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PATIENT INFORMATION

FIRST NAME _____ MIDDLE _____ LAST NAME _____

LOCAL ADDRESS _____ DATE OF BIRTH ____/____/____ SEX _____

CITY _____ STATE _____ ZIP _____ EMAIL ADDRESS _____

SOCIAL SECURITY _____ CELL PHONE ( ) _____

ETHNICITY: ___ NOT HISPANIC/LATINO ___ HISPANIC/LATINO ___ REFUSED HOME PHONE ( ) _____

RACE: ___ AMERICAN INDIAN/ALASKA NATIVE ___ ASIAN ___ WHITE WORK PHONE ( ) _____

___ BLACK/AFRICAN AMERICAN ___ NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER REFERRING PHYSICIAN _____

___ OTHER ___ OTHER SPECIFIED _____ PRIMARY PHYSICIAN _____

PREFERRED LANGUAGE _____ PHONE ( ) _____

___ MARRIED ___ SINGLE ___ WIDOWED ___ DIVORCED EMPLOYER _____

___ EMPLOYED ___ RETIRED ___ FULL TIME STUDENT ADDRESS _____

PERMANENT ADDRESS

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT

NAME _____ HOME PHONE ( ) _____

RELATIONSHIP _____ WORK PHONE ( ) _____

IS THE PATIENT THE FINANCIALLY RESPONSIBLE PARTY? ☐ YES ☐ NO IF NO PLEASE COMPLETE THIS SECTION

RELATIONSHIP _____ SEX _____ DAYTIME PHONE ( ) _____

FIRST NAME _____ MIDDLE _____ EMPLOYER _____

LAST NAME _____ ADDRESS _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

IS THE REASON FOR YOUR VISIT THE RESULT OF AN ACCIDENT? ☐ YES ☐ NO IF YES PLEASE COMPLETE THIS SECTION

NOTE: NOT ALL FMC OFFICES ACCEPT AUTO OR WORKMAN COMPENSATION PATIENTS.

PLEASE CHECK WHICH TYPE OF ACCIDENT: ☐ WORKMAN COMPENSATION ☐ AUTOMOBILE ☐ OTHER

DATE OF ACCIDENT ____/____/____ Place of accident _____ How did accident happen? _____

CLAIM # _____ CLAIM REPRESENTATIVE/ADJUSTER _____

IF WORKMAN COMPENSATION PLEASE COMPLETE THIS SECTION

EMPLOYER NAME _____ EMPLOYER PHONE( ) _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR INSURANCE CARD TO THE RECEPTIONIST

INSURANCE COMPANY _____ INSURED'S DOB _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY _____

INSURANCE/CARD HOLDER'S NAME _____ RELATIONSHIP _____

ID# _____ GROUP # _____ PHONE ( ) _____

SIGNATURE _____ DATE _____

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FLORIDA MEDICAL CLINIC, P.A.

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Consent for Purposes of Treatment, Payment and Health Care Operations

I consent to the use or disclosure of my protected health information by Florida Medical Clinic, P.A. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to the conduct health care operations of Florida Medical Clinic, P.A. I understand that diagnosis or treatment of me by Florida Medical Clinic, P.A. may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the Florida Medical Clinic, P.A. *Notice of Privacy Practices* prior to signing this document. The Florida Medical Clinic, P.A. *Notice of Privacy Practices* has been provided to me. The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Florida Medical Clinic, P.A. The *Notice of Privacy Practices* for Florida Medical Clinic, P.A. is also provided at 38135 Market Square, Zephyrhills, FL 33542. This *Notice of Privacy Practices* also describes my rights and the duties of Florida Medical Clinic, P.A. with respect to my protected health information. Florida Medical Clinic, P.A. reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices.*

Lifetime Authorization: By signing below I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agent or this physician or supplier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself or to the party who accepts assignment. The original authorization will be kept on file by Florida Medical Clinic, P.A.

I may obtain a revised *Notice of Privacy Practices* by requesting in writing from Florida Medical Clinic, P.A. or asking for one at the time of my next appointment.

