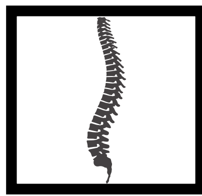


Samuel A. Joseph, Jr., M.D.
Ron Chatterjee, M.D.
Thuy M. Nguyen, D.O.

Your appointment has been scheduled: ____

Your appointment time is: ____________________________

Please arrive at: ___________________________________

- o 2727 West Dr. Martin Luther King Jr. Blvd.
  Suite 590
  Tampa, FL 33607
- o 11268 Winthrop Main Street
  Suite 101
  Riverview, FL 33578
- o 1840 Mease Drive (Medical Arts Building)
  Suite 309
  Safety Harbor, FL 34695
- o 710 94th Avenue North
  Suite 309
  St. Petersburg, FL 33702

You must bring the following to your appointment:

- ✓ New Patient Packet completed
- ✓ MRI films, CT films, X-Ray films and reports for all films. __________________________
- ✓ Photo ID
- ✓ Insurance ID

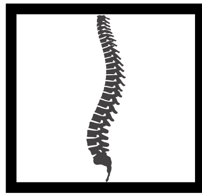
If you have any questions related to your MRI films, CT, X-Ray, or reports, please call (813) 534-6269.

Thank you,

Joseph Spine Institute

2727 W. Dr. Martin Luther King Jr. Blvd., Suite 590 • Tampa, Florida 33607
1840 Mease Drive, Suite 309 • Safety Harbor, Florida 34695
710 94th Avenue North, Suite 309 • St Petersburg, Florida 33702
11268 Winthrop Main Street, Suite 101 • Riverview, Florida 33578

Phone: 813-534-6269 • Fax: 813-870-0008



NEW PATIENT INFORMATION

Chart: ___________________________________ Date: _____/_____/ 20_____
Month Day Year

Patient Name: _____________________________________ DOB: _______________ Age:________

Primary Care Physician: ____

Emergency Contact: _________________________ Phone Number: _________________________

Male / Female (circle one) ( ) Right Handed ( ) Left Handed

Is your problem related to:

Auto Accident: [ ] Yes [ ] No Date: ______________________________

Job Injury: [ ] Yes [ ] No Date: ______________________________

Other: [ ] Yes [ ] No Date: ______________________________

Which physician can we thank for your referral?____

Briefly describe your main complaint/problem. Also, describe the injury that caused these symptoms, if applicable:

____
____
____
____
____

How long have you had this problem? ____

[For physician use only. History of present illness. [Preliminary notes: refer to dictation for more details]

____
____
____
____
____

SPINE PAIN

Relationship to Injury

- ☐ Injury Related
- ☐ Related to repetitive activity
- ☐ Not related to specific injury

Injury Setting

- ☐ At home
- ☐ At work
- ☐ Motor Vehicle Accident

Past Evaluation Setting

- ☐ Primary Care
- ☐ Specialty Provider
- ☐ Emergency Room
- ☐ Hospitalization
- ☐ Urgent Care

Past Evaluation

- ☐ Spine x -rays
- ☐ Spine CT
- ☐ Spine CT myelogram
- ☐ Spine MRI
- ☐ Bone Scan
- ☐ Electromyography
- ☐ Nerve conduction studies
- ☐ Provocation discography
- ☐ Diagnostic selective nerve block
- ☐ Rheumatology evaluation
- ☐ Neurology evaluation
- ☐ Neurosurgery Evaluation
- ☐ Orthopedic Evaluation

Past Treatment

- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Non-opioid analgesics
- ☐ Opioid analgesics
- ☐ Muscle relaxants
- ☐ Tricyclic antidepressants
- ☐ Anticonvulsants
- ☐ Corticosteroids
- ☐ Physical therapy
- ☐ Chiropractic Therapy
- ☐ Manipulation
- ☐ TENS Unit
- ☐ Mental health care
- ☐ Laminotomy

Past Treatment Continued

- ☐ Laminectomy
- ☐ Discectomy
- ☐ Spinal fusion
- ☐ Vertebroplasty
- ☐ Kyphoplasty
- ☐ Artificial disc replacement
- ☐ Injections

Past Procedures

- ☐ None
- ☐ Nerve block
- ☐ Trigger point injection
- ☐ Epidural injection
- ☐ Radiofrequency neurolysis
- ☐ Lysis of epidural adhesions
- ☐ Spinal cord stimulation
- ☐ Intrathecal pump
- ☐ Facet injection

