Who is responsible for this patient? □ Self □ Parent □ Employer □ Other _____

How did you hear about us? _____

Patient's Last Name _____ First Name _____Middle Initial _____

Patient's Social Security Number _____ Date of Birth _____

Address _____ Apt # _____

City _____ State _____ Zip Code _____

Telephone#: Home/Cell ( ) _____ Business ( ) _____

Race: _____ Ethnicity: _____ Sex: □ Male □ Female

Would you like to sign up for patient portal? □ Yes □ No

Email Address: _____

Do you have an alternate address? □ Yes □ No If yes, please print here: _____

_____

Marital Status (check one): □ Single □ Married □ Divorced □ Widowed □ Separated

Employment Status (check one): □ Full- Time □ Part- Time □ Retired □ Other _____

Employer: _____ Occupation: _____

Employer Address: _____

Student: □ Yes □ No □ Full- Time □ Part- Time

Spouse/Parent Name: Last _____ First _____ Middle Initial _____

SSN: _____ Date of Birth: _____

Employer: _____

Employer Address: _____ Phone # _____

Name of closest relative not living with you: _____

Relationship: _____ Phone #: _____

Referring Physician: _____

Address: _____ Phone #: _____

INSURANCE INFORMATION

PLEASE PRINT

Primary Insurance: _____ Secondary Insurance: _____

Insured's Name: _____ Insured's Name: _____

I.D. # _____ I.D. # _____

Relationship to Patient: _____ Relationship to Patient: _____

ACCIDENT INFORMATION

EMPLOYER: _____ Date of injury: _____

Place of accident or injury: _____ Was the Accident: □ Work- Related □ Auto-Related

Date & Time of Accident: _____ □ Other __

Do you have notice of injury on file? □ Yes □ No W. C. Claim# _____

Attorney Name: _____ Insurance Co: _____

Policy Holder: _____ Address: _____

I.D.# _____ _____ Zip: _____

Telephone# _____Were X-rays taken of this injury or problem? □ Yes □ No

If yes, where were X-rays taken? _____ Date X-rays taken _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE READY FOR THE RECEPTIONIST. PAYMENT FOR PROFESSIONAL SERVICES IS DUE AND PAYABLE WHEN SERVICE IS RENDERED. A $40 NO SHOW FEE WILL BE APPLIED IF YOUR APPOINTMENT IS NOT CANCELLED WITHIN 24 HOURS.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative **Date**

OFFICE POLICY FOR PRESCRIPTION REFILL REQUESTS

We require a 48 hour notice for all prescription refill requests.
Please leave the following information on the Medical Assistant's voice mail:

- Your Name & Telephone Number
- Your Physician's Name
- Pharmacy Telephone Number
- Medication Name & Strength

Dear Patients,

We are now doing electronic prescriptions. Please list your preferred pharmacy below.

Pharmacy Name: _____Pharmacy Phone #: _____
Address: _____
_____

Please initial: _____ **Date: _____**

INSURANCE ASSIGNMENT & RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Celebration Minimally Invasive Spine Institute all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance admissions.

The above-named physician may use my health care information and may disclose such information to the above- named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Patient Guardian or Personal Representative Relationship to Patient

MEDICARE/MEDIGAP AUTHORIZATION

Print Name: _____ Date of Birth: _____

Medicare#:_____ Patient I.D. #: _____

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Celebration Minimally Invasive Spine Institute, for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to the centers for Medicare and Medicaid Services, any Medigap insurer and their agents any information needed to determine these benefits and related services.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Patient Guardian or Personal Representative Relationship to Patient

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Patient Guardian or Personal Representative Relationship to Patient

CONSENT FOR EVALUATION OR TREATMENT

Patient Name: _____ Date of Birth: _____

By signing below, I voluntarily agree to the following provisions of this form: Consent to Treatment

I allow Celebration Minimally Invasive Spine Institute (the "Practice") to provide health care services to me that may be deemed to be routine or otherwise necessary. I consent to evaluation or treatment that the assigned healthcare provider may deem necessary. This may include diagnostic, radiology and laboratory procedures, and medication administration. I understand that I have the right to refuse consent to any proposed procedure or treatment at any time prior to its performance.