Financial Responsibility

I understand that insurance billing is a service provided as a courtesy and that I am at all times financially responsible to Florida Medical Clinic, P.A. (FMC) and or its affiliated entities for any charges not covered by healthcare benefits. It is my responsibility to notify FMC of any changes in my healthcare coverage. In some cases exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by FMC and/or my healthcare insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form that I am accepting financial responsibility as explained above for all payment for medical services and/or supplies received.

Assignment of Benefits

I authorize direct remittance of payment of all insurance benefits, including Medicare, if I am a Medicare beneficiary, to Florida Medical Clinic, P.A. (FMC) for all covered medical services and supplies provided to me during all courses of treatment and care provided by FMC and/or its affiliated entities or otherwise at its direction. I understand and agree this Assignment of Benefits will constitute a continuing authorization, maintained on file with FMC, which will authorize and allow for direct payment to FMC of all applicable and eligible insurance benefits for all subsequent and continuing treatment, services, supplies and/or care provided to me by FMC.

Initials _____

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Ownership Disclosure

I understand that Florida Medical Clinic, P.A. is a physician-owned medical practice comprised of the offices of primary care physicians, specialty care physicians and associated ancillary services. These ancillary services include laboratory, pathology, radiology/diagnostic, physical therapy, pharmacy and ambulatory surgery center services. During the course of my care, I may be referred to one or more of these ancillary departments. I have the right to choose where to receive these services. I understand I am not obligated to receive these services at a Florida Medical Clinic ancillary department.

Acknowledgement of Receipt
Notice of Privacy Practices

I acknowledge that I have received a copy of Florida Medical Clinic's Notice of Privacy Practices, which describes how FMC will use and protect my health information. This Notice describes my rights under the Health Insurance Portability and Accountability Act (HIPPA) and FMC's policies on use and disclosure of my protected health information.

_____
Name of Patient

_____
Name of Guardian or Personal Representative

_____
Signature of Patient

_____
Signature of Guardian or Personal Representative

_____
Date

Florida Medical Clinic, P.A.
Zephyrhills, FL 33542

cg / FMC Consent for Treatment, Payment & Health Care Operations

Florida Medical Clinic, P.A.
Authorization to Share Protected Health Information

Patient Name:	Second Form of Identification (SS#/DOB/Account#)

I authorize the physicians and staff of:

- ☐ All FMC Departments
- ☐ The following FMC Departments

Specify:

_____

_____

_____

to share protected health information with the following persons:

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

This includes (please check all areas that apply)

- ☐ All Medical Information
- ☐ Lab Results
- ☐ X-ray Results
- ☐ Medication (RX Renewal and Pickup)
- ☐ Telephone Consults
- ☐ Hospital Information
- ☐ Insurance Information
- ☐ Dialysis Clinic Information
- ☐ Appointment Information
- ☐ Other (please specify)

This authorization will be in effect until authorization is revoked.

Patient's Signature_____ Date_____

Witness _____

Ira J. Guttentag, M.D.
Richard M. Gray, M.D.
Stephen J. Raterman, M.D.
Geoffrey A. Cronen, M.D.
Sean Willey, D. O.
James E. Riordan, PA-C, M.S.
Justin Bidwell, PA-C, ATC
Josh Gilliam, PA-C, ATC
Marlena Howe, ARNP-C
Kimberly Myers, ARNP

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813. 979.0440

38107 Market Square
Zephyrhills, FL 33542
813.780.1555

2100 Via Bella Blvd.
Land 0' Lakes, FL 34639
813. 979.0440

ORTHOPAEDIC DIVISION

PRESCRIPTION RENEWAL POLICY

Prescriptions and refills are issued only during regular office hours. Some renewals can be authorized without the doctor seeing the patient. Other prescriptions will not be renewed without an office visit because of the need to closely monitor the effects.

Our daily hours for prescription renewals are between the hours of 10 a.m. and 3 p.m., so please have your pharmacy call before 3 p.m. If you are unable to call between 10 a.m. and 3 p.m., please feel free to leave a message for the nurses for prescription requests (979-0440 or 780-1555) before 10 a.m. and after 3 p.m. We require at least 24 hours notice in order to fill most prescriptions.

