FLORIDA SPINECARE CENTER

Dear Patient,

Thank you for making an appointment at Florida Spine Care Center. **In order to have any prescriptions filled, we must have your pharmacy address and phone number where indicated on the paperwork below**.

We would like to remind you to bring all original films and studies that you have previously had performed. This includes MRI's, Myelograms, CT Scans and/or x-rays.(Many facilities are giving disks with this information instead of the actual films. Dr. Broom prefers the actual films) unfortunately, if your diagnostic tests are not with you or sent prior to your appointment, it may be necessary to reschedule.

Please do not forget to bring your copays or referrals if applicable. Payment arrangements should have been discussed while making your appointment. If you have any questions or concerns, please feel free to contact our billing department prior to your appointment at (407)481-2244.

Thank you and we look forward to meeting you!!!

The Staff of Florida Spine Care Center

******Please note: Parking is located on and around Orange Avenue. If you wish to utilize the parking garage located in the rear of the building, there is a charge of $4.00. Since this is run independently from our practice, we are unable to validate or reimburse you for this fee. Thank You.**

Continue to Forms Below

OFFICE USE ONLY	PATIENT NUMBER	TYPE OF EXAM	DOCTOR / NUMBER	PATIENT TYPE/ NUMBER	❑ SMOKER ❑ NON-SMOKER	BY:

FLORIDA SPINE CARE CENTER / SURGICAL & NON SURGICAL SPINE CARE

PATIENT INFORMATION

PLEASE PRINT - ALL UNSHADED AREAS

PATIENT

NAME FIRST-MIDDLE-LAST				EMAIL		AGE	TODAYS DATE — —
RACE	AFRICAN AMERICAN ❑ AMERICAN INDIAN ❑	NATIVE HAWAIIAN ❑ ASIAN ❑	WHITE ❑ OTHER ❑	NON HISPANIC OF LATINO ❑ HISPANIC OR LATINO ❑	SEX M ❑ F ❑	SOCIAL SECURITY NUMBER — —	
STREET ADDRESS				CITY		STATE	ZIP
HOME PHONE ( )	WORK PHONE ( )	MOBILE PHONE NUMBER ( )		MARITAL STATUS S ❑ M ❑ W ❑ DIV ❑ SEP ❑		DATE OF BIRTH	
EMPLOYER NAME AND ADDRESS (IF APPLICABLE)		CITY-STATE-ZIP		OCCUPATION			
PHARMACY NAME	PHARMACY ADDRESS			PHARMACY PHONE NUMBER			

SPOUSE OR RESPONSIBLE PARTY (IF NOT PATIENT)

NAME FIRST-MIDDLE-LAST (IF MINOR, FATHER'S NAME)	RELATIONSHIP (Mother, Friend, etc)	SOCIAL SECURITY NUMBER	HOME PHONE ( )	WORK PHONE ( )
STREET ADDRESS	CITY	STATE	ZIP	
EMPLOYER NAME AND ADDRESS	CITY-STATE-ZIP	PHONE ( )	OCCUPATION	

NEAREST RELATIVE NOT LIVING WITH YOU

PERSON TO CONTACT IN EMERGENCY (NEXT OF KIN)	THEIR RELATIONSHIP TO YOU	HOME PHONE ( )	WORK PHONE ( )
STREET ADDRESS	CITY-STATE-ZIP		

MEDICAL COMPLAINT AND PRIOR TREATMENT

EXPLAIN			DURATION
DATE OF ACCIDENT	PLACE OF ACCIDENT	STILL WORKING YES ❑ NO ❑	DATE STOPPED WORKING
HOW DID ACCIDENT HAPPEN?		ATTORNEY NAME/PHONE #:	
PRIOR TREATMENT		WHEN	WHERE
BY WHOM	PRIOR X-RAYS YES ❑ NO ❑	WHEN	WHERE
HOW DID YOU HEAR ABOUT US? ❑ INTERNET ❑ FRIEND/FAMILY ❑ PREVIOUS PATIENT ❑ LAWYER ❑ PHYSICIAN ❑ OTHER		REFERRING PERSON SO WE CAN THANK THEM	
REFERRING PHYSICIAN	ADDRESS/PHONE		
PEDIATRICIAN/FAMILY PHISICIAN	ADDRESS/PHONE		

INSURANCE INFORMATION

INSURANCE COMPANY	PHONE	❑HMO ❑ COPAYS_____ ❑PPO ❑ COPAYS_____
INS. CLAIMS MAIL TO:		
STREET		
CITY-STATE-ZIP	ADJUSTER NAME/#	
POLICY #	❑ AUTHORIZATION ❑ REFERRAL ❑ CLAIM #	
INSURED PERSON	SS#	
GROUP/EMPLOYER NAME	PHONE	
EMPLOYER ADDRESS		

