PINELLAS PHYSIATRY ASSOCIATES

4400 140th Avenue N. | Suite 110 | Clearwater, FL 33762
Tel: (727) 327-2600
Fax: (727) 327-2644

Marc Reiskind, MD | Kevin Creed, MD | Annette Eichenbaum, DO
Board Certified in Physical Medicine and Rehabilitation

Medical Rehabilitation | Brain & Spinal Cord Injury | Musculoskeletal Medicine | Electro Diagnosis | Osteopathic Manipulation

Date: _____

Dear Patient:

Thank you for selection Pinellas Physiatry Associates, P.A. as your Rehabilitation Physician Specialists. I have enclosed the forms that we required to have on file at the time of your visit.

Please have these forms filled out as completely as possible prior to the visit or arrive 30 minutes prior to the scheduled visit to complete the forms.

Should you arrive late or not have the forms completed prior to your appointment time, **we may need to reschedule** your appointment to maintain our other patients scheduled appointments.

Should you have any questions regarding the forms or your appointment, please do not hesitate to contact me.

Sincerely,

PPA/Scheduler

Enclosures

Patient's Name: _____ Date: _____

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Patient Information Sheet

Today's Date: _____ Referred By: _____

(Dear Patient: It is very important that you fill in all information that pertains to you. Please PRINT clearly.)

Primary Care Physician Name: _____ Telephone: _____

Patient Name: _____ Cell Phone: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

City: _____ State: _____ Zip Code: _____

Sex: M _____ F _____ Social Security #: _____ Date of Birth: _____

Do you have Medicare? ____ Yes ____ No If Yes, the number is _____

Do you have Medicaid? ____ Yes ____ No If Yes, the number is _____

Do you have Health Insurance? ____ Yes ____ No If Yes, please fill in information below.

PLEASE CHECK ONE Is this a: HMO ____ PPO ____ EPO ____ POS ____

Primary Insurance Name: _____ Secondary Insurance Name: _____

Send Claims to Address: _____ 2nd Insurance Address: _____

_____ _____

_____ _____

Primary Policy/Contact #: _____ 2nd Policy/Contract #: _____

Group #: _____ Group #: _____

If your insurance is a HMO, it is your responsibility to insure an authorization is obtained prior to being seen.

Is your illness/injuries related to an auto accident? ____ Yes ____ No If Yes, please fill in below

Auto Insurance Company: _____ Date of Accident: _____

Send Claims to Address: _____ Name of Adjustor: _____

_____ PIP Claim #: _____

Policy #: _____ Insurance Phone #: _____

Is your illness/injuries related to a work accident? ____ Yes ____ No If Yes, please fill in below

Date of Accident: _____ Employer: _____

W/C Insurance Name: _____ Name of Adjustor: _____

W/C Claims Address: _____ Adjustor Phone #: _____

_____ Case Manager Name: _____

W/C Claim #: _____ Case Manager Phone #: _____

Attorney's Name: _____ Telephone #: _____

I HEREBY AUTHORIZE PAYMENT OF BENEFITS DUE TO ME TO BE MADE DIRECTLY TO: PINELLAS PHYSIATRY ASSOCIATES, P.A. I UNDERSTAND THAT I AM AND REMAIN FINANCIALLY RESPONSIBLE FOR THESE CHARGES AND I AUTHORIZE THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY THAT ACCEPTS ASSIGNMENT ON THIS CLAIM. IN THE CASE OF WORKERS COMP, I UNDERSTAND THAT THE WORKERS COMP CARRIER IS FINANCIALLY LIABLE FOR ALL ACCEPTED CLAIMS.

Signature of Patient ***or*** Legal Guardian: _____

Patient's Name: _____ Date: _____

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Acknowledgement Agreement

This is an acknowledgement that _____ on _____
(Patient's Name) (Date)

received a copy of the **Pinellas Physiatry Associates, P.A.** Notice of Privacy Practices dates 04/13/2003

_____
(Patient's Signature)

_____
(Legal Representative)

_____
(Authority to Sign for Patient)

(*Internal Use Only*)

If this acknowledgement is not signed, please provide a description of your efforts in obtaining the signed acknowledgement and the reason the acknowledgement was not obtained.

