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Physical Medicine & Rehabilitation
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Naples, Florida 34108

PATIENT INFORMATION

Date: _____ Account #:_____

First Name: _____ Middle Initial: _____ Last Name: _____

Social Security Number: _____ Date of Birth: _____ Sex: ___M___F

Home: ( ) _____ - _____ Mobile: ( ) _____ - _____ Work: ( ) _____ - _____

Preferred Contact Method: Home / Cell / Work Email Address (*please print clearly*): _____

Local Address: _____ City/State: _____ Zip Code: _____

Northern/Other Address: _____ City/State: _____ Zip Code: _____

Race:	White	Black	American Indian	Asian	Native Hawaiian	Other	Decline
Ethnicity:	Hispanic	Non-Hispanic	Type-Unknown	Decline			

Reason for visit: _____ If an injury, how did this occur: _____

Referred By: _____ Primary Care Physician: _____

Employer Name: _____ Occupation: _____

Spouse's Name: _____ Spouse's DOB: _____ Spouse's Wk #: _____

Health Ins. Carrier: _____ Auto Ins. Carrier: _____

If patient is a Minor, Parents Name: _____ Parents Employer: _____

Source of Payment (*Please Circle*): Primary Insurance Auto Self-Pay

EMERGENCY CONTACT

In the event of a medical emergency please contact:

_____

First and Last Name Relationship Phone Number

The information above is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance(s). I also authorize Gardner Orthopedics to release any information to my insurance(s) required to process my claims

_____

Patient/Guardian Signature Date

Please review forms, make appropriate changes and initial
*******THE SECTION BELOW IS ONLY FOR UPDATING PAPERWORK FOR YOUR SECOND AND THIRD YEAR OF TREATMENT*******

☐ Updated ☐ No Changes _____ _____
Patient Initial Date

☐ Updated ☐ No Changes _____ _____
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Notice of Privacy Practice
You have the right to obtain a paper copy of this notice from us upon request.

Name: _____Date: _____DOB: _____Account #:_____

Release of Information

Do you authorize the release of appointment information, medical and financial claims information?
_____Yes _____ No

If yes, this information may be released to the individual(s) listed below:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

This Release of Information will remain in effect until terminated by me in writing.

If unable to reach me:

☐ You may leave a detailed message.

☐ Please leave a message asking me to return your call.

☐ Other: _____

When leaving message:
Please call

☐ My Home ☐ My Work ☐ My Cell

Number: _____-_____-_____ Ext: _____

The best time to reach me is (day) _____ between (time) _____ and _____

Patient Signature: _____ Date: _____

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Name: _____Date: _____DOB: _____Account:_____

Accident or Injury Details

Many insurances companies require accident/injury details after they receive our claim. Please answer the following questions and explain how this accident/injury occurred.

NO ___ If not due to an accident, please describe your symptoms; when they started, and the manner in which they started.

_____

_____

YES ___ please answer the following that apply below:

Date of Injury: _____
Location of Injury (home, work, etc.): _____

Please check if Auto, Motorcycle, slip/fall, or "Other Accident" please answer the following:

____ Auto ____ Motorcycle ____ ATV/Dirt Bike ____ Bicycle ____Slip/Fall ____ Other

Provide a brief description of how accident occurred:

_____

_____

If Auto/Motorcycle:

Were you the ____driver or ____passenger?
Do you own the vehicle? ____Yes ____ No

If motorcycle related, do you have PIP insurance that would cover medical expenses relating to this accident? ____Yes ____ No
Has a claim been made with your auto insurance carrier? ____Yes ____ No

If Work related, please answer the following:

Name of employer at the time of injury: _____
Are you self-employed? ____ Yes ____ No
Do you receive a W-2 (employee) or 1099 (subcontractor) from this employer at year end?
____ W-2 ____1099
Have you filed a Workers' Compensation claim? _____
Has the employer or the workers' compensation carrier accepted or denied liability?
____ accepted ____ denied

Attorney Information

Have you sought the assistance of an attorney relating to this accident/injury? ___ Yes ____ No
If yes, please provide: Attorney's name: _____
Attorney's address: _____
Attorney's phone: _____

To the best of my knowledge the above information is true, accurate and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, insurance carrier, or plan to make available to my health insurance company, _____, all records necessary for processing claims filed by me or on my behalf. I authorize all insurance payments, including auto, PIP, and medpay to be made directly to Gardner Orthopedics. I authorize my auto insurance carrier _____ to release information regarding my PIP benefits and to provide a PIP log to Gardner Orthopedics when requested.