SECONDARY CARRIER

INSURANCE COMPANY	PHONE	❑HMO ❑ COPAYS_____ ❑PPO ❑ COPAYS_____
INS. CLAIMS MAIL TO:		
STREET		
CITY-STATE-ZIP	ADJUSTER NAME/#	
POLICY #	❑ AUTHORIZATION ❑ REFERRAL ❑ CLAIM #	
INSURED PERSON	SS#	
GROUP/EMPLOYER NAME	PHONE	
EMPLOYER ADDRESS		

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of all medical information necessary to process this claim and is pertinent to my medical care. I assign all medical and/or surgical benefits to *Michael J. broom M.D., P.A.* This assigment will remain in efect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

SIGNATURE (parent if minor) _____ DATE _____

MEDICARE AUTHORIZATION TO RELEASE INFO AND MEDICARE ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf to *Michael J. broom M.D., P.A.* for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefits payable for related services. This assignment will remain in efect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR NON-COVERED SERVICES AS EXPLAINED TO ME BY THE PHYSICIAN, I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

SIGNATURE (parent if minor) _____ DATE _____

FLORIDA SPINECARE CENTER

MEDICAL HISTORY

Date _____

Name _____ Birthdate _____ Sex _____ Race _____

HEALTH HISTORY OF THE PATIENT

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Serious Injuries		
Lung Disease		
Tuberculosis		
Phlebitis		
Anemia		
Stomach Ulcers		
Liver Trouble		
Thyroid Trouble		
Other Illnesses		
Explain all Yes answers:		

_____

_____

_____

Surgical Procedures (include approx. dates):

_____

_____

_____

_____

Current Medications and Dosage:

_____

_____

_____

Allergies to Medicine: (None ☐)

_____

_____

_____

FAMILYHISTORY

	Yes	No
Stroke		
Heart Trouble		
High Blood Pressure		
Diabetes		
Arthritis		
Gout		
Seizures		
Mental Illness		
Kidney Trouble or Stones		
Cancer		
Bleeding Disorders		
Alcoholism		
Other		

Explain all Yes answers:

_____

_____

_____

Cause of death of parents, or brothers, or sisters:

_____

_____

_____

SOCIAL HISTORY

Most Recent Occupation _____

_____

Married ☐ Single ☐ Divorced ☐

Widowed ☐

Number of Children Living _____

Number of Pregnancies _____

Presently Living Alone? Yes ☐ No ☐

Smoke _____ packs per day

Alcohol: Never ☐ Occasional ☐

Moderate to Heavy ☐

Drug Overuse: ☐ None ☐

Presently ☐ Past Problem ☐

REVIEW OF SYSTEMS

Have you recently had or do you now have:

	Yes	No
Reading Glasses		
Change of Vision		
Loss of Hearing		
Ear Pain		
Hoarseness		
Nosebleeds		
Difficulty Swallowing		
Morning Cough		
Shortness of Breath		
Chills or Fever		
Heart or Chest Pain		
Abnormal Heartbeat		
Badly Swollen Ankles		
Calf Cramps with Walking		
Poor Appetite		
Toothache		
Gum Trouble		
Nausea or Vomiting		
Stomach Pain		
Ulcers		
Frequent Belching		
Frequent Loose Bowel Movements		
Blood in Bowel Movements		
Frequent Constipation		
Hemorrhoids		
Frequent Urination (pass water)		
Burning on Urination		
Difficulty Starting Urination		
Difficulty Stopping Urination		
Get Up Every Night to Urinate		
Frequent Headaches		
Blackouts		
Seizures		
Frequent Rash		
Hot or Cold Spells		
Recent Weight Change		
Nervous Exhaustion		
Insomnia		
Depression		
Nervous Tension		
Women Only:		
Irregular Peroids		
Vaginal Discharge		
Frequent Spotting		

FLORIDA SPINECARE CENTER

Medical History –Spine/Pain

ID #:_____ Date:_____

For office use only

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Age: _____

E-Mail: _____ Height: _____ Weight: _____

Primary Care Physician: _____ Clinic/Practice Name: _____

Reason for Visit: _____

Which body part(s) is/are involved?