_____

_____

_____

_____

Print Name: _____ Date: _____

Patient's Name: _____ Date: _____

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Authorization for the Release of Medical Records

Patient: _____

Date of Birth: _____ **Telephone #:** _____

Social Security #: _____

1. I hereby authorize _____ to release medical, psychiatric, alcohol and/or drug abuse, HIV (Human Immunodeficiency Virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to:

   _____
   Patient, Hospital, Physician, Other

   _____ _____ _____ _____
   Address City State Zip

2. Information to be released:

   ____ Complete Medical Records ____ Discharge Summary

   ____ History and Physical ____ Office Visit Notes

   ____ Consultation Report ____ Lab Notes

   ____ Operative Report ____ Other: _____

3. The above information is to be released for the following purpose and that purpose only. Any other use is forbidden.

   _____

   _____

4. I also understand that I may revoke this authorization at any time in writing to Pinellas Physiatry Associates except to the extent that action has been taken in reliance on it (e.g., probation, parole, etc.).

5. I will not hold Pinellas Physiatry Associates or its representatives responsible for any mental or physical damage which may be caused by the receipt of the records by myself or others.

6. This authorization shall remain in force until _____, or for a reasonable time to accomplish the purpose for which it is given.

_____ _____

Signature of Patient ***or*** Authorized Legal Representative

Date

_____ _____

Relationship to Patient

Witness Signature

Patient's Name: _____ Date: _____

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New Patient History

Who referred you? _____

Why are you here? _____

_____

_____

_____

How long have you had this problem? _____

What treatments have you had for this problem? _____

_____

_____

_____

What diagnostic studies have you undergone for this problem (include dates)?

_____

_____

_____

What medical problems do you have?

_____ High Blood Pressure
_____ High Cholesterol
_____ Diabetes
_____ Arthritis
_____ Gastric (Stomach) Reflux
_____ Obesity
_____ Irritable Bowel Syndrome
_____ Gout
_____ Heart Disease
_____ Sleep Apnea
_____ Fibromyalgia
_____ Hypothyroidism
_____ Stroke
_____ Other: _____

What surgeries have you had and when?

_____ Appendectomy _____
_____ Gall Bladder _____
_____ Fractures _____
_____ Open Heart Surgery _____
_____ Thyroid Removal _____
_____ Bladder Surgery _____
_____ Stomach Surgery _____
_____ Bowel Surgery _____
_____ Foot Surgery _____
_____ Other: _____
_____ Other: _____
_____ Other: _____

Have you been hospitalized in the past three years? _____ No _____ Yes

If Yes, where, when and for what problem? _____

_____

_____

_____

Family History:

Father: Alive: _____ Yes _____ No - Medical Problems: _____

Mother: Alive: _____ Yes _____ No - Medical Problems: _____

Siblings: Alive: _____ Yes _____ No - Medical Problems: _____

Alive: _____ Yes _____ No - Medical Problems: _____

Alive: _____ Yes _____ No - Medical Problems: _____

Other diseases that run in the family: _____

_____

Social History:

Do you smoke? _____ Yes _____ # Per Day _____ No _____ Quit

Do you drink alcohol? _____ Yes _____ Per Day/Week _____ No _____ Quit

Do you use illicit drugs? _____ Yes _____ No

Do you live in a: ____ House ____ Apartment ____ Manufactured Home ____ Condominium ____ Boat

Do you have any steps to enter your home? ____ No _____ Yes _____ # ____ Elevator

Does anyone live with you? _____ No ____ Yes Who? _____

Are you able to walk? _____ Yes _____ No _____ With Help _____ With Assistive Device ____ Cane

_____ Walker _____ Crutches _____ Braces

Do you use a wheelchair? _____ Manual _____ Scooter _____ Power Chair

Are you able to dress yourself? _____ Yes _____ No _____ With Help

Are you able to feed yourself? _____ Yes _____ No _____ With Help

Are you able to toilet yourself? _____ Yes _____ No _____ With Help

Schooling: _____ Some High School _____ High School Graduate _____ GED _____ Some College

Are you working? _____ Yes _____ No _____ Retired _____ Disabled

Patient's Name: _____ Date: _____

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Pain Questions:

When did your pain start? _____

Were you hurt at work or in an accident? ____ No ____ Yes

If Yes, what date? _____

How did the pain start? _____

_____

_____

Please complete the pain drawing (provided in the packet) to describe the pain location and character of your pain.