_____ _____

Signature of Patient, Patient Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Patient Guardian or Personal Representative Relationship to Patient

Patient Name: _____ Date of Birth: _____

AUTHORIZATION TO VERBALLY COMMUNICATE WITH FAMILY MEMBERS AND FRIENDS INVOLVED IN YOUR CARE

AUTORIZACION PARA COMMUNICACION CON FAMILIARES Y AMIGOS INVOLUCRADO EN SU CUIDADO

I, _____ (print name) hereby authorize Celebration Minimally Invasive Spine Institute to verbally disclose the minimum amount of protected health information necessary to individuals listed below who are directly involved in my care or payment of my care.

Yo, _____ (escriba su nombre en letra de molde) por la presente autorizo a Celebration Minimally Invasive Spine Institute, a divulgar verbalmente la cantitad minima de informacion de salud protegida necesaria para los individuos nombrados a continuacion que estan directamente involucrados en mi cuidado o en el pago de mi cuidado.

1. _____ _____
Name/*Nombre* (Please print/*En letra molde)* Relationship/*Relacion*

_____ _____
Address/*Direccion* City/*Ciudad* State/*Estado* Phone Number/*Numero de telefono*

2. _____ _____
Name/*Nombre* (Please print/*En letra molde)* Relationship/*Relacion*

_____ _____
Address/*Direccion* City/*Ciudad* State/*Estado* Phone Number/*Numero de telefono*

This authorization will expire on the following date, event or condition: _____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information designated above unless initialed below or otherwise required by law.

Esta autorizacion vencera en la sigiente fecha, evento o condicion: _____

Comprendo que esta autorizacion cubre todos o cualquier parte de los expedimientos indicados arriba, los cuales podrian incluir informacion psiquiatrica, y/o pruebas/asesoramiento genetico, y/o de abuso de alcohol/drogas, y/o SIDA (Sindrome de Inmunodeficiencia Adquirida) (AIDS segun sus siglas en ingles), y/o podria incluir el resultado de una prueba de VIH (Virus de Inmunodeficiencia Humano) (HIV segun sus siglas en ingles) o el hecho de que se llevo a cabo una prueba de VIH. Especificamente autorizo que se divulgue la informacion segun se ha indicado arriba al menos que este marcado abajo con mis iniciales o en alguna otra forma sea exigido por la ley.

Please indicate information you **DO NOT** want disclosed: (Initial each selection)

*Indique la informacion que **NO QUIERE** que se divulgue: (ponga sus iniciales en cada seccion)*

_____ HIV/AIDS *VIH/SIDA* _____ Drug and/or Alcohol Abuse/*Abuso de sustancias y/o alcohol)*

_____ Mental Health *Salud mental*

_____ Genetic Counseling/Testing Information/Information/Informacion sobre asesoria o pruebas geneticas

_____ Other (be specific)/ Oftros (sea especifico) _____

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Celebration Minimally Invasive Spine Institute may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.

Si yo no especifico un evento o condición de vencimiento, la autorización vencera en un año. Comprendo que esta autorización es revocable al dar aviso por escrito a la oficina donde se retiene la autorización original, excepto al grado de accion ya tomada de acuerdo con esta autorización. Comprendo que mi información médica protegida que se usada o divulgada de acuerdo con esta autorización podria estar sujeta a una nueva divulgación por el recibidor y que la privacidad de mi información médica protegida ya no podría estar protegida bajo la ley. Tambien comprendo que Celebration Minimally Invasive Spine Institute no puede poner condiciones a la disposición de tratamiento, pago, inscripción en el plan de salud o elegibilidad de beneficios en la disposición de esta autorización. Comprendo que yo recibiré una copia firmada de este formulario.

