MEMORIAL NEUROSPINE
3627 University Blvd. South, Suite 415
Jacksonville, FL 32216
Phone (904) 296-2522 Fax (904) 296-8173

Dear Patient: _____

This letter is to confirm your appointment with our office on:

_____ at _____ with _____

Please arrive for your new patient appointment 20 minutes before your scheduled time with this packet completed.

Please bring your films or CD with the reports. Also, please bring any prior records that may be relevant to your visit. It is your responsibility to have these reports/records with you. Your appointment will be rescheduled if you arrive without them. It is highly unlikely that another facility will mail them to our office. So please insure we have them prior to your visit if you requested that they be mailed to us. If the testing was done at a Memorial or Orange Park Hospital facility, then we do not need you to bring the films.

Please complete the enclosed packet and bring it with you on your scheduled appointment day. The release of the PHI Form should be completed with names of any individuals you authorize us to speak with on your behalf (family, spouse, etc.). Please remember to bring your insurance card, identification, and copay with you.

ALL APPOINTMENTS MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE.

PAYMENT IS REQUIRED AT THE TIME OF SERVICE.

Our office is located in the Medical Office Building adjoining Memorial Hospital on the right side. You will need to park and enter the double doors of this 8-story medical building and take the elevator to the 4th floor.

Please feel free to contact the office with any questions you may have regarding your appointment. We look forward to meeting you.

The Staff at Memorial Neurospine

Is the reason for your visit today Workers' Comp? ❑ Yes ❑ No

Is the reason for your visit today an Auto Accident? ❑ Yes ❑ No

If Yes, please provide the insurance information.

Insurance Carrier Name: _____

Claim Number: _____

Claim Address: _____

Date of Accident: _____

Adjustor's Name/Phone #: _____

Patient Signature: _____ Date: _____

If this is an Auto Accident and you have a Letter of Protection, Memorial NeuroSpine does not accept Letters of Protection. The patient would be responsible for payment after auto is exhausted.

I, _____ certify that I have read and understand the above statement.

Patient Registration Form (eCW)

PATIENT INFORMATION (Please Print)

❑ Dr. ❑ Miss ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Sir

Patient's Name (Last) _____(First) _____(MI) _____ Previous Name _____

Address Line 1 _____

City, State _____ Zip _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Primary Care Provider (PCP) _____ Referring Provider _____

Rendering Provider Name (this practice) _____ E-Mail Address _____

Date of Birth MM _____/ DD _____/ YYYY_____ Sex ❑ F-Female ❑ M-Male ❑ Transgender

Race ❑American Indian/Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Black/African American ❑White ❑Hispanic ❑Other ❑Declined

Ethnicity ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined

Language ❑ English ❑ Spanish ❑ Indian ❑ Japanese ❑ Chinese ❑ Korean ❑ French ❑ German ❑ Russian ❑ Other _____

Marital Status ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Social Security Number _____-____-_____ Employer Name _____

Employment Status ❑ 1-Full-Time ❑ 2-Part-Time ❑ 3-Not Employed ❑ 4-Self-Employed ❑ 5-Retired ❑ 6-Active Military

Student Status ❑ F-Full-Time Student ❑ P-Part-Time Student ❑ N-Not a Student

Emergency Contact Last Name _____ First Name _____

Phone Number _____ Do you have a living will? ❑ Yes ❑ No

Emergency Contact Relationship to Patient _____ ❑ Guardian

Address Line 1 _____

City, State _____ Zip _____

Home Phone _____ Cell No. _____ Work Phone _____ Ext. _____

Referring Provider _____

RESPONSIBLE PARTY INFORMATION (Information used for patient balance statements)

Responsible Party ❑ Another Patient ❑ Guarantor ❑ Self Check here if information is same as patient ❑

Responsible Party Name (Last) _____ (First) _____ (MI) _____

Guarantor Account Number _____ Date of Birth MM ____/ DD _____/ YYYY_____

Social Security Number _____-____-_____ Telephone _____

E-Mail Address _____ Sex ❑ F-Female ❑ M-Male

Address Line 1 _____

City, State _____ Zip _____

Employer _____ Employer Phone Number _____

PRIMARY INSURANCE INFORMATION (Provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/ DD _____/ YYYY_____

PRIMARY INSURANCE INFORMATION (Provide your insurance card to the front desk at check-in)

Insurance Company/Phone Number _____ (_____)_____

Name of Insured _____ Relationship to Insured _____

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Date of Birth MM _____/ DD _____/ YYYY_____

HCA Physician Services

MEMORIAL NEUROSPINE

Patient Consent Form

Please Read and Sign

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Memorial NeuroSpine** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Memorial NeuroSpine** to use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Memorial Neurospine Center.

