Initials: __________

Staff Initials: __________

OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection - Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

1. The services or treatment set forth below were **actually rendered.** This means that those services have **already been provided.**

____

____

2. I have the right and the **duty to confirm** that the services have already been provided.
3. I was **not solicited** by any person to seek any services from the medical provider of the services described above.
4. The medical provider has **explained** the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to $500.

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

A. I have **not solicited** or caused the insured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.

B. The treatment or services rendered were explained to the insured person, or his or her guardian, **sufficiently** for that person to sign this form with informed consent.

C. The accompanying statement or bill is **properly completed** in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to **truthfully, accurately**, and in a **substantially complete** manner.

D. The coding of procedures on the accompanying statement or bill is proper. This means that **no service has been upcoded, unbundled**, or constitutes an invalid **or not medically necessary diagnostic test** as defined by Section 627.732 (15) and (16), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable *(Signature by his/ her own hand):*

______________________	______________________	______________
Name *(PRINT or TYPE)*	Signature	Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The **original** of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may **not** be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

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Pub. 1/2004

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2401 UNIVERSITY PARKWAY
SUITE 106
SARASOTA, FL. 34243
Phone: (941) 923-0999
Fax (941) 923-0090

Letter of Protection

Patient/Client Name: ______________________ Date of Accident: ____________________

I do hereby authorize **Spine Rehabilitation Associates Inc.** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of myself in regards to the accident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly to said provider such sums as may be due and owing him/her for professional service rendered me both by reason of this accident and by reason of any other bills that are due his/her office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said provider; I hereby further give a lien on my case to this provider against any and all proceeds of my settlement, judgment or verdict which be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith. After payment of attorney's fees and costs

I fully understand that I am directly and fully responsible to said provider for all professional bills submitted by him/her for services rendered me and that this agreement is made solely for said providers additional protection and in consideration of his awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee.

I agree to promptly notify said provider of any changes or addition of attorney(s) used by rue in connection with this accident, and I instruct my attorney to do the same and to promptly deliver a copy of the lien to any such substituted or added attorney(s).

Please acknowledge this letter by signing below and returning to the provider's office. I have been advised that if my attorney does not wish to cooperate in protecting the provider's interest, the provider will not await payment and may declare the entire balance due and payable.

Date: ____________________ **patient's Signature:** ____

The undersigned being attorney of record for the above patient does herby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate said provider named above. Attorney further agrees that in the events this lien is litigated that the prevailing party will be awarded attorney fees and cost.

Date: ____________________ **Attorney's Signature:** ____

Please date, sign and return one copy to provider's office. Also keep one copy for your records
NOTE: A copy of this form is valid as the original

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FINANCIAL POLICY

Providing quality care for our patients is our primary concern. It is, however, the responsibility of the patient to know and understand the guidelines of their insurance policy. Payment is expected at the time services are rendered.
For your convenience, **we accept cash, checks and all major credit cards.**

Also, I understand that I will be responsible for all charges rendered by my dependents or myself regardless of any arbitrary determination of usual and customary rates by my insurance company. After my insurance makes payments for its portion of its covered services, I will remain responsible for any and all balances that are due for those services. **Payment is expected within 30 days** from our office billing you for those services. Should our office have to unfortunately send your account to our collections department, you will be also responsible for any and all collections fees, costs or expenses.

RETURNED CHECK FEES

Should your payment issued by check be returned to our office for insufficient funds, there will be returned check fee of $20.00 per returned item. Should there be a continued problem with your payments received, you will be asked to make any all-future payments via an alternate payment method.

MISSED APPOINTMENTS:

Out of respect for the doctor's time as well as our other patients, please note that our office will charge a **"NO SHOW FEE".** This will be charged for **ALL** missed and cancelled appointments not handled within the allotted time frame. **The fees are as followed:**

- New Patients Appointments- ($150.00) One Hundred and Fifty Dollars (Requires (24) hours' notice)
- Established Patients- ($75.00) Seventy Five Dollars (Requires (24) hours' notice)
- EMG/NCS- ($250.00) One Hundred and Fifty Dollars (Requires (48) hours' notice)

- If we experience any difficulty in collecting from your insurance carrier; our office will ask that you contact your insurance carrier and inquire about any delays, non-payments or appeals necessary for payment.