_____ _____
Patient Signature/Firma del paciente Date/Fecha Witness Signature/Firma del testigo Date/Fecha

☐ I wish to revoke this authorization. Signature:_____ Date: _____

☐ Deseo revocar esta autorizacion. Firma: _____ Fecha: _____

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Private Practices describes how we may use and disclose your protection health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. 'Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bill, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, if necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

Celebration - MINIMALLY INVASIVE SPINE INSTITUTE

Patient Name:_____

CURRENT HISTORY Date: _____

What is the main reason for your visit? (Check all that apply)

□ Back Pain □ Leg Pain □ Neck Pain □ Arm Pain

□ Other _____

How long has this been a problem?

□ Less than 2 Months □ 2-3 Months □ 6-12 Months □Greater than 1 Year

□ Further Comments: _____

_____

Have you been treated by any other Care Giver for this condition? □ Yes □ No

If yes, please list: _____

_____

What treatments have you had for this problem? (Check all that apply)

□ Nothing □ Chiropractic Care □ Acupuncture □ Injections

□ Physical Therapy (please check all) □ When?: _____

□ Stretching □ Strengthening □ Traction □ Iontophoresis/Topical Steroid

□ TENS □ Massage □ Ultra Sound □ Heat/Ice

□ Therapeutic Ball □ Medications □ Muscle Relaxers □ Pain Medications

□ Anti- Inflammatory (Prescription)

□ Anti-Inflammatory over the counter (Aspirin, Tylenol, Aleve, Etc.) □ Other: _____

Have you had any test for this problem? □ Yes □ No

□ X-RAY □ MRI □ Discography □ CT □ EMG

□ CT/Myelogram □ Bone Scan □ Other (please specify) _____

Current problem is the result of a(n) (check all that apply):

□ Injured at work □ Auto Accident □ Sport □ No Apparent Reason

Is there any litigation pending?

□ Lawsuit □ Workers Comp □ Disability Claim □ Social Security Claim

Celebration - MINIMALLY INVASIVE SPINE INSTITUTE

Patient Name: _____

Date: _____

Current problem began: (Check all that apply)

□ Suddenly □ Gradually □ Lifting □ Twisting □ Fall

□ Bending □ Pulling □ Other _____

What makes the pain worse?

□ During Exercise □ After Exercise □ Prolonged sitting □ Prolonged Standing

□ Walking □ Bending Forward □ Bending Backward □ Pushing

□ Pulling □ Squatting □ Night pain

□ Other _____

What reduces your pain?

□ Nothing □ Lying down □ Sitting □ Standing □ Walking □ Medication

□ Shifting/Changing positions □ Other _____

PAST MEDICAL HISTORY

SPINE Surgical History:

Date:	Surgery:	Complication:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Surgical History:

Date:	Surgery:	Complication:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current or Past Illnesses:

Date:	Illness or Hospitalization
_____	_____
_____	_____
_____	_____

Celebration - MINIMALLY INVASIVE SPINE INSTITUTE

Patient Name: _____

Date: _____

Are you allergic to latex? □ Yes □ No

Medication Allergies:

_____

_____

_____

Medication and Dosage:

Medication	Strength	# of pills per day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

SOCIAL HISTORY

Age: _____

Occupation: _____

Are you? □ Single □ Married □ Divorced □ Widowed

Are you working? □ Full time □ Part time □ Disabled □ Retired □ Not working

Do you exercise? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Type of exercise/Activity? _____

Do you have children? □ Yes □ No How many? _____

Do you live alone? □ Yes □ No

Do you have lots of stairs? □ Yes □ No

Do you smoke? □ Yes □ No Packs per day_____ for _____ years

Use other nicotine products? □ Yes □ No

Which product do you use? □ Chew □ Gum □ Patch □ Cigars

□ Other_____

Have you quit smoking? □ Yes □ No How long ago? _____

Drink alcohol? □ Daily □ 1-2 x/week □ 1-2 x/month □ 1-2x/year □ Never

Celebration - MINIMALLY INVASIVE SPINE INSTITUTE

Patient Name: _____

Date: _____

Do you have a family history of:

Arthritis	□ Yes	□ No	□ Who? _____
Blood clots/excessive bleeding	□ Yes	□ No	□ Who? _____
Hypertension	□ Yes	□ No	□ Who? _____
Diabetes	□ Yes	□ No	□ Who? _____
Cancer	□ Yes	□ No	□ Who? _____
Adverse Reaction to Anesthesia	□ Yes	□ No	□ Who? _____
Mental Health Disorders	□ Yes	□ No	□ Who? _____
Cardiac Disorders	□ Yes	□ No	□ Who? _____

Other: _____

REVIEW OF SYSTEM

Are you currently or have you had problems with:

Please describe all yes answer

Skin	□ Yes □ No	_____
Ears, Nose, Throat	□ Yes □ No	_____
Cardiac/High blood pressure	□ Yes □ No	_____
Lungs, (Asthmas, Infection)	□ Yes □ No	_____
Stomach/Digestion	□ Yes □ No	_____
Bladder/ Bowel Movement	□ Yes □ No	_____
Hematologic/ Bleeding problems	□ Yes □ No	_____
Diabetes	□ Yes □ No	_____
Cancer	□ Yes □ No	_____
Musculoskeletal	□ Yes □ No	_____
Neurological	□ Yes □ No	_____
Psychiatric problems	□ Yes □ No	_____
Reproductive/Sexual problems	□ Yes □ No	_____
Fever/Chills	□ Yes □ No	_____
Night Sweat	□ Yes □ No	_____
Night pain	□ Yes □ No	_____
Unexpected Weight loss	□ Yes □ No	_____

Patient Signature: _____ Date: _____

Print Patient Name: _____

Electronic Physician Signature On File

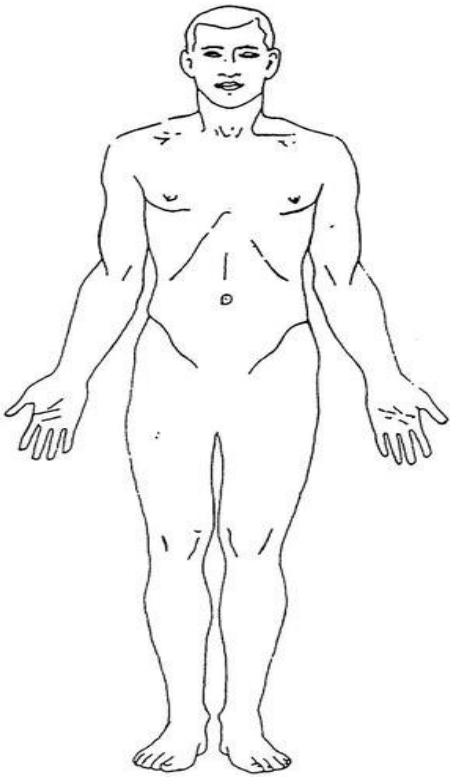
Celebration - MINIMALLY INVASIVE SPINE INSTITUTE

Patient Name: _____

Date: _____

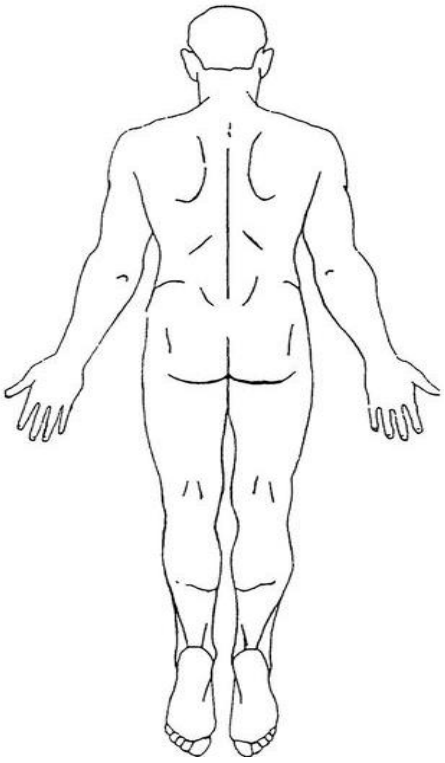
Spine Surgery New Patient Questionnaire

WHERE IS YOUR PAIN NOW?