I acknowledge that I have been given **Memorial NeuroSpine** Notice of Privacy Practices. I understand that if I have questions or complaints that I should contact the Privacy Official .
Patient Initial: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient (or Responsible Party) Signature Date

PATIENT NAME: _____ DATE OF BIRTH: _____

PATIENT FINANCIAL AGREEMENT

1. _____ (Patient or Guardian Initials)
   Financial Agreement.
   - I acknowledge that as a courtesy, **Memorial Neurospine** may bill my insurance company for services provided to me.
   - I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any copayment, co-insurance and/or deductible, or charges not covered by insurance.
   - I understand that there is a fee for returned checks.

2. _____ (Patient or Guardian Initials)
   Third Party Collection. I acknowledge that **Memorial Neurospine** may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____ (Patient or Guardian Initials)
   Assignment of Benefits. I hereby assign to **Memorial Neurospine** any insurance or other third-party benefits available for health care services provide to me. I understand **Memorial Neurospine** has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to **Memorial Neurospine**, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____ (Patient or Guardian Initials)
   Medicare Patient Certification and Assignment of Benefits. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to **Memorial Neurospine** by the Medicare or Medicaid program.

5. _____ (Patient or Guardian Initials)
   Consent to Telephone Calls for Financial Communications. I agree that in order for **Memorial Neurospine**, or EBO Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that **Memorial Neurospine** or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation or wireless, I have provided **Memorial Neurospine** or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____ (Patient or Guardian Initials)
   A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X_____ Date_____

If you are not the Patient, please identify your Relationship to the Patient.

(Check relationship(s) from list below):

❑ Spouse ❑ Parent ❑ Legal Guardian ❑ Guarantor ❑ Healthcare Power of Attorney
❑ Other: _____

MEMORIAL NEUROSPINE
PATIENT HIPAA ACKNOWLEDGMENT AND CONSENT FORM

Patient Name (Printed): _____ Date of Birth: _____

Notice of Privacy Practice/clinics.

_____ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

-OR-

I do not consent ____ (Patient/Representative Initials) to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice/clinic's health care operations purposes (e.g., quality improvement activities).

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is** _____.
I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that i**s_____.

-OR-

I **decline _____** (Patient/ Representative Initials) to receive communication via text.
I **decline _____** (Patient/ Representative Initials) to receive communication via cellular telephone call.
I **decline _____** (Patient/ Representative Initials) to receive communication via email.

Note: *This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- ***I do want*** ____ (Patient/Representative Initials) to designate the following individual(s) to pick up a prescription order on my behalf:
    - Name: _____ Date:_____
    - Name: _____ Date: _____

- ***I do not want*** ____ (Patient/ Representative Initials) to designate anyone to pick-up my prescription order.

Patient/Parent/Guardian/Patient Representative Signature _____ Date: _____

Patient/Parent/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ Date of Birth: _____

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Section A: This section must be completed for all Authorizations

Patient Name:	**Birth Date:**	**Patient 's Phone:**	**Last Four Digits SSN *(optional)*:**

Provider's Name:	**Recipient's Name:**		
Memorial NeuroSpine			
Provider's Address:	**Address 1:**		
3627 University Blvd. S, Suite 415 Jacksonville, FL 32216	**Address 2:**	**Recipient's Phone:**	**Recipient's Fax:**
	City:	**State:**	**Zip:**

Request Delivery (If left blank, a paper copy will be provided):

☐ **Paper Copy** ☐ **Electronic Media, if available (*e.g.*, USB drive, CD/DVD)** ☐ **Encrypted Email** ☐ **Unencrypted Email**

NOTE: In the event the facility is unable to accommodate an electronic delivery as requested, an alternative delivery method will be provided (e.g., paper copy). There is some level of risk that a third party could see your PHI without your consent when receiving unencrypted electronic media or email. We are not responsible for unauthorized access to the PHI contained in this format or any risks (e.g., virus) potentially introduced to your computer/device when receiving PHI in electronic format or email.