Signature: _____ Date: _____

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Name: _____Date: _____DOB: _____Account #:_____

CONSENT TO EXAMINATION, TREATMENT AND STATEMENT OF FINANCIAL POLICY AND RESPONSIBILITY

By my signature below I attest that I am capable of reading and comprehending this form without assistance, and have signed the form of my own free will. I agree that I have been made aware of the availability of assistance and or interpreter to help me in completing this form, and declined any aid.

By my signature below I hereby authorize the physicians of Gardner Orthopedics with the assistance of other health care providers and assistants selected by them, to provide medical care and treatment to me. I further agree to undergo examinations, x-rays, blood tests and or any other diagnostic modalities that the physician may determine to be important and or relevant to my care.

By my signature below I authorize the doctor to treat or correct any unexpected conditions or problem found during the examination, diagnostic procedure and or care, treatment therapy, or remedy listed above. I agree that the doctor will explain my medical condition(s), symptom, and or trauma, if known, and will explain and proposed examination, diagnostic procedure, and or care, treatment, therapy or remedy. **I agree to clarification if needed.**

By my signature below I agree that the doctor will explain other relevant and available alternatives, including associated risks, to the examination, diagnostic procedure, and or treatment proposed. I agree that I will be provided the opportunity to discuss relevant and available alternatives. **I agree to ask for clarification if needed.**

By my signature below I understand that there are certain risks inherent to the diagnosis and treatment of any disease, physical trauma, and or condition. I agree that the doctor will discuss the risks of the specific examination, diagnostic procedure, and or treatment proposed, including risks that are specific to me. I further agree that the doctor will explain the risks of not having the examination, diagnostic procedure or treatment proposed. **I agree to ask for clarification if needed.**

By my signature below I agree that I am submitting to the examination, diagnostic procedure and or treatment of my own free will. I further agree that I can ask questions and raise concerns with the doctor about my condition, the risks inherent to the examination, diagnostic procedure and or treatment and my treatment options. I agree that my questions and concerns will be discussed and answered to my satisfaction. I further attest that I understand that I may ask questions concerning my examination or treatment and that **I may stop treatment at any time for clarification of treatment options.**

By my signature below I attest that I have stated or noted my past medical history to the best of my ability, and further attest that I have **not taken and undisclosed medications or drugs prior to examination and or treatment.**

By my signature below I agree that the doctor or any individual employed by the physician has not provided me a guarantee or assurance that the examination, diagnostic procedure and or care, treatment, therapy or remedy will cure or improve the condition(s) listed above. I further understand the examination, diagnostic procedure and or care, treatment, therapy or remedy may make my conditions worse.

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Name: _____Date: _____DOB: _____Account #:_____

By my signature below I agree that, as part of the examination, diagnostic procedure, and/or care, treatment, therapy or remedy provided, the doctor may obtain certain protected health information, including past medical history. I understand that this will include a review, if necessary, of past, current or future health records, including records of procedures such as physical examinations, x-rays, blood or urine tests. I understand that further information will be gleaned, as necessary, from direct and telephonic conversations with the doctor and/or the doctor's health care staff, or from my responses to any questionnaire submitted prior to the initiation of the proposed examination, diagnostic procedure, and/or care, treatment, therapy or remedy. I understand that the information sought may include, but is not necessarily limited to, the following:

- Document of past medical history
- Records of physical exams and procedures
- Laboratory, x-ray, MRI and other test results
- Records of medication or drug usage
- Records of implanted or external medical devices
- Information related to diagnosis and treatment of a mental health condition Information about HIV/AIDS
- Information about hepatitis infection
- Information about sexually transmitted diseases
- Information about infectious diseases that must be reported to Public Health Authorities