During the evening and on weekends, it is difficult to determine if a prescription or refill is indicated without the patient's medical file. Therefore, prescriptions and refills will not be refilled during the evening or on weekends.

Please remember:

1. Prescriptions **will not** be refilled in the evenings (after 3p.m.) or on the weekends.
2. Please call at least 24 hours in advance for prescription refills.
3. Patients must be seen at least every three months to keep prescriptions current.

Also, please be aware that we will not be responsible for any prescribed narcotics which have been misplaced. Narcotics will not be refilled before your renewal date. Florida Medical Clinic, PA has the authority to conduct random drug screens on any patient who has been prescribed narcotics.

I have read and I understand the above mentioned policy.

_____

Patient's Signature Date

_____

Print Patient's Name

_____

Witness Date

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WWW.FMCSPINE.COM

NAME: _____ **DATE:** _____

DOB: ____/_____/_____ **AGE:**_____ ☐ **MALE** ☐ **FEMALE** **HEIGHT:** ____**FT** ____**IN.** **WEIGHT** ____**LBS**

All patients please answer the following questions:

1. Referring doctor name and full address:_____

   _____

   If not referred, how did you choose this office?_____

   Internist or family doctor name and address: _____

   _____

2. Chief Complaint (check all that apply):

   ☐ Neck Pain Arm: ☐ Pain ☐ Numbness ☐ Weakness ☐ Back Pain

   Leg: ☐ Pain ☐ Numbness ☐ Weakness Other: _____

3. How long has the pain (or your problem) been present? _____
4. Has your problem worsened recently? ☐ No ☐ Yes - How recently?_____

   _____
5. What started the pain (or problem)? _____

   _____
6. Coughing or sneezing (☐ Increases ☐ Sometimes increases ☐ Does not increase) the pain
7. There is: ☐ No loss of bowel or bladder control ☐ Loss of bowel or bladder control since _____
8. I have: ☐ Not missed any work because of this problem ☐ Missed (how many?) _____ work days
9. Treatments have included: ☐ No medicines, therapy, manipulations, injections, or brace

Neck	Back		Neck	Back	
☐	☐	Physical therapy, exercise	☐	☐	Anti-inflammatory medications
☐	☐	Massage & ultrasound	☐	☐	Narcotic medication
☐	☐	Traction	☐	☐	Epidural steroid injections ____ times which relieved the pain for (how long?) _____
☐	☐	Manipulation			
☐	☐	Tens unit	☐	☐	Trigger point injections ____ times which relieved the pain for (how long?) _____
☐	☐	Shoulder injections			
☐	☐	Braces	☐	☐	Other: _____

10. List pain medications and dose taken for your spine problem: ☐ None

Medication	Dose

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11. Previous doctors seen about this problem: ☐ None

Doctor	Specialty	City	Treatments

12. Tests done to evaluate your problem, the dates and the location they were done: ☐ None

	Neck	Back	# 1 DATE WHERE	#2 DATE WHERE	#3 DATE WHERE
Plain x-rays	☐	☐			
Myelogram	☐	☐			
CT Scan	☐	☐			
MRI	☐	☐			
EMGs	☐	☐			
Bone Scan	☐	☐			

13. REVIEW OF SYSTEMS: Check all that apply. ☐ None Apply

- ☐ Reading glasses
- ☐ Change of vision
- ☐ Loss of hearing
- ☐ Ear pain
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Difficulty swallowing
- ☐ Morning cough
- ☐ Shortness of breath
- ☐ Fever or chills
- ☐ Heart or chest pain
- ☐ Abnormal heartbeat
- ☐ Swollen ankles
- ☐ Calf cramps w/ walking
- ☐ Poor appetite
- ☐ Toothache
- ☐ Gum trouble
- ☐ Nausea or vomiting
- ☐ Stomach pain
- ☐ Ulcers
- ☐ Frequent belching
- ☐ Frequent diarrhea
- ☐ Frequent Constipation
- ☐ Hemorrhoids
- ☐ Frequent urination
- ☐ Burning on urination
- ☐ Difficulty starting urination
- ☐ Get up more than once every night to urinate
- ☐ Frequent headaches
- ☐ Blackouts
- ☐ Seizures
- ☐ Frequent rash
- ☐ Hot or cold spells
- ☐ Recent weight change
- ☐ Nervous exhaustion