Email Address (If email checked above. Please print legibly):

This authorization will expire on the following: (Fill in the Date or the Event but not both.)

Date: **Event:**

Purpose of disclosure:

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ All PHI in medical record		☐ Operative Information		☐ Labor/delivery summary	
☐ Admission form		☐ Cath lab		☐ OB nursing assess	
☐ Dictation reports		☐ Special test/therapy		☐ Postpartum flow sheet	
☐ Physician orders		☐ Rhythm Strips		☐ Itemized bill/billing statements	
☐ Intake/outtake		☐ Nursing Information		☐ UB-92:	
☐ Clinical Test		☐ Transfer forms		☐ Other:	
☐ Medication Sheets		☐ ER Information		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, genetic information, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
6. I get a copy of this form after I sign it

Section B: Is the request of PHI for the purpose of marketing and/or does it involve the sale of PHI? ☐ Yes ☐ No

If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.

Will the recipient receive financial remuneration in exchange for using or disclosing this information? ☐ Yes ☐ No

If yes, describe:

May the recipient of the PHI further exchange the information for financial remuneration? ☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient's Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Photo ID Verified: _____

Memorial NeuroSpine

Patient _____ Referring Physician _____
Date _____ Date of Birth _____ Primary Care Physician _____

Chief Complaint (reason for visit)

_____

_____

_____

History of Present Illness

Please check the following symptoms that you have:

❑ back pain ❑ leg pain ❑ tingling / numbness in leg
❑ neck pain ❑ arm pain ❑ tingling / numbness in arm

When did your symptoms begin?_____

_____

Are you experiencing any problems controlling your bladder or bowel?

Bowel: ❑ Yes ❑ No Bladder: ❑ Yes ❑ No

Do you wake up at night because of your pain? ❑ Yes ❑ No

What makes your pain better? ❑ lying down ❑ sitting ❑ walking ❑ bending ❑ Other: _____

What makes your pain worse? ❑ lying down ❑ sitting ❑ walking ❑ bending

Are you currently working? ❑ yes ❑ no, due to pain ❑ retired ❑ disabled

Prior Treatments

Medications: NSAIDS _____ Muscle relaxants _____ Narcotics _____
Steroids _____ None _____

Physical Therapy

Date _____ Back exercise _____ Back school _____ Traction _____ Vax-D _____ None _____

Pain Management **Benefits**

Epidural steroids _____ _____
Nerve Blocks _____ _____
Facet Blocks _____ _____
IDET _____ _____
Spinal Cord Stimulator _____ _____
Intrathecal Pump _____ _____
Chronic Narcotic pain suppression _____ _____ None _____

Surgery

Type:	Date:	Surgeon:
Diskectomy _____	_____	_____
Decompression _____	_____	_____
Fusion _____	_____	_____
Other _____	_____	_____
None _____		

Memorial NeuroSpine

MEDICAL HISTORY FORM

Patient: _____ Date: _____

Rate your pain on a scale of 0 to 10, with 0 being no pain and 10 the most severe pain. Please use an X.

0 1 2 3 4 5 6 7 8 9 10

Mark these drawings according to where you hurt. Please use the scale below to indicate which sensations you are feeling.

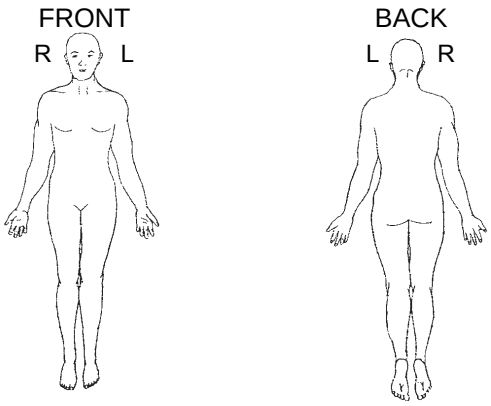
/ / / Stabbing

XXX Burning

+ + + Aching

= = = Numbness

000 Pins & Needles



Medical History

Patient Medical History

Diabetes	❑ Yes	❑ No
Hypertension	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Stroke	❑ Yes	❑ No
Heart trouble	❑ Yes	❑ No
Arthritis/gout	❑ Yes	❑ No
Convulsions	❑ Yes	❑ No
Bleeding tendency	❑ Yes	❑ No
Acute infections	❑ Yes	❑ No
Venereal disease	❑ Yes	❑ No
Hereditary defects	❑ Yes	❑ No

Previous other Surgeries / Serious Injuries When?