Symptoms

- ☐ Back pain
- ☐ Back stiffness
- ☐ Decrease spine range of motion
- ☐ Decreased flexion
- ☐ Decreased extension
- ☐ Decreased lateral bending
- ☐ Decreased rotation
- ☐ Extremity numbness ____
- ☐ Extremity tingling ____
- ☐ Extremity weakness ____
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Muscle spasm
- ☐ Crackling sensation
- ☐ Tenderness
- ☐ Shoulder pain

Pain Location

- ☐ Upper back
- ☐ Mid back
- ☐ Low back
- ☐ Left upper back
- ☐ Left mid back
- ☐ Left low back
- ☐ Left sacroiliac region

Pain Location Continued

- ☐ Left anterior neck
- ☐ Left lateral neck
- ☐ Right posterior neck
- ☐ Right anterior neck
- ☐ Right lateral neck

Radiation

- ☐ None
- ☐ Left arm
- ☐ Left flank
- ☐ Left groin
- ☐ Left buttock
- ☐ Left thigh
- ☐ Left calf
- ☐ Left great toe
- ☐ Left lateral foot
- ☐ Right arm
- ☐ Right flank
- ☐ Right groin
- ☐ Right buttock
- ☐ Right thigh
- ☐ Right calf
- ☐ Right great toe
- ☐ Right lateral foot
- ☐ Left trapezius
- ☐ Left chest
- ☐ Left shoulder
- ☐ Left upper arm
- ☐ Left forearm
- ☐ Left hand
- ☐ Right trapezius
- ☐ Right chest
- ☐ Right shoulder
- ☐ Right upper arm
- ☐ Right forearm
- ☐ Right hand

Pain Quality

- ☐ Sharp
- ☐ Dull
- ☐ Aching
- ☐ Burning
- ☐ Shooting
- ☐ Stinging
- ☐ Stabbing
- ☐ Throbbing

Timing

- ☐ Constantly
- ☐ Frequently
- ☐ Intermittently
- ☐ Occasionally
- ☐ Rarely
- ☐ During the day
- ☐ At night

Severity

- ☐ Mild
- ☐ Moderate in severity
- ☐ Severe

Progression

- ☐ Worsening
- ☐ Unchanged
- ☐ Improving
- ☐ Resolved

Exacerbating Factors

- ☐ Bending
- ☐ Climbing stairs
- ☐ Lifting
- ☐ Reaching
- ☐ Sitting
- ☐ Sleeping
- ☐ Standing
- ☐ Turning head to the right
- ☐ Turning head to the left
- ☐ Use of the right arm
- ☐ Use of left arm
- ☐ Walking
- ☐ Neck flexion
- ☐ Neck extension
- ☐ Neck movement

Relieving Factors

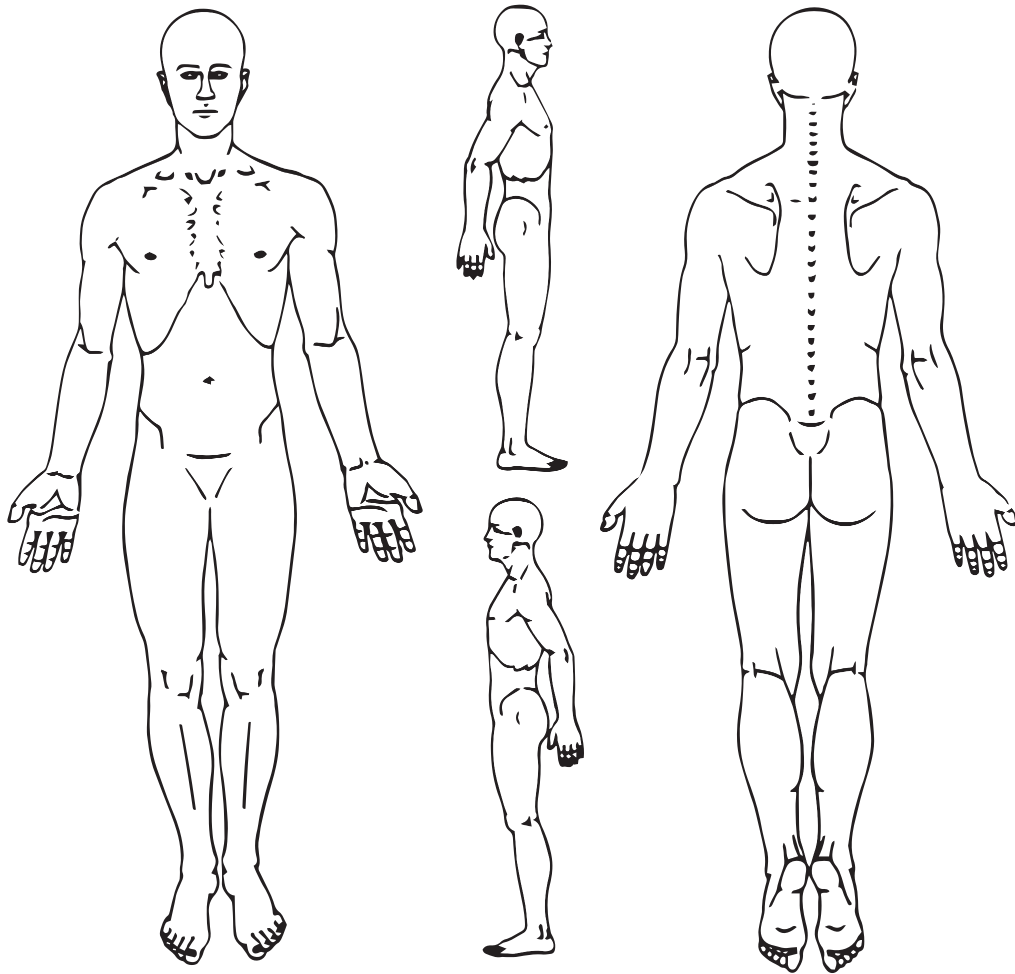
- ☐ Ice
- ☐ Heat
- ☐ Rest
- ☐ Lying down
- ☐ Stretching
- ☐ Nonsteroidal anti-inflammatory drugs
- ☐ Non-opioid analgesics
- ☐ Opioid analgesics
- ☐ Physical therapy
- ☐ Back brace
- ☐ Acupuncture
- ☐ Manipulation
- ☐ Injection Treatments
- ☐ Chiropractor
- ☐ Other _________________________