Neck: ☐ Arm: ☐ R ☐ L Shoulder: ☐ R ☐ L

Back: ☐ Leg: ☐ R ☐ L Knee: ☐ R ☐ L

Face/Head: ☐ Hip: ☐ R ☐ L Other: ☐ _____

Does your back pain radiate into your leg? ☐ Left ☐ Right ☐ Neither Which is more painful? ☐ Back ☐ Leg ☐ Equal

Does your neck pain radiate into your arm? ☐ Left ☐ Right ☐ Neither Which is more painful? ☐ Neck ☐ Arm ☐ Equal

How long have you had this pain? _____ Have you had this pain before? ☐ No ☐ Yes How long ago? _____

Was there any injury or accident? ☐ No ☐ Yes Explain: _____

How would you describe the pain? ☐ Dull / Aching ☐ Sharp/Stabbing ☐ Throbbing ☐ Tightness ☐ Burning

☐ Other: _____

How often does the pain occur? ☐ Changes in severity but always present ☐ Intermittent (comes and goes, sometimes no pain)

My pain symptoms are: ☐ Improving ☐ Getting worse ☐ Staying the same

PAIN LEVEL – Numerical Rating Scale (0 to 10)

Current pain level:	***No Pain-***	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 ***-Worst***
Lowest level in past week:	***No Pain-***	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 ***-Worst***
Highest level in past week:	***No Pain-***	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 ***-Worst***
How severe is your low back pain?	***No Pain-***	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 ***-Worst***
How severe is your leg pain?	***No Pain-***	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 ***-Worst***
How severe is your neck pain?	***No Pain-***	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 ***-Worst***
How severe is your arm pain?	***No Pain-***	☐0	☐1	☐2	☐3	☐4	☐5	☐6	☐7	☐8	☐9	☐10 ***-Worst***

ACTIONS AFFECTING PAIN LEVEL

*If you have **LOW BACK** pain, please address the following activities (otherwise, skip this section):*

	WORSE	BETTER	NO EFFECT	REMARKS
Bending forward	☐	☐	☐	
Leaning back	☐	☐	☐	
Sitting	☐	☐	☐	
Standing	☐	☐	☐	
Walking	☐	☐	☐	
Physical Activity	☐	☐	☐	
Rest	☐	☐	☐	
Lying flat	☐	☐	☐	
Lying with hips and knees bent	☐	☐	☐	
Rising out of bed/chair	☐	☐	☐	
Coughing/Sneezing	☐	☐	☐	

Other: _____

What activities are the most bothersome? _____

What helps the most to improve your pain? _____

FLORIDA SPINECARE CENTER

Medical History –Spine/Pain

ID #:_____ Date:_____

Provider: #:_____

For office use only

ACTIONS AFFECTING PAIN LEVEL

If you have NECK pain, please address the following activities (otherwise, skip this section):

	WORSE	BETTER	NO EFFECT	REMARKS
Looking down towards ground	☐	☐	☐	
Looking up towards ceiling	☐	☐	☐	
Turning head left or right	☐	☐	☐	
Computer or watching TV	☐	☐	☐	
Coughing / Sneezing	☐	☐	☐	
Driving	☐	☐	☐	
Overhead activities (with arms)	☐	☐	☐	

Other: _____

What activities are the most bothersome? _____

What helps the most to improve your pain? _____

*If you have **PAIN ANYWHERE ELSE**, please fill out this section (otherwise, skip this section):*

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

ASSOCIATED SYMPTOMS

Do you have any of the following symptoms? And, if so, please describe:

	NO	YES	REMARKS
Numbness / tingling	☐	☐	Where?
Weakness in the arm or leg	☐	☐	Describe:
Bladder incontinence	☐	☐	If yes, is this a change from previously? ☐ No ☐ Yes
Bowel incontinence	☐	☐	If yes, is this a change from previously? ☐ No ☐ Yes
Joint swelling or stiffness	☐	☐	Which joints?
Sleep interrupted by pain	☐	☐	
Headaches	☐	☐	
Fever or chills	☐	☐	

Activities or hobbies limited due to pain: _____

Do your legs tire/hurt if you walk too far? ☐ No ☐ Yes If yes, how far can you walk? ☐ Less than 1 block ☐ 1-3 blocks ☐ More than 3 blocks

Which of the following relieves your leg pain when walking? ☐ Leaning forward on a cart ☐ Sitting ☐ Stopping and standing without sitting ☐ Nothing

Do you exercise regularly? ☐ No ☐ Yes How often? _____ times per week Type of exercise: _____

Do you use a walking aid, wheelchair, other assistive device? ☐ No ☐ Yes Specify: _____

For your current back or neck pain, please mark the boxes for the timeframe that any tests were done?