_____

_____

_____

_____

Patient Social History

Marital status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed

Use of alcohol: ❑ Never ❑ Rarely ❑ Moderate ❑ Daily

Use of tobacco: ❑ Never ❑ Previously, but quit Current packs/day: _____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Memorial NeuroSpine

Patient: _____ Date: _____

System Review:				
CONSTITUTIONAL SYMPTOMS			**MUSCULOSKELETAL**	
Good general health lately	❑ Yes ❑ No		Joint pain	❑ Yes ❑ No
Recent weight change	❑ Yes ❑ No		Joint stiffness or swelling	❑ Yes ❑ No
Fever	❑ Yes ❑ No		Weakness of muscles or joints	❑ Yes ❑ No
Fatigue	❑ Yes ❑ No		Muscle pain or cramps	❑ Yes ❑ No
Headaches	❑ Yes ❑ No		Back pain	❑ Yes ❑ No
EYES			Cold extremities	❑ Yes ❑ No
Eye disease or injury	❑ Yes ❑ No		Difficulty in walking	❑ Yes ❑ No
Wear glasses / contact lens	❑ Yes ❑ No		**INTEGUMENTARY (skin, breast)**	
Blurred or double vision	❑ Yes ❑ No		Rash or itching	❑ Yes ❑ No
Glaucoma	❑ Yes ❑ No		Change in skin color	❑ Yes ❑ No
EARS / NOSE / MOUTH / THROAT	❑ Yes ❑ No		Change in hair or nails	❑ Yes ❑ No
Hearing loss or ringing	❑ Yes ❑ No		Varicose Veins	❑ Yes ❑ No
Earaches or draining	❑ Yes ❑ No		Breast pain	❑ Yes ❑ No
Chronic sinus problems or rhinitis	❑ Yes ❑ No		Breast discharge	❑ Yes ❑ No
Nose bleeds	❑ Yes ❑ No		**NEUROLOGICAL**	
Mouth sores	❑ Yes ❑ No		Frequent or recurring headaches	❑ Yes ❑ No
Bleeding gums	❑ Yes ❑ No		Light headed or dizzy	❑ Yes ❑ No
Bad breath or bad taste	❑ Yes ❑ No		Convulsions or seizures	❑ Yes ❑ No
Sore throat or voice change	❑ Yes ❑ No		Numbness or tingling sensations	❑ Yes ❑ No
Swollen glands in neck	❑ Yes ❑ No		Tremors	❑ Yes ❑ No
CARDIOVASCULAR	❑ Yes ❑ No		Paralysis	❑ Yes ❑ No
Heart trouble	❑ Yes ❑ No		Stroke	❑ Yes ❑ No
Chest pain or angina pectoris	❑ Yes ❑ No		Head injury	❑ Yes ❑ No
Palpitation	❑ Yes ❑ No		**PSYCHIATRIC**	
Shortness of breath with walking or lying flat	❑ Yes ❑ No		Memory loss or confusion	❑ Yes ❑ No
Swelling of feet, ankles or hands	❑ Yes ❑ No		Nervousness	❑ Yes ❑ No
RESPIRATORY			Depression	❑ Yes ❑ No
Chronic or frequent coughs	❑ Yes ❑ No		Insomnia	❑ Yes ❑ No
Spitting up blood	❑ Yes ❑ No		**ENDOCRINE**	
Shortness of breath	❑ Yes ❑ No		Glandular or hormone problem	❑ Yes ❑ No
Asthma or wheezing	❑ Yes ❑ No		Thyroid disease	❑ Yes ❑ No
GASTROINTESTINAL			Diabetes	❑ Yes ❑ No
Loss of appetite	❑ Yes ❑ No		Excessive thirst or urination	❑ Yes ❑ No
Change in bowel movements	❑ Yes ❑ No		Heat or cold intolerance	❑ Yes ❑ No
Nausea or vomiting	❑ Yes ❑ No		Skin becoming dryer	❑ Yes ❑ No
Frequent diarrhea	❑ Yes ❑ No		Change in hat or glove size	❑ Yes ❑ No
Painful bowel movement or constipation	❑ Yes ❑ No		**HEMATOLOGIC / LYMPHATIC**	
Rectal bleeding or blood in stool	❑ Yes ❑ No		Slow to heal after cuts	❑ Yes ❑ No
Abdominal pain or heartburn	❑ Yes ❑ No		Bleeding or bruising tendency	❑ Yes ❑ No
Peptic ulcer (stomach or duodenal)	❑ Yes ❑ No		Anemia	❑ Yes ❑ No
GENITOURINARY	❑ Yes ❑ No		Phlebitis	❑ Yes ❑ No
Frequent urination	❑ Yes ❑ No		Past transfusion	❑ Yes ❑ No
Burning or painful urination	❑ Yes ❑ No		Enlarged glands	❑ Yes ❑ No
Blood in urine	❑ Yes ❑ No		**ALLERGIC / IMMUNOLOGIC**	
Change in force of strain when urinating	❑ Yes ❑ No		History of skin reaction or other adverse reaction to:	
Incontinence or dribbling	❑ Yes ❑ No		Penicillin or other antibiotic	❑ Yes ❑ No
Kidney stones	❑ Yes ❑ No		Morphine, Demerol, or other narcotics	❑ Yes ❑ No
Sexual difficulty	❑ Yes ❑ No		Novocaine or other anesthetics	❑ Yes ❑ No
Male – testicle pain	❑ Yes ❑ No		Aspirin or other pain remedies	❑ Yes ❑ No
Female – pain with periods	❑ Yes ❑ No		Tetanus antitoxin or other serums	❑ Yes ❑ No
Female – irregular periods	❑ Yes ❑ No		Iodine methiolate or other antiseptics	❑ Yes ❑ No
Female – vaginal bleeding	❑ Yes ❑ No		Other drugs / medications _____	
Female - # of pregnancies _____ # of miscarriages _____			Known food allergies _____	
Female – date of last pap smear _____				