Women only:

- ☐ Irregular periods
- ☐ Vaginal discharge
- ☐ Frequent spotting

☐ Other:_____
_____
_____

14. MEDICAL HISTORY: Check all that apply. ☐ None Apply

- ☐ Heart attack
- ☐ Heart failure
- ☐ High blood pressure
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Ankylosing spondylitis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Stroke
- ☐ Seizures
- ☐ Mental illness
- ☐ Kidney stones
- ☐ Kidney failure
- ☐ Cancer
- ☐ Alcoholism
- ☐ Lung disease
- ☐ HIV
- ☐ AIDS
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Blood clot in leg
- ☐ Blood clot in lung
- ☐ Stomach ulcers
- ☐ Liver trouble
- ☐ Hepatitis
- ☐ Thyroid trouble
- ☐ Bleeding disorders
- ☐ Anemia
- ☐ Serious injuries (explain)

_____

☐ Other:_____

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15. SURGICAL HISTORY: Previous surgeries- List procedures, surgeon and date. ☐ None Apply

Operation	Surgeon	Date

16. FAMILY HISTORY: Check all that apply. ☐ None Apply

☐ Stroke
☐ Heart trouble
☐ High blood pressure
☐ Diabetes
☐ Arthritis
☐ Gout
☐ Seizures
☐ Spine problems
☐ Mental illness
☐ Kidney trouble or stones
☐ Cancer
☐ Bleeding disorders
☐ Alcoholism
☐ Other:_____
_____
_____

17. MEDICATIONS YOU TAKE: ☐ None

18. ALLERGIES TO MEDICATIONS: ☐ No known drug allergies

Causes:

Medication Name:	Rash	Swelling, or Shock	Wheezing	Upset Stomach	Unknown Reaction	Other:
_____	☐		☐	☐	☐	_____
_____	☐		☐	☐	☐	_____
_____	☐		☐	☐	☐	_____
_____	☐		☐	☐	☐	_____

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19. SOCIAL HISTORY:

a. Work status: ☐ Homemaker ☐ Retired ☐ Disabled ☐ On leave
☐ Unemployed ☐ Working: ☐ Full time ☐ Part time
Occupation: _____

b. Marital status: ☐ Married ☐ Single ☐ Co-habitating
☐ Widowed ☐ Divorced

c. Number of living children: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

d. I live: ☐ Alone ☐ With: _____

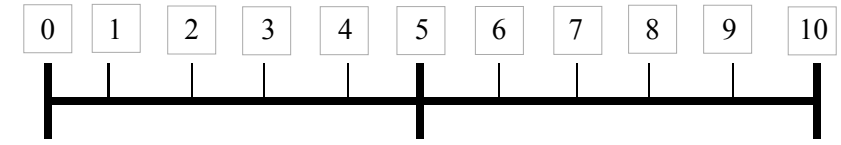
e. Tobacco use: ☐ Never (skip to F)
☐ Cigar ☐ Chew ☐ Pipe ☐ Cigarettes
_____ packs per day for _____ years.
☐ Quit-When? _____ after smoking
_____ packs per day for _____ years (total)

f. Alcohol: ☐ Never or rare
☐ Social ☐ Frequently drunk (more than twice a week)
☐ Alcoholic ☐ Recovering alcoholic

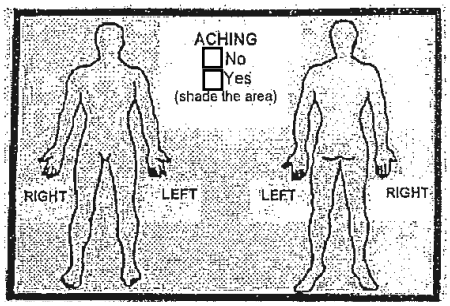
g. Drug overuse/abuse ☐ Never ☐ Currently ☐ In the past