☐ X-Ray	☐ <6 mo	☐ <12 mo
☐ MRI	☐ <6 mo	☐ <12 mo
☐ CT Scan	☐ <6 mo	☐ <12 mo
☐ Myelogram	☐ <6 mo	☐ <12 mo

FLORIDA SPINECARE CENTER

Medical History –Spine/Pain

ID #:_____ Date:_____

Provider: #:_____

For office use only

☐ Discogram	☐ <6 mo	☐ <12 mo
☐ EMG/NCV (nerve test)	☐ <6 mo	☐ <12 mo

PRIOR TREATMENTS

Please **ONLY** mark the type of treatment(s) that you have had in the past and how well they worked, **OTHERWISE LEAVE BLANK**:

Injections	☐ Better	☐ Worse	☐ No Change	Type:
Physical Therapy	☐ Better	☐ Worse	☐ No Change	How recently?
Surgery (back/neck)	☐ Better	☐ Worse	☐ No Change	Type of surgery and year?
TENS unit	☐ Better	☐ Worse	☐ No Change	
Heat / Ice	☐ Better	☐ Worse	☐ No Change	
Chiropractor	☐ Better	☐ Worse	☐ No Change	
Acupuncture	☐ Better	☐ Worse	☐ No Change	
Massage	☐ Better	☐ Worse	☐ No Change	

PRESENT MEDICATIONS

Are you currently taking any of the following medications? If so, indicate by marking the check box next to the medication.

☐ Coumadin/Warfarin ☐ Aspirin ☐ Plavix ☐ Aggrenox ☐ Ticlid ☐ Brilinta

NAME OF MEDICATION	DOSE (include strength and	NAME OF MEDICATION	DOSE (include strength and
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

If you need additional room, please provide a list.

PRIOR MEDICATIONS

Please **ONLY** indicate which medications you have used in the past for your current pain condition **(OTHERWISE LEAVE BLANK):**

ANTI-INFLAMMATORY	Helped?	**NARCOTICS / OPIOIDS**	Helped?	**NERVE MEDICATIONS**	Helped?
☐ Naproxen (aleve)	☐ No ☐ Yes	☐ Hydrocodone (Vicodin)	☐ No ☐ Yes	☐ Gabapentin neurontin	☐ No ☐ Yes
☐ Ibuprofen (advil, motrin)	☐ No ☐ Yes	☐ Tylenol with codeine	☐ No ☐ Yes	☐ Lyrica	☐ No ☐ Yes
☐ Diclofenac (voltaren)	☐ No ☐ Yes	☐ Oxycodone (Percocet)	☐ No ☐ Yes	☐ Amitriptyline (elavil)	☐ No ☐ Yes
☐ Tylenol (acetaminophen)	☐ No ☐ Yes	☐ Oxycontin	☐ No ☐ Yes	☐ Nortriptyline	☐ No ☐ Yes
☐ Celebrex	☐ No ☐ Yes	☐ Morphine, MS Contin	☐ No ☐ Yes	☐ Cymbalta	☐ No ☐ Yes
☐ Flector patch	☐ No ☐ Yes	☐ Hydromorphone (dilaudid)	☐ No ☐ Yes	☐ Effexor	☐ No ☐ Yes
MUSCLE RELAXANTS	Helped?	☐ Tramadol	☐ No ☐ Yes	☐ Savella	☐ No ☐ Yes
☐ Carisoprodol (soma)	☐ No ☐ Yes	☐ Nucynta (tapentadol)	☐ No ☐ Yes	☐ Lidoderm patch	☐ No ☐ Yes
☐ Cyclobenzaprine (flexeril)	☐ No ☐ Yes	☐ Fentanyl patch	☐ No ☐ Yes		
☐ Skelaxin (Metaxolone)	☐ No ☐ Yes	☐ Methadone	☐ No ☐ Yes		
☐ Methocarbamol (robaxin)	☐ No ☐ Yes	☐ Opana	☐ No ☐ Yes		
☐ Tizanidine (zanaflex)	☐ No ☐ Yes	☐ Suboxone	☐ No ☐ Yes		

SOCIAL HISTORY

Occupation: _____ When was the last time you worked? _____

☐ Restricted or Light-duty ☐ Temporary disability ☐ Permanent disability ☐ Retired ☐ Unemployed/Seeking job

Are you currently under worker's compensation? ☐ No ☐ Yes

Is there an ongoing lawsuit related to your visit today? ☐ No ☐ Yes

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco: ☐ No ☐ Yes How many packs per day? _____ How many years? _____ ☐ Quit _____ years ago

Alcohol: ☐ No ☐ Yes How much do you drink daily? _____ ☐ Quit _____ years ago

Have you ever drank heavily or abused alcohol? ☐ No ☐ Yes

Illicit Drugs: Have you ever used any illicit substances? ☐ No ☐ Yes Type: _____

Have you ever been addicted to or misused prescription drugs? ☐ No ☐ Yes Type: _____

FLORIDA SPINECARE CENTER

Have you had any history of neck or back problems in the past?