By my signature below I understand that Florida law generally requires that physicians carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that doctors of Gardner Orthopedics have elected, pursuant to Florida law, not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

By my signature below **I understand and agree to pay all deductible, co-payments, and fees due, less insurance payments**. As a courtesy to you, we will submit your claim to your insurance company. Any portion not covered by your insurance company, such as your co-insurance and/or deductible amount is due and payable at the time of service. Additionally, some insurance companies do not cover supplies, such as braces, slings, splints, etc. necessary for your treatment. You are responsible for these non-covered services.

Failure to make payment in full or failure to make arrangements for payment may result in your account being placed with a collection agency. Should it become necessary to send your account to the collection agency, collection costs may include, but are not limited to, collection agency fees, court costs, attorney fees, interest on unpaid balances and any other fees or costs associated with the collection of unpaid balance. A $35.00 returned check fee will be added to your account for all retuned checks.

I agree that Gardner Orthopedics may request and use my prescription medication history from other healthcare providers or third party pharmacy benefit payors for treatment purposes.

_____ _____

Patient or Patient's Representative Date

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Name: _____ DOB: _____ Account #: _____Sex: ☐ Male ☐ Female

Primary Care Physician: _____

Pain Management Physician: _____

Past Medical History- Have you been diagnosed with any of the following conditions? Please Circle Yes or No.

Heart Disease/Conditions	Yes	No	Blood Clots/DVT	Yes	No	Rheumatoid Arthritis	Yes	No
Heart Attack	Yes	No	Bleeding Disorder	Yes	No	Osteoarthritis	Yes	No
Angina/Chest Pain	Yes	No	Hypertension	Yes	No	Gout	Yes	No
Congestive Heart Failure	Yes	No	Stroke	Yes	No	Thyroid Disease	Yes	No
COPD/Emphysema	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	HIV/AIDS	Yes	No
Pneumonia	Yes	No	Anemia	Yes	No	Seizures	Yes	No
Kidney Disease/Conditions	Yes	No	Sickle Cell Disease	Yes	No	Anxiety	Yes	No
Renal Failure	Yes	No	Stomach/Intestinal Ulcers	Yes	No	Depression	Yes	No
Diabetes	Yes	No	Cancer	Yes	No	Fibromyalgia	Yes	No
Herpes	Yes	No	Shingles	Yes	No			
Other:								

Surgeries- Please list all surgeries with the approximate date.

DATE; PROCEDURE

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Please review forms, make appropriate changes and initial
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☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

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Name: _____Date: _____DOB: _____Account #:_____

Medications-Please list all medications with dosage and frequency. (If you have a list of your medications, please attach copy.)

1._____Dosage_____Frequency_____
2._____Dosage_____Frequency_____
3._____Dosage_____Frequency_____
4._____Dosage_____Frequency_____
5._____Dosage_____Frequency_____
6._____Dosage_____Frequency_____
7._____Dosage_____Frequency_____
8._____Dosage_____Frequency_____
9._____Dosage_____Frequency_____
10._____Dosage_____Frequency_____

Pharmacy Name: _____ Phone Number: _____-_____-_____

Drug and Food Allergies or adverse reactions (include penicillin, aspirin, anti-inflammatory drugs and local anesthesia)

_____

_____

Social History:

Marital Status: (Please Circle Choice) Married Single Divorced Widow(er)
Number of Children_____ Presently living alone? ____Yes ____No

Smoking Status:_____ Never Smoker_____ Former Smoker _____ Date Started: _____ Date Ended: _____
_____Current every day smoker - If yes, please list the amount you smoke: _____ pack(s) per day _____ packs per week

Do you drink alcoholic beverages regularly? _____Yes _____ No
If yes please list amount: _____ drink(s) per day _____ drink(s) per week.
What is your occupation? _____

I certify to the best of my knowledge that the information listed above is true and accurate.