- We may also ask that you pay your claim and be reimbursed directly from your insurance carrier, should your insurance company directly the payment directly to the patient. **YOU WILL BE NOTIFIED OF THIS PRIOR TO SEEING THE DOCTOR.**

- I authorize Spine Rehabilitation Associates, Inc to release any and all necessary information to any health insurance carrier in order to secure payment of the charges for services rendered to me and to any physician responsible for continuing care or to my attorney.

- I have read and also had the opportunity to ask questions as it relates to my insurance rights as a patient in this office. I fully understand the financial policy to the best of my ability. I should address any concerns I may have to the doctor or the office manager on staff.

Patient Initials: ___________

Staff Initials: ___________

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SELF-PAY

Payment is required at the time services are rendered.
NO EXCEPTIONS WILL BE MADE

COMMERCIAL INSURANCE

Patient is responsible for paying at the time of service any and all deductible, co-payments, co-insurance and non-covered services. We will do our best to check with your insurance and verify this information prior to your appointment.

Our office is a provider with most insurance companies. If you're insurance carrier requires a **REFERRAL**, it will be the responsibility of the patient to get this from his/her primary care physician prior to seeing the doctor. If the referral is not acquired before the appointment your appointment may need to be rescheduled.

WORKER'S COMPENSATION

Spine Rehabilitation Associates, Inc is a provider for most Florida Workers Compensation plans; it is the responsibility of the patient to confirm which carriers are covered in our office. If you have Out of State Workers Compensation, you must have a written authorization obtained by your adjustor prior to your appointment with the doctor. Lastly, after you have reached Maximum Medical Improvement and as your primary treating provider; you may be responsible for a $10.00 co-payment per visit with the doctor contingent upon the requirements of your carrier.

MEDICARE

We are Medicare providers and our office does accept Medicare assignment. You are responsible for any Part B deductible or coinsurance.

MEDICARE REPLACEMENT POLICIES

WE DO NOT HOWEVER- take all Medicare Replacement plans and it will be the patient responsibility to verify coverage with our office before seeing the doctor.

I hereby authorize Spine Rehabilitation Associates, Inc to release any and all necessary information to any health insurance carrier in order to secure payment of the charges for services rendered to me and to any physician responsible for continuing my care or to my attorney.

MEDICARE LIFETIME AUTHORIZATION: I certify that the information given by me in applying for payment under TITLE XVIII Social Security Administration or its intermediaries or carriers as it relates to any information needed for this or a related Medicare claim. I assign the benefits payable for the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

Patient Signature: ______________________________ Date: ____________________

Signature of Parent/Guardian: ______________________________ Date: ____________________

Patient Initials: __________

Staff Initials: __________

APPLICATION FOR FLORIDA "NO FAULT" BENEFITS

Date:____________________ File Number:____________________

Insurance Company:____

Policy Number:____________________ Date of Accident:____________________

TO ENABLE US TO DETERMINE IF YOU ARE ENTITLED TO BENEFITS UNDER THE FLORIDA PERSONAL INJURY PROTECTION LAW, PLEASE COMPLETE THIS FORM AND RETURN IT PROMPTLY. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURANCE COMPANY MAKES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, IS GUILTY OF A FELONY OF THE THIRD DEGREE.

Name:____________________ Address:____________________

Phone Number:____________________ City, State, Zip Code:____________________

Date of Birth:____________________ Social Security Number:____________________

How long have you been a resident of Florida?____________________

Date of accident:____________________ Time of accident:____________________

Location of accident:____

Description of accident:____

Make and model of vehicle you were occupying during accident:____________________

As a result of this accident, were you injured?__________If yes, complete the form. If no, sign below and return to us.