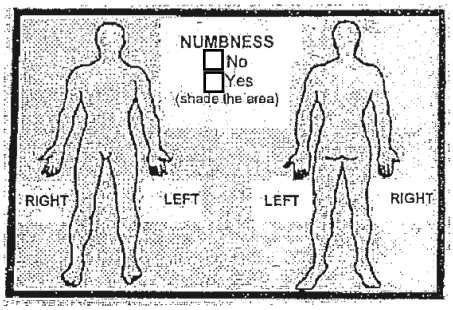
h. Because of this spine problem, I have filed or plan to file:
☐ A lawsuit ☐ A Worker's Compensation claim
☐ Neither a lawsuit or Worker's Compensation claim

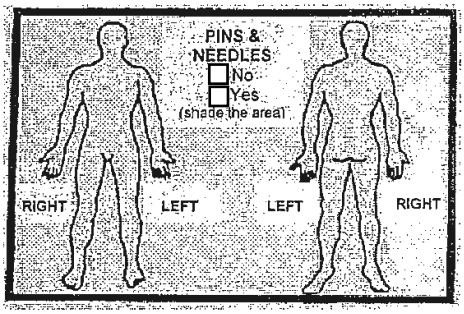
MY PAIN / DISCOMFORT IS (CIRCLE NUMBER)

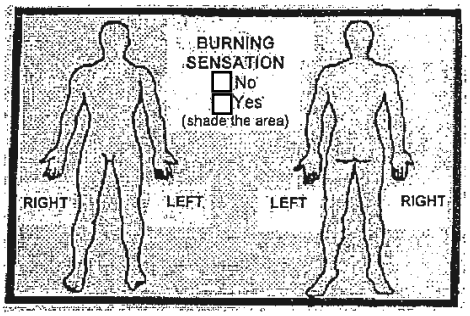


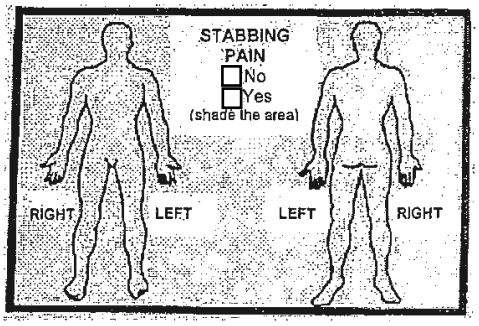
No Pain Slight Mild Moderate Severe Excruciating Pain as bad as it could be











_____ _____
Patient Signature Date

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All patients please answer the following questions:

In the past week, how often have you suffered: (Please circle the number that applies)	None of the time	A little of the time	Some of the time	A good part of the time	Most of the time	All of the time
1. Low back and/or buttock pain	1	2	3	4	5	6
2. Leg pain	1	2	3	4	5	6
3. Numbness or tingling in leg and/or foot	1	2	3	4	5	6
4. Weakness in leg and/or foot (such as difficulty lifting foot)	1	2	3	4	5	6

In the past week, how bothersome have these symptoms been? (Please circle the number that applies)	Not at all bothersome	Slightly bothersome	Somewhat bothersome	Moderately bothersome	Very bothersome	Extremely bothersome
5. Low back and/or buttock pain	1	2	3	4	5	6
6. Leg pain	1	2	3	4	5	6
7. Numbness or tingling in leg and/or foot	1	2	3	4	5	6
8. Weakness in leg and/or foot (such as difficulty lifting foot)	1	2	3	4	5	6

9. Generally speaking, are your symptoms getting better or worse?
(**Check only one**)

☐ Getting much better ☐ Getting somewhat better ☐ Staying about the same
☐ Getting somewhat worse ☐ Getting much worse

10. If you had to spend the rest of your life with the symptoms you have right now, how would you feel about it?
(**Check only one**)

☐ Very dissatisfied ☐ Somewhat dissatisfied ☐ Neutral
☐ Somewhat satisfied ☐ Very satisfied