Patient Signature: _____Date:_____

Please review forms, make appropriate changes and initial
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☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

☐ Updated ☐ No Changes _____ _____ _____ _____
Patient Initial Date Doctor Initial Date

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Name: _____Date: _____DOB: _____Account #:_____

Family Medical History- (does anyone in your immediate family have any of the following illnesses?)
Please circle all that apply:

Cancer	Father	Mother	Sibling	N/A	Lung Disease	Father	Mother	Sibling	N/A
Diabetes	Father	Mother	Sibling	N/A	Heart Disease	Father	Mother	Sibling	N/A
Immune Disorders	Father	Mother	Sibling	N/A	Thyroid Disease	Father	Mother	Sibling	N/A
Rheumatoid Arthritis	Father	Mother	Sibling	N/A	Kidney Disease	Father	Mother	Sibling	N/A
Degenerative Arthritis	Father	Mother	Sibling	N/A					

Immunizations: (approximate date or age)
Flu: _____ Tetanus: _____

Review of Symptoms: Are you currently or have you had problems with any of the following (circle)?

Musculoskeletal	Body Part		_____	Genitourinary	Yes	No	_____
Weight loss/ Weight changes	Yes	No	_____	Skin	Yes	No	_____
Fever	Yes	No	_____	Neurological	Yes	No	_____
Eyes/ Ears/ Nose/ Throat	Yes	No	_____	Endocrine	Yes	No	_____
Heart/Cardiovascular	Yes	No	_____	Hematologic	Yes	No	_____
Lungs/ Respiratory	Yes	No	_____	Psychiatric	Yes	No	_____
Gastrointestinal	Yes	No	_____	Other	Yes	No	_____

I certify to the best of my knowledge that the information listed above is true and accurate.

Patient Signature: _____Date:_____

Please review forms, make appropriate changes and initial
*******THE SECTION BELOW IS ONLY FOR UPDATING PAPERWORK FOR YOUR SECOND AND THIRD YEAR OF TREATMENT*******

☐ Updated ☐ No Changes

_____	_____	_____	_____
Patient Initial	Date	Doctor Initial	Date

☐ Updated ☐ No Changes

_____	_____	_____	_____
Patient Initial	Date	Doctor Initial	Date

For office use only:

Initial	Date	Initial	Date	Initial	Date	Initial	Date	Initial	Date

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Patient Name: _____ DOB:_____ Acct #: _____

NECK DISABILITY INDEX

This questionnaire is designed to help us better understand how your neck pain affects your ability to manage everyday life activities. Please **MARK IN EACH SECTION** the **ONE BOX** that applies to you. Although you may consider that two of the statements in any one section relate to you, please mark the box that **MOST CLOSELY** describes your present-day situation.

SECTION 1 – PAIN INTENSITY

- ☐ I have no pain at the moment.
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment.
- ☐ The pain is fairly severe at the moment.
- ☐ The pain is very severe at the moment.
- ☐ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE

- ☐ I can look after myself at the moment 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 slow 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 causing 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 items are conveniently positioned, i.e., on a table.
- ☐ Pain prevents me from lifting heavy weights, but I can manage light Weights if they are conveniently positioned.
- ☐ I can lift only very light weights.
- ☐ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ☐ I can do as much work as I want.
- ☐ I can only do my usual work, but no more.
- ☐ I can do most of my usual work, but no more.
- ☐ I cannot do my usual work.
- ☐ I can hardly do any work at all.
- ☐ I cannot do any work at all.

SECTION 5 – HEADACHES

- ☐ I have no headaches at all.
- ☐ I have slight headaches that come infrequently.
- ☐ I have moderate headaches that come infrequently.
- ☐ I have moderate headaches that come frequently.
- ☐ I have severe headaches that come frequently.
- ☐ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ☐ I can concentrate fully without difficulty.
- ☐ I can concentrate fully with slight difficulty.
- ☐ I have a fair degree of difficulty concentrating.
- ☐ I have a lot of difficulty concentrating.
- ☐ I have a great deal of difficulty concentrating.