____________________ ____________________
Signature Date

Description of Injury:____

Were you treated by a doctor?__________If yes, name and address:____________________

Were you treated at a hospital?__________If yes, name and address:____________________

Amount of medical expenses to date: $__________Will you have more expenses?__________

At the time of accident, were you employed?__________If yes, did you lose any wages?__________

If yes, amount lost? $__________Your weekly salary or wage: $__________

Date disability from work began:__________Date you returned to work:__________

Have you received benefits under Worker's Compensation?______If yes, amount and frequency: $__________

Name and addresses of employer or previous employer along with occupation and dates of employment:

____

As a result of this accident, have you had any other expenses?__________If yes, explain below with expense amounts.

____

____________________ ____________________
Signature Date

Review of Systems - Do you have any of the following?

Patient Name: ______________________ Date of Visit: ______________________

Constitutional

☐ Yes ☐ No Fever
☐ Yes ☐ No Fatigue
☐ Yes ☐ No Significant weight loss
☐ Yes ☐ No Weakness
☐ Yes ☐ No Loss of appetite
☐ Yes ☐ No Significant weight gain

Skin

☐ Yes ☐ No Skin disease
☐ Yes ☐ No Discoloration
☐ Yes ☐ No Cysts
☐ Yes ☐ No Pigmentation Changes
☐ Yes ☐ No Tumors/Cancer

Head

☐ Yes ☐ No Frequent or severe headaches

Eyes/Vision

☐ Yes ☐ No Eye injury
☐ Yes ☐ No Blurred vision
☐ Yes ☐ No Decreased vision
☐ Yes ☐ No Burning
☐ Yes ☐ No Light sensitivity
☐ Yes ☐ No Infection of Pain
☐ Yes ☐ No Double Vision
☐ Yes ☐ No Eye Itching
☐ Yes ☐ No Tearing

Ear, Nose, Throat, Mouth

☐ Yes ☐ No Ear pain
☐ Yes ☐ No Ear discharge
☐ Yes ☐ No Sinus problems
☐ Yes ☐ No Voice change
☐ Yes ☐ No Ear Infection
☐ Yes ☐ No Loss of hearing
☐ Yes ☐ No Recurrent throat problems
☐ Yes ☐ No Dental Disease

Cardiovascular

☐ Yes ☐ No Chest pain
☐ Yes ☐ No High blood pressure
☐ Yes ☐ No Swelling of the feet or ankles
☐ Yes ☐ No Palpitations
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Varicose Veins

Respiratory

☐ Yes ☐ No Chronic cough
☐ Yes ☐ No Emphysema
☐ Yes ☐ No Pneumonia
☐ Yes ☐ No Coughing of blood
☐ Yes ☐ No Asthma
☐ Yes ☐ No Chronic Bronchitis
☐ Yes ☐ No Tuberculosis

Gastrointestinal

☐ Yes ☐ No Frequent indigestion or reflux
☐ Yes ☐ No Vomiting of blood
☐ Yes ☐ No Liver disease
☐ Yes ☐ No Frequent constipation
☐ Yes ☐ No Blood in stools
☐ Yes ☐ No Rectal disease
☐ Yes ☐ No Nausea or vomiting
☐ Yes ☐ No Abdominal pain
☐ Yes ☐ No Change in Bowel Habits
☐ Yes ☐ No Diarrhea
☐ Yes ☐ No Hemorrhoids

Genitourinary

☐ Yes ☐ No Painful or difficult urination
☐ Yes ☐ No Kidney infection/stones
☐ Yes ☐ No Blood in the urine
☐ Yes ☐ No Venereal disease

Neurologic

☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Convulsions

Psychiatric

☐ Yes ☐ No Depressions
☐ Yes ☐ No Mood swings
☐ Yes ☐ No Alcoholism
☐ Yes ☐ No Nervousness
☐ Yes ☐ No Sleep disturbances
☐ Yes ☐ No Drug Abuse Treatment

Endocrine

☐ Yes ☐ No Increased thirst, appetite or urination
☐ Yes ☐ No Hair loss
☐ Yes ☐ No Diabetes

Hematologic

☐ Yes ☐ No Bleedings gums
☐ Yes ☐ No Spontaneous nose bleeds
☐ Yes ☐ No Easy bruising
☐ Yes ☐ No Easy bleeding that is hard to stop