Leg Pain		%
Arm Pain		%
Neck Pain		%
Back Pain		%
Total		%

Please indicate in the above table the percentage of pain that you currently feel in your legs, arms, neck and back.

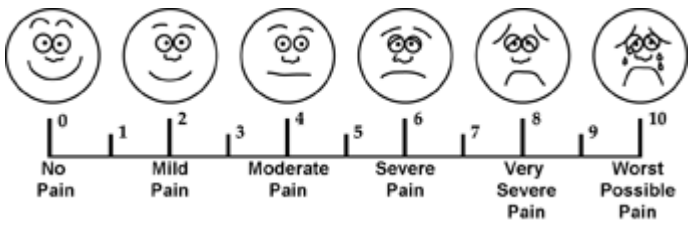


Use the body diagrams to show where you feel the following sensations.

Ache	Numbness	Burning	Stabbing
AAA	000	XXX	///
AAA	000	XXX	///
AAA	000	XXX	///

Grade your overall Pain

Please place an X *on the hash mark* that most accurately describes your overall degree of pain now.



_____

CELEBRATION MINIMALLY INVASIVE SPINE INSTITUTE

Patient Name: _____ Date: _____

Could you please complete this questionnaire? It is designed to give us information as to how your spine trouble has affected your ability to manage everyday life. Please answer every section.

Mark one box only in each section that most closely describes you today.

I have "Chronic Pain" or pain or pain that has bothered me for 3 months or more:

□ Yes □ No

Check one of the following:

□ Prior to Surgery □ After Surgery 3 Months □ After Surgery 1 Year

□ After Surgery 6 Weeks □ After surgery 6 Months □ After Surgery 2 Years

Section 1: Pain Intensity 0 □ I have no pain at the moment. 1 □ The pain is very mild at the moment. 2 □ The pain is moderate at the moment. 3 □ The pain is fairly severe at the moment. 4 □ The pain is very severe at the moment. 5 □ The pain is the worst imaginable at the moment.	**Section 6: Standing** 0 □ I can stand as long as I want without extra pain. 1 □ I can stand as long as I want but it gives me extra pain 2 □ Pain prevents me from standing for more than 1 hour. 3 □ Pain prevents me from standing for more than half an hour. 4 □ Pain prevents me from standing for more than 10 minutes. 5 □ Pain prevents me from standing at all
Section 2. Personal Care (Washing, dressing, etc.) 0 □ I can look after myself normally without causing Extra pain. 1 □ I can look after myself normally but it is very painful. 2 □ It is painful to look after myself and I am slow and careful. 3 □ I need some help but manage most of my personal care. 4 □ I need help every day in most aspects of self-care. 5 □ I do not get dressed, wash with difficulty and stay in bed.	**Section 7: Sleeping** 0 □ My sleep is never disturbed by pain. 1 □ My sleep is occasionally disturbed by pain. 2 □ Because of pain I have less than 6 hours' sleep. 3 □ Because of pain I have less than 4 hours' sleep. 4 □ Because of pain I have less than 2 hours' sleep. 5 □ Pain prevents me from sleeping at all.
Section 3. Lifting 0 □ I can lift heavy weights without extra pain. 1 □ I can lift heavy weights but it gives extra pain. 2 □ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on the table. 3 □ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently placed. 4 □ I can lift only very light weights. 5 □ I cannot lift or carry anything at all.	**Section 8: Sex Life** 0 □ My sex life is normal and causes me no extra pain. 1 □ My sex life is normal but increases the degree of pain. 2 □ My sex life is nearly normal but is very painful. 3 □ My sex life is severely restricted by pain. 4 □ My sex life is nearly absent due to pain. 5 □ Pain prevents any sex life at all.
Section 4: Walking 0 □ Pain does not prevent me from walking any distance. 1 □ Pain prevents me from walking more than 1 mile. 2 □ Pain prevents me from walking more than a quarter of a mile. 3 □ Pain prevents me walking more than a 100 yards. 4 □ I can only walk using a stick or crutches. 5 □ I am bed most of the time and have to crawl to the toilet	**Section 9: Social Life** 0 □ My social life is normal and causes me no extra pain. 1 □ My social life is normal but increase the pain 2 □ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sports, etc. 3 □ Pain has restricted my social life and I do not go out as often. 4 □ Pain has restricted social life to my home. 5 □ I have no social life because of pain.
Section 5: Sitting 0 □ I can sit in any chair as long as I like. 1 □ I can sit in my favorite chair as long as I like. 2 □ Pain prevents me from sitting for more than 1 hour. 3 □ Pain prevents me from sitting for more than half an hour. 4 □ Pain prevents me from sitting for more than 10 minutes. 5 □ Pain prevents me from sitting at all.	**Section 10: Traveling** 0 □ I can travel anywhere without pain. 1 □ I can travel anywhere but it gives extra pain. 2 □ Pain is bad but I manage to journeys over 2 hours. 3 □ Pain restricts me to journeys more than 1 hour. 4 □ Pain restricts me to short necessary journeys less than 30 minutes. 5 □ Pain prevents me from traveling except to receive treatment.