Associated Symptoms

- ☐ Headache
- ☐ Neck pain
- ☐ Dizziness
- ☐ Difficulty walking
- ☐ Difficulty sleeping
- ☐ Urinary issues
- ☐ Bowel issues
- ☐ Sexual dysfunction
- ☐ Depression
- ☐ Upper extremity paresthesias
- ☐ Upper extremity weakness
- ☐ Tinnitus
- ☐ Impaired hearing
- ☐ Impaired memory
- ☐ Impaired vision

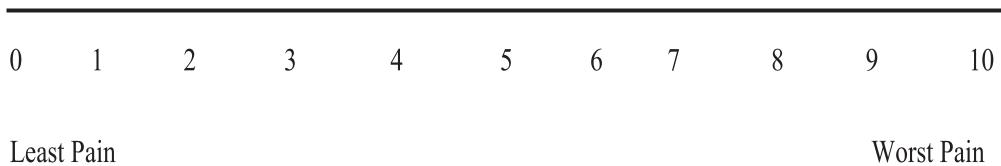
Functional Limitations

- ☐ General Activity
- ☐ Walking ability
- ☐ Work
- ☐ Housework
- ☐ Activities of daily living
- ☐ Hobbies
- ☐ Social relationships
- ☐ Sleep
- ☐ Enjoyment of life
- ☐ Exercising
- ☐ Physical activity
- ☐ Mobility



If you have PAIN, what percentage of your pain is ___________% Back, ___________% Leg, ___________% Neck and ___________% Arm (Total 100%)

Mark an X on the line indicating the usual degree of the pain :
(0 = no pain and 10 = the worst pain)



2727 W. Dr. Martin Luther King Jr. Blvd., Suite 590 • Tampa, Florida 33607
1840 Mease Drive, Suite 309 • Safety Harbor, Florida 34695
710 94th Avenue North, Suite 309 • St Petersburg, Florida 33702
11268 Winthrop Main Street, Suite 101 • Riverview, Florida 33578
Phone: 813-534-6269 • Fax: 813-870-0008

How long can you **STAND** with no or minimal pain? ___________ minutes.

WALKING DISTANCE with no or minimal pain:
[ ] 0-50 ft [ ] 50-200 ft [ ] 200-500 ft [ ] 500+ ft [ ] ½ mile +

Do you need SUPPORT to help you walk? [ ] Y [ ] N
If yes, what kind of brace?____

List below the PREVIOUS PHYSICIANS (MD, DO, Chiropractor) you have seen for your main complaint/problem.