Is your pain constant? ____ Yes ____ No

Does your pain vary in intensity? ____ No ____ Yes, from best (0-10) ____ to worst (0-10) ____

What activities reduce your pain?

___ Lying Down
___ Sitting
___ Standing
___ Walking
___ Exercises
___ Pain Pills
___ Injections
___ Muscle Relaxers
___ NSAID's
___ Nothing
___ Other: _____

What activities worsen your pain?

___ Exercises (during)
___ Exercises (after)
___ Sitting
___ Standing
___ Walking
___ Bending Forward
___ Bending Backward
___ Coughing
___ Sneezing

Are you still working? ____ Yes ____ No

Patient's Name: _____ Date: _____

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Review of Systems

If you are experiencing any of the following, please circle below:

a. **General:** overall poor state of health, weight loss, fever, night sweats, change in appetite

b. **Skin:** rashes, itching, skin color change, change in a wart or a mole

c. **Head:** headaches, trauma to the head

d. **Eyes:** blurred vision, double vision, date of your last exam: _____

e. **Ears:** difficulty hearing, ringing in the ears, a feeling of spinning, ear infections, ear discharge

f. **Nose and Sinuses:** nose bleeds, nasal stuffiness, sinusitis, change in sense of smell

g. **Mouth/Throat:** dentures, sore throat, mouth lesions, date of last dental exam: _____

h. **Neck:** lumps, "swollen glands," pain in the neck region

i. **Breasts:** pain, history of breast lumps, bleeding, nipple discharge, do not perform self-exams

j. **Respiratory:** coughing, wheezing, productive cough, shortness of breath, pain with breathing

k. **Cardiac:** chest pain, palpitations, awakening at night short of breath, short of breath when lying flat in bed, swelling of legs, heart murmurs, high blood pressure

l. **Gastrointestinal:** nausea, vomiting, change in bowel habits, dark or tarry stool, ulcers, coughing up blood, constipation, diarrhea, abdominal pains, weight gain

m. **Genitourinary:** burning with urination, feeling the need to urinate frequently, feeling an urgency to urinate, waking up at night to urinate, discharge from genitals, venereal diseases, change in libido, sexual problems, blood in urine

n. **Gynecologic/Reproductive:** (*Woman Only*)**:** Age when period began: _____ Last menstrual period: _____

Frequency and duration of periods: _____ Number of pregnancies: _____

Age at menopause: _____ Osteoporosis (thin bones)

o. **Musculoskeletal:** weakness, arthritis, gout, joint pains, back pain, swelling, stiffness, cramps, numb/tingling hands or feet (pins/needles feeling), difficulty speaking, difficulty swallowing

p. **Peripheral Vascular:** varicose veins, thrombophlebitis, pain in legs with walking, Raynaud's phenomenon (blue fingers in the cold), poor circulation, amputations

q. **Neuropsychiatric:** seizures, fainting, weakness, extreme mood changes, difficulty sleeping, anxiety, depression, psychiatric care, thoughts of suicide

r. **Endocrines:** heat or cold intolerance, extreme thirst, frequent urination, extreme hunger

s. **Blood:** easy bruising, transfusions reactions, excessive bleeding, history of anemia

Patient's Name: _____ Date: _____

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Pain Questionnaire

Patient's Name: _____ Number: _____ Date: _____

This questionnaire has been designed to give the doctor information as to how your pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 – Pain Intensity

- ☐ I can tolerate the pain without having to use painkillers.
- ☐ The pain is bad but I can manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

Section 2 – Personal Care (Washing Dressing, ect.)

- ☐ I can look after myself normally without causing extra pain.
- ☐ I can look after myself normally but it causes extra pain.
- ☐ It is painful to look after myself and I am sow and careful.
- ☐ I need some help but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights but it gives me extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ☐ I can lift very light weights.
- ☐ I cannot lift or carry anything at all.