SECTION 7 – SLEEPING

- ☐ I have no trouble sleeping.
- ☐ My sleep is slightly disturbed for less than 1 hour.
- ☐ My sleep is mildly disturbed for up to 1-2 hours.
- ☐ My sleep is moderately disturbed for up to 2-3 hours.
- ☐ My sleep is greatly disturbed for up to 3-5 hours.
- ☐ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ☐ I can drive my car without neck pain.
- ☐ I can drive as long as I want with slight neck pain.
- ☐ I can drive as long as I want with moderate neck pain.
- ☐ I cannot drive as long as I want because of moderate neck pain.
- ☐ I can hardly drive at all because of severe neck pain.
- ☐ I cannot drive my car at all because of neck pain.

SECTION 9 – READING

- ☐ I can read as much as I want with no neck pain.
- ☐ I can read as much as I want with slight neck pain.
- ☐ I can read as much as I want with moderate neck pain.
- ☐ I cannot read as much as I want because of moderate neck pain.
- ☐ I cannot read as much as I want because of severe neck pain.
- ☐ I cannot read at all.

SECTION 10 – RECREATION

- ☐ I have no neck pain during all recreational activities.
- ☐ I have some neck pain with all recreational activities.
- ☐ I have some neck pain with a few recreational activities.
- ☐ I have neck pain with most recreational activities.
- ☐ I can hardly do recreational activities due to neck pain.
- ☐ I cannot do any recreational activities due to neck pain.

Date: _____ **Score :** _____ **(50)** **Benchmark -5 = :** _____

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Patient Name: _____ DOB:_____ Acct #: _____

OWESTRY LOW BACK DISABILITY QUESTIONNAIRE

INSTRUCTIONS: This questionnaire has been designed to give us information as to how your back pain has affected your ability to manage everyday life. Please answer every section and mark in each section only the **ONE** box which applies to you at this time. We realize you may consider 2 of the statements in any section may relate to you, but **please mark the box which most closely describes your current**

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

2. PERSONAL CARE (e.g. Washing, Dressing)
- ☐ 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 slow 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.

3. LIFTING
- ☐ I can lift heavy weights without extra pain.
- ☐ I can lift heavy weights, but it gives extra pain.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, i.e., 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 only very light weights.
- ☐ I cannot lift or carry anything at all.

4. WALKING
- ☐ Pain does not prevent me walking any distance.
- ☐ Pain prevents me walking more than one mile.
- ☐ Pain prevents me walking more than ½ mile.
- ☐ Pain prevents me walking more than ¼ 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.

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 ½ hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

6. STANDING
- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than one hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing at all.

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

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, i.e. dancing, etc.
- ☐ 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.

9. TRAVELLING
- ☐ 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 restricts me to journeys of less than one hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents me from traveling except to the doctor or hospital.

10. EMPLOYMENT/HOMEMAKING
- ☐ My normal homemaking/job activities do not cause pain.
- ☐ My normal homemaking/job activities increase my pain, but I can still Perform all that is required of me.
- ☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g. lifting/vacuuming)
- ☐ Pain prevents me from doing anything but light duties.
- ☐ Pain prevents me from doing even light duties.
- ☐ Pain prevents me from performing any job or homemaking chores.