Memorial NeuroSpine

Patient: _____ Date: _____

Current Medications - both prescription and OTC (over-the-counter):

Medication Name	Dosage	Frequency

Medication Allergies: _____

Special Questions: (Indicate Yes or No)

Change in Handwriting _____

Problem with stairs _____

Fine finger movement difficulties _____

Walking or balance problems _____

Patient Signature: _____ Date: _____

Memorial NeuroSpine
FUNCTIONAL CAPACITY AND PHYSIOLOGICAL ASSESSMENT

SF-36 HEALTH SURVEY

INSTRUCTIONS: This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Answer every question by marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your heal is:

(circle one)

Excellent 1

Very good 2

Good 3

Fair 4

Poor 5

2. Compared to one year ago, how would you rate your health in general now?

(circle one)

Much better now than a year ago 1

Somewhat better now than one year ago 2

About the same as one year ago 3

Somewhat worse now than one year ago 4

Much worse now than a year ago 5

Date: _____

Name: _____

DOB: _____

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

(circle one number on each line)

Activities	**Yes, Limited A Lot**	**Yes, Limited A Little**	**No, Not Limited At All**
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

(circle one number on each line)

	YES	**NO**
a. Cut down on the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Were limited in the kind of work or other activities	1	2
d. Had difficulty performing the work or other activities (For example, it took extra effort.)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious).

(circle one number on each line)

	YES	NO
a. Cut down the amount of time you spent on work or other activities	1	2
b. Accomplished less than you would like	1	2
c. Didn't do work or other activities as carefully as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

(circle one)

Not at all 1

Slightly 2

Moderately 3

Quite a bit 4

Extremely 5

7. How much bodily pain have you had during the past 4 weeks?

(circle one)

None 1

Very Mild 2

Mild 3

Moderate 4

Severe 5

Very Severe 6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

(circle one)

Not at all 1

Slightly 2

Moderately 3

Quite a bit 4

Extremely 5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks?

(circle one number on each line)

	All of the Time	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

(circle one)

None 1

Most of the time 2

Some of the time 3

A little of the time 4

None of the time 5

11. How TRUE or FALSE is each of the following statements for you?

(circle one number on each line)

	Definitely True	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5