In the past week, please tell us how pain has affected your ability to perform the following activities.
(Please circle the <u>ONE</u> statement that best describes your average ability)

11. My pain intensity.....	0 Comes and goes, very mild	1 Mild and does, not change much	2 Comes and goes, is moderate	3 Is moderate and does not change much	4 Comes and goes, is severe	5 Is severe and does not change much
12. Getting dressed (in the past week)	0 I can dress myself without pain	1 I can dress myself without increasing pain	2 I can dress myself but pain increases	3 I can dress myself but with significant pain	4 I can dress myself but with very severe pain	5 I cannot dress myself

QUESTIONS CONTINUE ON NEXT PAGE

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(Please circle the ONE statement that best describes your average ability)

13. Lifting (in the past week)	0 I can lift heavy objects without pain	1 I can lift heavy objects but it is painful	2 Pain prevents me from lifting heavy objects off the floor, but I can manage if they are on a table	3 Pain prevents me from lifting heavy objects but I can lift medium-weight objects if they are on a table	4 I can only lift light objects	5 I cannot lift anything
14. Walking and running (in the past week)	0 I can run or walk without pain	1 I can walk comfortably but running is painful	2 Pain prevents me from walking more than 1 hour	3 Pain prevents me from walking more than 30 min.	4 Pain prevents me from walking more than 10 min.	5 I am unable to walk or can walk only a few steps at a time
15. Sitting (in the past week)	0 I can sit in any chair as long as I like	1 I can only sit in a special chair for as long as I like	2 Pain prevents me from sitting more than 1 hour	3 Pain prevents me from sitting more than 30 min.	4 Pain prevents me from sitting more than 10 min.	5 Pain prevents me from sitting at all
16. Standing (in the past week)	0 I can stand as long as I like	1 I can stand as long as I want but it gives me pain	2 Pain prevents me from standing for more than 1 hour	3 Pain prevents me from standing for more than 30 min.	4 Pain prevents me from standing more than 10 min.	5 Pain prevents me from standing at all
17. Sleeping (in the past week)	0 I sleep well	1 Pain occasionally interrupts my sleep	2 Pain interrupts my sleep half of the time	3 Pain often interrupts my sleep	4 Pain always interrupts my sleep	5 I never sleep well
18. Social and recreational life (in the past week)	0 My social and recreational life is unchanged	1 My social and recreational life is unchanged but it increases pain	2 My social and recreational life is unchanged but it severely increases pain	3 Pain has restricted my social and recreational life	4 Pain has severely restricted my social and recreational life	5 Pain prevents a social and recreational life
19. Traveling (in the past week)	0 I can travel anywhere	1 I can travel anywhere but it gives me pain	2 Pain is bad but I can manage to travel over 2 hours	3 Pain restricts me to trips less than 1 hour	4 Pain restricts me to trips of less than 30 min.	5 Pain prevents me from traveling
20. My sex life	0 My sex life is unchanged	1 My sex life is unchanged but causes pain	2 My sex life is nearly unchanged but is very painful	3 My sex life is severely restricted by pain	4 My sex life is nearly absent because of pain	5 Pain prevents any sex life at all
21. Changing degree of my pain..	0 Pain is completely better	1 Pain fluctuates but overall is getting better	2 Pain seems to be getting better but improvement is slow	3 Pain is neither getting better or getting worse	4 Pain is gradually worsening	5 Pain is rapidly worsening
22. Employment / Homemaking..	0 My normal homemaking/job duties do not cause pain	1 My normal homemaking/job duties increase my pain but I can still perform all that is required of me	2 I can perform most of my homemaking /job duties but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming)	3 Pain prevents me from doing anything but light duties	4 Pain prevents me from doing even light duties	5 Pain prevents me from performing any job or homemaking chores

Physician Signature _____ Date _____

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Neck or Arm Form

This section is for patients with **NECK OR ARM** pain, numbness or weakness:

1. What % of your pain is neck pain and what % is arm pain? (check appropriate box)

☐ Neck 0%, Arm 100% ☐ Neck 10%, Arm 90% ☐ Neck 25%, Arm 75% ☐ Neck 40%, Arm 60%
☐ Neck 50%, Arm 50% ☐ Neck 60%, Arm 40% ☐ Neck 75%, Arm 25% ☐ Neck 90%, Arm 10%
☐ Neck 100%, Arm 0%

2. There is: ☐ No arm pain ☐ Arm pain is as follows (check the following):

a. ☐ Right 0%, Left 100% ☐ Right 10%, Left 90% ☐ Right 25%, Left 75% ☐ Right 40%, Left 60%
☐ Right 50%, Left 50% ☐ Right 60%, Left 40% ☐ Right 75%, Left 25% ☐ Right 90%, Left 10%
☐ Right 100%, Left 0%

b. The arm pain is present in the (check the following):

Right: ☐ Upper back ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
Left: ☐ Upper back ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger

3. Raising the arm: ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain
4. Moving the neck: ☐ Improves the pain ☐ Worsens the pain ☐ Does not affect the pain
5. There is: ☐ No weakness of the arms and hands ☐ Weakness of the (check the following):

Right: ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger
Left: ☐ Shoulder ☐ Upper arm ☐ Forearm ☐ Hand/finger

6. There is: ☐ No numbness of the arms and hands ☐ Numbness of the (check the following):

Right: ☐ Upper arm ☐ Forearm ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Small finger
Left: ☐ Upper arm ☐ Forearm ☐ Thumb ☐ Index finger ☐ Long finger ☐ Ring finger ☐ Small finger

7. There is difficulty picking up small objects like coins or buttoning buttons. ☐ Yes ☐ No
8. There is problem with balance or tripping frequently. ☐ Yes ☐ No
9. There are: (☐ Frequent ☐ Occasional ☐ No) headaches in the back of the head.

- END OF NECK & ARM QUESTIONS -

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Your life. Our specialty.

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Patients with HEADACHES

This section is for patients with **HEADACHES:**

1. What If you have headaches, how would you describe their intensity and frequency?

I have (check one)

☐ Slight ☐ Moderate ☐ Severe Headaches

They come (check one)

☐ Infrequently ☐ Frequently ☐ Almost all of the time ☐ I have no headache at all

2. The headaches are located (check the following):

☐ In the back of my neck ☐ In the back of my head

☐ The side of my head/temple area ☐ In the front of my head (near my eyes)

3. How long have you suffered from headaches?

☐ Several days ☐ Several weeks ☐ Several months ☐ Greater than 1 year

4. When do the headaches occur most commonly?

☐ Morning ☐ Afternoon ☐ While at work ☐ Evening ☐ No pattern

5. What is your average headaches pain level throughout the day? (please circle)

0 1 2 3 4 5 6 7 8 9 10

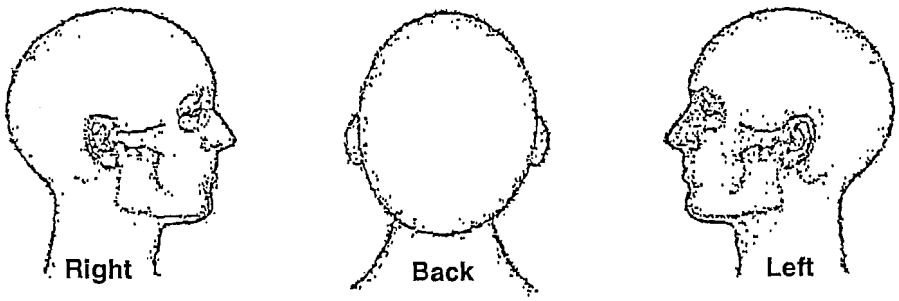
6. How would you describe your pain?

☐ Throbbing ☐ Squeezing ☐ Pressure ☐ Dull ☐ Stabbing ☐ Shooting

7. What medications (either prescription or over the counter) do you take for headaches?

_____

8. Please shade in the areas below where you experience your discomfort:



- END OF HEADACHE QUESTIONS -