Date: _____ **Score:** _____ **(50)** **Disability Level:**_____

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GARDNER ORTHOPEDICS

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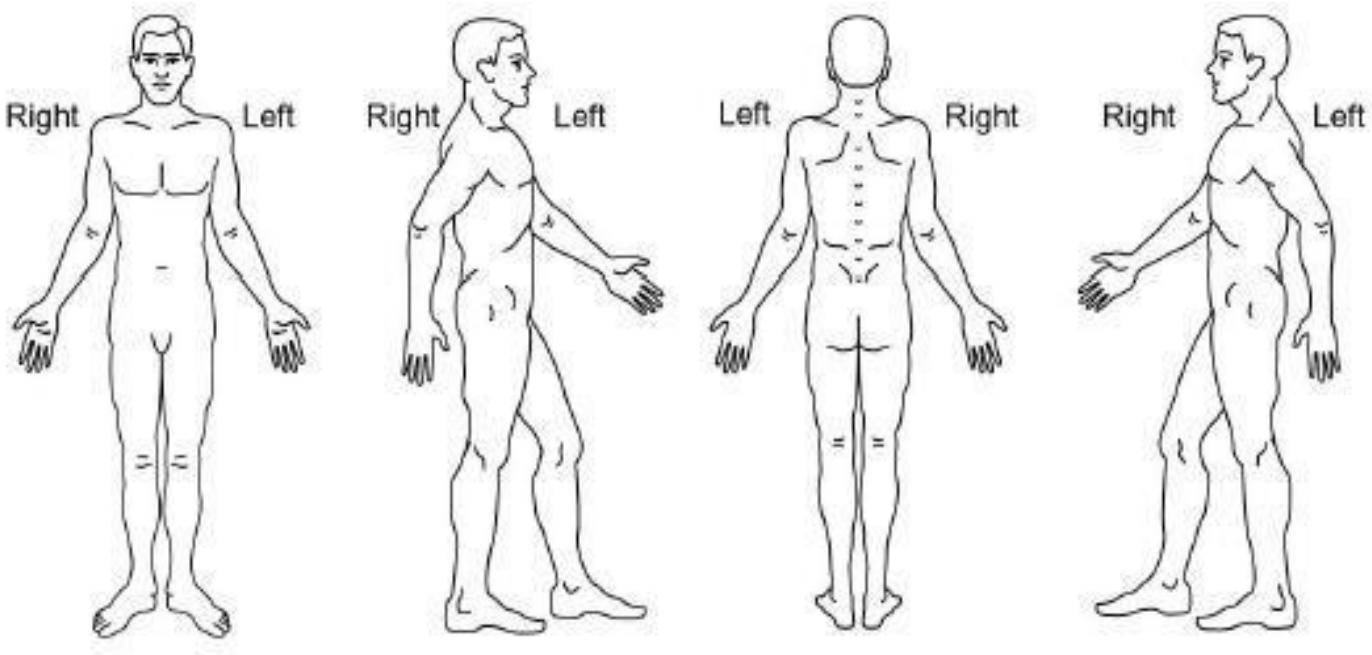
Physical Medicine & Rehabilitation
840 111th Ave. N, Ste. #7
Naples, Florida 34108

DATE: _____

Patient Name: _____ DOB:_____ Acct #: _____

When you come to the office, please highlight the areas where you are having your symptoms.



Check all of the following that describe your symptoms:

☐ Dull/Aching ☐ Hot/Burning ☐ Shooting ☐ Stabbing/Sharp

☐ Cramping ☐ Numbness ☐ Spasming ☐ Throbbing

☐ Squeezing ☐ Tingling/Pins and Needles ☐ Tightness

When are your symptoms at its worst?

☐ Mornings ☐ Daytime ☐ Evenings ☐ Middle of the night

☐ Always the same

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How often do the symptoms occur?

☐ Constant ☐ Changes in severity but always present ☐ Intermittent (comes and goes)

If "0" is no pain and "10" is the worst pain and you need to go to the ER, how would you rate it?

Right Now: _____ The Best It Gets: _____ The Worst It Gets: _____

Mark which of the following makes your symptoms <u>WORSE</u>:

☐ Bending
☐ Changes in Weather
☐ Climbing Stairs
☐ Coughing/Sneezing
☐ Driving
☐ Lifting Objects
☐ Rising from a seated position
☐ Sitting
☐ Standing
☐ Twisting
☐ Vacuuming

☐ Walking – If yes, how far can you walk before you need to rest? _____

What other factors worsen or affect your pain which is not mentioned above?

_____

_____

Do you get any of these associated symptoms?