Section 4 – Walking

- ☐ Pain does not prevent me from walking any distance.
- ☐ Pain prevents me from walking more than one mile.
- ☐ Pain prevents me from walking more than one-half mile.
- ☐ Pain prevents me from walking more than one-quarter mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 – Sitting

- ☐ I can sit in any chair as long as I like.
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more than one hour.
- ☐ Pain prevents me from sitting more than 30 minutes.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting almost all the time.

Section 6 - Standing

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives extra pain.
- ☐ Pain prevents me from standing more than 1 hour.
- ☐ Pain prevents me from standing more than 30 mins.
- ☐ Pain prevents me from standing more than 10 mins
- ☐ Pain prevents me from standing at all.

Section 7 - Sleeping

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets I have less than 6 hours sleep.
- ☐ Even when I take tablets I have less than 4 hours sleep.
- ☐ Even when I take tablets I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

Section 9 – Traveling

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives me extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain is bad but I manage journeys less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

- ☐ My pain is rapidly getting better.
- ☐ My pain fluctuates but overall is definitely getting better.
- ☐ My pain seems to be getting better but improvement is slow at the present.
- ☐ My pain is neither getting better nor worse.
- ☐ My pain is gradually worsening.
- ☐ My pain is rapidly worsening.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score____x2)/(_____Sections x 10) =_____ %ADL

Comments:_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

Patient's Name: _____ Date: _____

Pain Scale

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate which score is for which complaint.

Example:

Headache Neck Low Back

0 1 (2) 3 (4) 5 6 7 8 (9) 10

1. What is your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10

2. What is your TYPICAL or AVERAGE pain?

0 1 2 3 4 5 6 7 8 9 10

3. What is your pain AT ITS BEST (How close to "0" does your pain get at its best)?

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its best? _____%

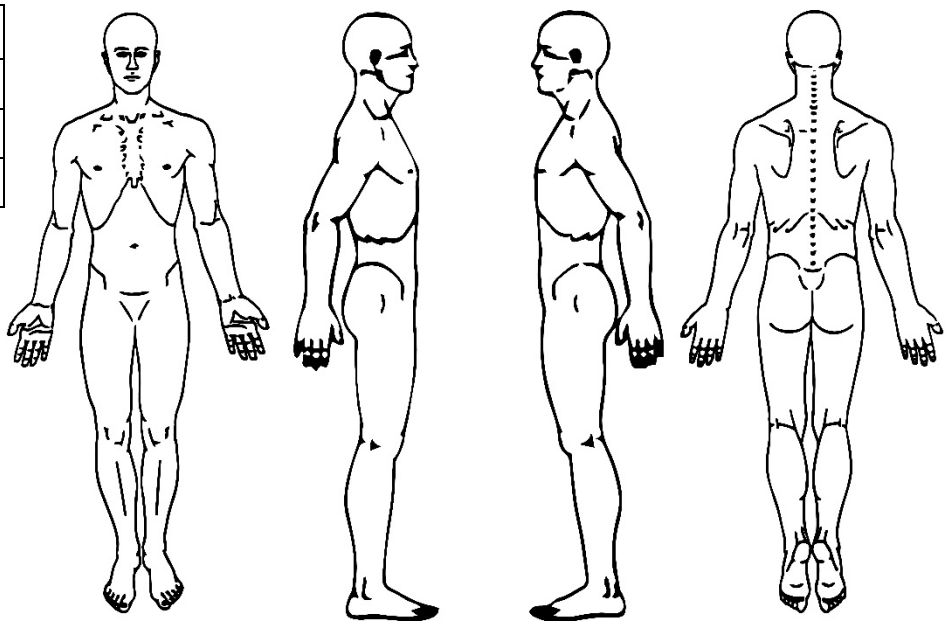
4. What is your pain AT ITS WORST (How close to "10" does your pain get at its worse)

0 1 2 3 4 5 6 7 8 9 10

What percentage of your awake hours is your pain at its worse? _____%

Mark the area on the body where you feel the described sensations.
Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness	—
Constant Throbbing Ache	xxx
INC Sensitivity	0000
Sharp Twinge	////



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Current Medication List

It is imperative that all medication (prescribed, over the counter and herbal) are listed and kept up to date.
If you can't complete this form, please bring your bottles and we will list them for you.

	Medication:	Dosage:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Date this form was completed: _____