SPINE REHABILITATION ASSOCIATES, INC

2401 UNIVERSITY PARKWAY STE 106, SARASOTA, FL 34243
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Patient Name: ______________________________ Date: ______________________

In percentages, please relay how much of the pain is in the following? This should add up to equal 100%

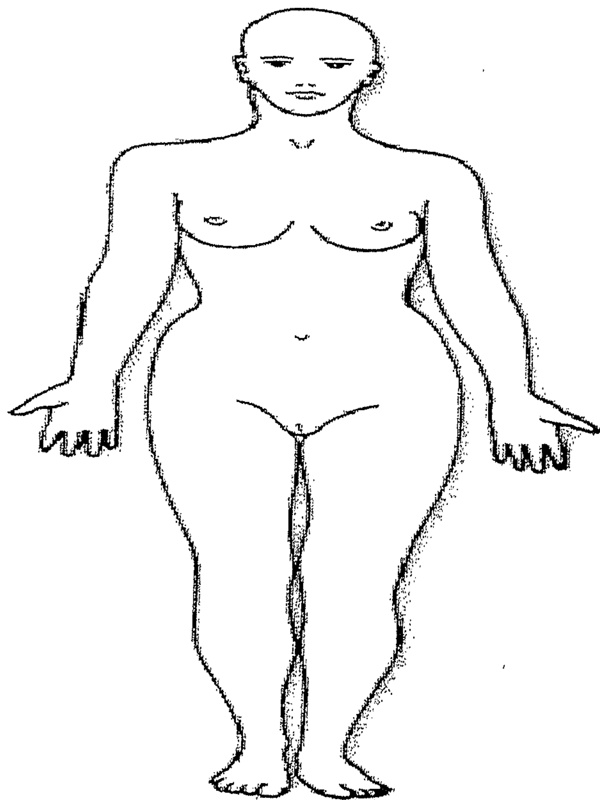
_________% of back pain _________% of neck pain

_________% in your legs _________% in your arms

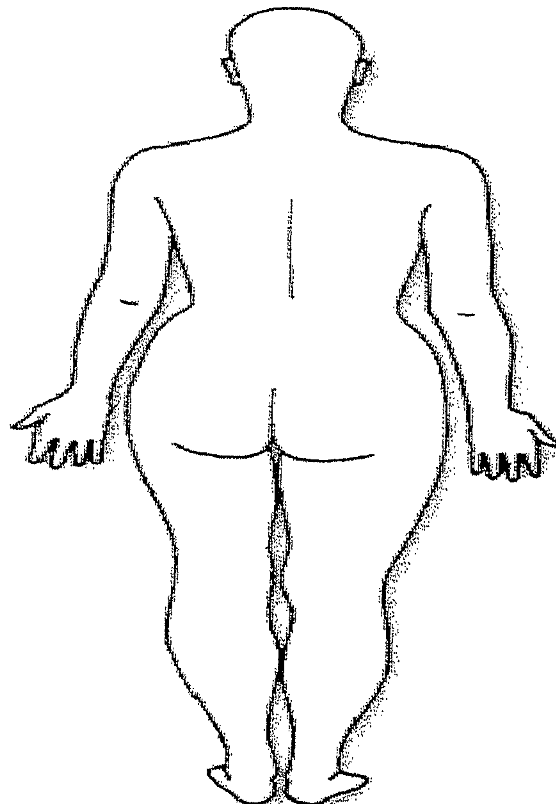
On the following diagram, please mark the areas on your body where you feel the following sensation:

PAIN: Should be marked as XXXXX
TINGLING: Should be marked as +++++
NUMBNESS: Should be marked as OOOOO
PINS/NEEDLES: Should be marked as *****

FRONT VIEW



BACK VIEW



Please use the scale below to indicate the level of pain or place the pain level on the diagram at each problem area: **BELOW IS THE SCALE TO RATE YOUR PAIN.**

No Pain 1 2 3 4 5 6 7 8 9 10 Severe Pain

Patient Initials: ___________

Staff Initials: ___________