☐ Fevers ☐ Chills ☐ Night sweats
☐ Unintentional weight loss ☐ Bladder incontinence ☐ Bowel incontinence
☐ Numbness in genital area ☐ Restless Legs ☐ Balance issues
☐ Trouble falling asleep ☐ Muscle tension or stiffness
☐ Headaches ☐ Vision changes ☐ Light sensitivity

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Mark which of the following makes your symptoms <u>BETTER</u>:

☐ Heat/ Hot showers
☐ Ice
☐ Massage
☐ Exercising
☐ Changing positions
☐ Sitting in a Recliner
☐ Rest/Lying down
☐ Sitting
☐ Topical Medications
☐ Stretching
☐ Walking
☐ Leaning on a shopping cart

☐ Taking Medications – If yes, what kind? _____

_____

☐ Any other factors that improve your pain which is not mentioned above?

_____

_____

What have you tried for your symptoms so far? Write approximate dates on the line.

☐ Physical Therapy _____
☐ Chiropractic Care _____
☐ Acupuncture _____
☐ Massage _____
☐ Injections
  ☐ Epidurals _____
  ☐ Radiofrequency ablation _____
☐ Surgery _____

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What medications have you tried for your pain so far?

	Helped	No Help	Side Effects
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐
_____	☐	☐	☐

Do you exercise?

☐ Daily ☐ Weekly ☐ Rarely ☐ Pain won't allow me

What kind of exercise do you do or you would like to return to?

☐ Walking ☐ Running ☐ Tennis ☐ Pickleball

☐ Bike riding ☐ Swimming ☐ Going to the gym ☐ Yoga

☐ Other: _____

Past and/or Current Medical History:

☐ Asthma ☐ COPD ☐ Sleep Apnea

☐ Bleeding Problems ☐ Diabetes Type 1 ☐ Diabetes Type 2

☐ Fibromyalgia ☐ Neuropathy ☐ Peripheral Vascular Disease

☐ High Blood Pressure ☐ Liver Disease ☐ Kidney Disease

☐ Rheumatoid Arthritis ☐ Fainting Spells ☐ On Blood Thinners

☐ Immune Conditions: _____

☐ Orthopedic Conditions: _____

☐ Other diagnosed conditions not listed: _____

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Please list <u>ANY</u> and <u>ALL</u> Pain Specialists and/or Neurosurgeons you have seen in the past:

Name: _____ When? _____

Name: _____ When? _____

Name: _____ When? _____

Name: _____ When? _____

Which modalities, if any, were helpful when provided by the above physician(s)?

_____

_____

_____

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MEDICAL RECORDS REQUEST FORM

Patient's Name: _____ SSN#:XXX-XX-_____ DOB: _____

INFORMATION NEEDED:

_____ Complete Medical Records
_____ Operative Report
_____ Radiology Films
_____ DEXA Scan / Nerve Conduction Study
_____ Lab Reports
_____ Physical/Occupational Therapy Records
_____ Complete Billing Records
_____ Complete Work Comp Records
_____ Complete Auto Accident Records
_____ X-ray CD ($5 fee in house)
_____Other: _____

– FOR PATIENT RECORDS TO BE RELEASED FROM GARDNER ORTHOPEDICS– PLEASE ALLOW 5 TO 10 BUSINESS DAYS

Purpose for Request: _____Continuing Care_____Second Opinion_____Personal Record Keeping

Delivery options:

_____I will pick up _____To be picked up by_____(Photo ID Required)
_____Mail to Address below
Send to:_____
Address:_____City:_____State:_____ Zip:_____
Attention:_____Phone #:_____ Fax #:_____

– FOR PATIENT RECORDS TO BE OBTAINED FROM OTHER FACILITIES –

I hereby authorize and request that you release the following medical information to:

To Physician/Hospital/Facility: _____Gardner Orthopedics_____
Address: _____3033 Winkler Ave. Suite 100_____ City: ____Fort Myers____ State: ___FL___ Zip:___33916____

SEND BY: Courier: _____ FAX:_____ US MAIL _____ To Be Picked Up _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDs virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all healthcare information pertaining to such diagnosis, testing, or treatment. As required by state and federal law, Gardner Orthopedics may not use or disclose your health information except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures on the protected health information described on the form.

I hereby authorize _____ to release information as described above.

Patient's signature or Legal Representative: _____ Date: _____

Signature of parent or guardian: _____