CELEBRATION MINIMALLY INVASIVE SPINE INSTITUTE

TO BE COMPLETED BY THE PATIENT

Visit Date _____

1. In general, would you say your health is:
□ Excellent □ Very good □ Good □ Fair □ Poor

2. Compared to one year ago, how would you rate your health in general now?
□ Much better than 1 year ago □ Somewhat better now than 1 year ago
□ About the same as 1 year ago □ Somewhat worse now than 1 year ago
□ Much worse than 1 year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

1. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

3. Lifting or carrying groceries
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

4. Climbing several flights of stairs
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

5. Climbing one flight of stairs
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

6. Bending, kneeling, or stooping
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

7. Walking more than a mile
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

8. Walking several hundred yards
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

9. Walking one hundred yards
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

10. Bathing or dressing yourself
□ Yes, limited a lot □ Yes, limited a little □ No, not limited at all

CELEBRATION MINIMALLY INVASIVE SPINE INSTITUTE

TO BE COMPLETED BY THE PATIENT

(Continued)

4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

a. Cut down on the amount of time you spent on work or other activities
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

b. Accomplished less than you would like
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

c. Were limited in the kind of work or other activities
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

d. Had difficulty performing the work or other activities (for example, it took extra effort)
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

5. During the past 4 weeks how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

a. Cut down on the amount of time you spent on work or other activities
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

b. Accomplished less than you would like
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

c. Did work or other activities less carefully than usual
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

6. During the past 4 weeks to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?
□ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

7. How much bodily pain have you had during the past 4 weeks?
□ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

8. During the past 4 weeks how much did pain interfere with your normal work (including both work outside the home and housework)?
□ Not at all □ Slightly □ Moderately □ Quite a bit □ Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks….

a. Did you feel full of life?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

b. Have you been very nervous?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

c. Have you felt so down in the dumps that nothing could cheer you up?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

TO BE COMPLETED BY THE PATIENT

(Continued)

d. Have you felt calm and peaceful?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

e. Did you have a lot of energy?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

f. Have you felt downhearted and depressed?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

g. Did you feel worn out?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

h. Have you been happy?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

i. Did you feel tired?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

10. During the <u>past 4 weeks</u>, how much time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?
□ All of the time □ Most of the time □ Some of the time □ A little of the time □ None of the time

11. How TRUE or FALSE is <u>each</u> of the following statements for you?

a. I seem to get sick a little easier than other people
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

b. I am as healthy as anybody I know.
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

c. I expect my health to get worse.
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

d. My health is excellent.
□ Definitely true □ Mostly true □ Don't know □ Mostly false □ Definitely false

Patient Initials: _____

RELEASE OF MEDICAL RECORDS

DATE: _____

TO: Dr. Faissal Zahrawi M.D.
400 Celebration place Ste. A280
Celebration, Florida 34747
Phone # 407-566-4411
Fax # 407-566-4416

I hereby request that my medical records be sent to:

_____ _____
Physicians Name Fax Number

_____
Address

_____
City State Zip

_____
Patient's Name (print) Date of Birth

_____
Address

_____
City State Zip

SS# _____

Patient's Signature _____