Physician	Specialty	Dates	Treatment

Indicate which **DIAGNOSTIC STUDIES** you have had in evaluation of your main complaint/problem. (include dates)

Test	Date	Test	Date	Test	Date
X- Ray		EMG/NVC/SSEP		CT Scan	
Bone Scan		Arthogram		Dexa Scan	
Myelogram		MRI		Diskogram	
Other:					

PAST MEDICAL HISTORY Check below if you have had any of the following:

	✓	Comments		✓	Comments
Bowel disorders			Osteoporosis		
Cancer-where			Pacemaker		
Depression			Polio		
Diabetes			Psoriasis		
Heart disease			Rheumatoid arthritis		
High blood pressure			Seizures		
High cholesterol			Serious infection		
Kidney disease			Stroke		
Lung disease			Thyroid condition		
Multiple myeloma			Ulcers		
Prior Accidents:					

List any **SURGERY OR SURGERIES** you have had:

Type	Date	Outcome

List any **DRUG ALLERGIES** you have:

Drug	Type of Reaction

List **ALL CURRENT MEDICATIONS** as follows:

Name	Dose (Milligrams, grams)	How Often – (per day)	How Long

SOCIAL HISTORY & HABITS

Occupation: ____

Marital Status: | | Single | | Married | | Separated | | Divorced | | Widowed

Highest Level of Education: | | Less than high school | | High school graduate
| | Some college | | College Graduate | | Postgraduate | | Unknown

WORK STATUS

[ ] Full duty [ ] Light duty [ ] Off duty per physician [ ] Unemployed [ ] Retired

If you are **NOT** working a full day, how long have you been off work?

Have you had a work capacity assessment? [ ] Yes [ ] No

Are you disabled through Social Security? [ ] Yes [ ] No

TOBACCO USE

Do you currently use tobacco products? [ ] Yes [ ] No Start Age/Year:____Stopped______

If yes, indicate quantity per day: Cigarettes_____ Cigars_____ Chewing Tobacco (snuff)______

ALCOHOL USE

Do you currently consume alcoholic beverages? [ ] Yes [ ] No

If yes, indicate quantity per day: Beer _________ Wine __________ Distilled Spirits_________

FAMILY HISTORY

Has any member of your family been diagnosed with any of the following conditions (include deceased family members)? Place an "X" under the correct family member with the condition, and indicate if the family member passed away due to that condition.

	Father	Mother	Father's Parents	Mother's Parents	Brother(s)	Sister(s)
Anemia	______	______	______	______	______	______
Arthritis	______	______	______	______	______	______
Bleeding Disorder	______	______	______	______	______	______
Cancer	______	______	______	______	______	______
Coronary Artery Disease	______	______	______	______	______	______
Diabetes Mellitus	______	______	______	______	______	______
Gout	______	______	______	______	______	______
Hypertension	______	______	______	______	______	______
Osteoporosis	______	______	______	______	______	______
Seizures	______	______	______	______	______	______
Sickle Cell Disorder	______	______	______	______	______	______
Other: ________________	______	______	______	______	______	______

VITALS: Weight: _____________ Height: _____________ (Females only) LMP: ___________

REVIEW OF SYSTEMS:

Please place a check mark in the box next to any of the following symptoms or problems if you have experienced them recently or have concerns about them. If you don't understand something place a question mark "?" by it. Your doctor will discuss any positive responses with you.

General: ❘ **Normal**
- ❑ Weight Gain – Last 6 Months
- ❑ Weight Loss – Last 6 Months
- ❑ Poor Appetite
- ❑ Night Sweats
- ❑ Chills
- ❑ Fever

Skin: ❘ **Normal**
- ❑ Rash

HEENT: ❘ **Normal**
- ❑ Recent Changes in Vision
- ❑ Recent Changes in Hearing
- ❑ Recent Changes in Smell
- ❑ Recent Changes in Taste

Respiratory: ❘ **Normal**
- ❑ Short of Breath
- ❑ Cough
- ❑ Sputum
- ❑ History of Tuberculosis
- ❑ Wheezing

Cardiovascular: ❘ **Normal**
- ❑ Chest Pain
- ❑ Palpitations
- ❑ Shortness of Breath with Exercise
- ❑ Murmur
- ❑ Feet Edema

Musculoskeletal: ❘ **Normal**
- ❑ Cramps
- ❑ Muscle Weakness
- ❑ Joint Pain
- ❑ Joint Swelling
- ❑ Morning Stiffness

Gastrointestinal: ❘ **Normal**
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Indigestion
- ❑ Abdominal Pain
- ❑ Bloody or Dark Stools
- ❑ Unable to Control Bowel

Neurological: ❘ **Normal**
- ❑ Numbness/Tingling Feet
- ❑ Numbness/Tingling Hands
- ❑ Convulsions
- ❑ Dizziness

Genitourinary: ❘ **Normal**
- ❑ Blood in Urine
- ❑ Urinary Tract Infections
- ❑ Unable to Control Bladder
- ❑ Rushing to go
- ❑ Need to go Frequently

Psychiatric: ❘ **Normal**
- ❑ Problem Sleeping
- ❑ Crying Spells

Hematology: ❘ **Normal**
- ❑ Easy Bleeding
- ❑ Easy Bruising