❑ No ❑ Yes

❑ Neck ❑ Back

If so, please list the dates, treatment you received and how long it took to improve.

_____
_____
_____
_____

Please list all previous BACK or NECK surgeries. Please include the approximate dates, location of surgery and surgeon. Did your symptoms improve after surgery? If so, for how long?

_____
_____
_____
_____
_____

I certify that the information provided in this medical questionnaire is true and correct to the best of my knowledge.

_____ _____

Patient Signature *Date*

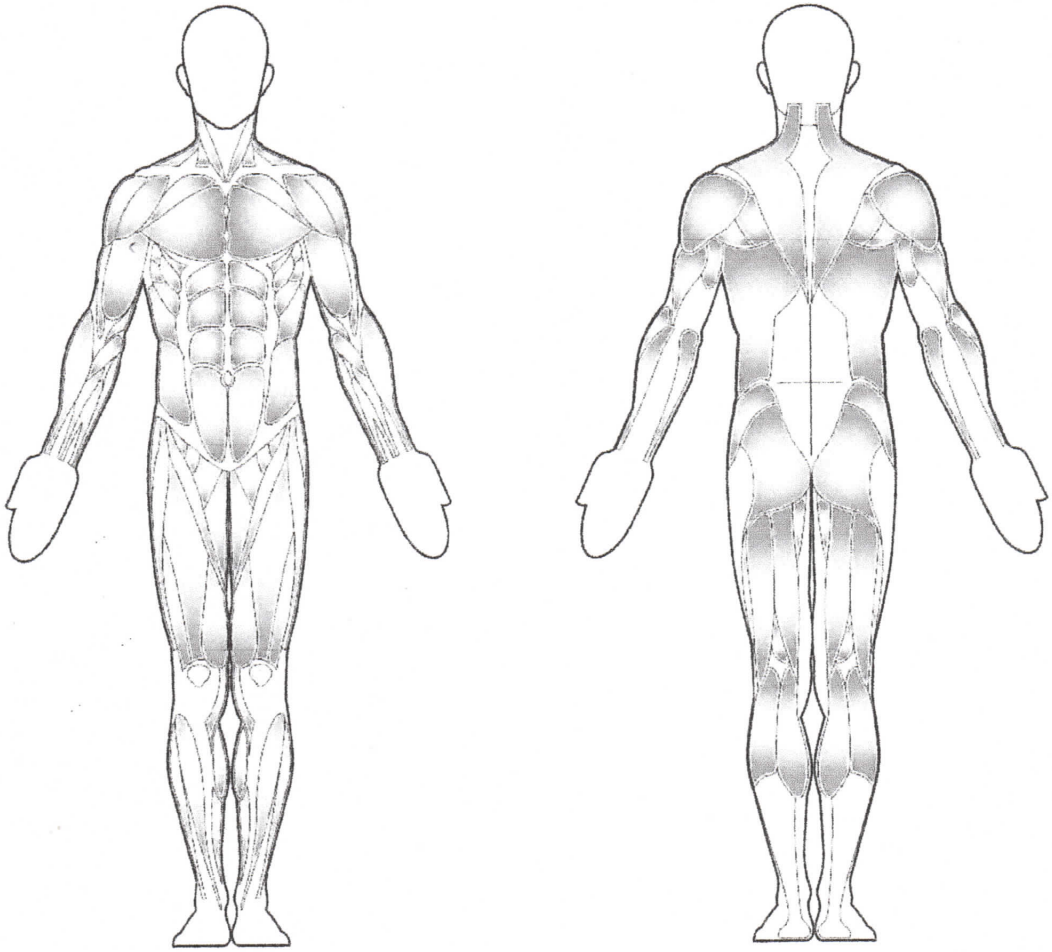
Florida SpineCare Center

Pain Diagram

Patient Name: _____ Date: _____

Using the appropriate symbol, mark the area(s) on your body where you feel each of the following sensations:

Numbness	Pins and Needles	Burning	Aching	Stabbing
----------	oooooooooooooo	^^^^^^^	XXXXXX	ϕϕϕϕϕϕ



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale which indicates how much pain you are feeling at this time.

| _____ |

No Pain Worst Pain Ever