

NEUROSURGERY
Robert H. Bradley, M.D.
F. Donovan Kendrick, M.D.



ADMINISTRATION
Liz A. Taylor

PHYSICIAN ASSISTANTS
Amy D. Rapp, PA-C
Heather L. Beck, PA-C

PHYSICAL MEDICINE
& REHABILITATION
Jeffry G. Pirofsky, D.O.

PHYSICIAN SERVICES
Kristin A. Paluch

Parker Pavilion 2065 East South Boulevard, Suite 204 Montgomery, Alabama 36116-2463
Phone: 334-281-6990 Fax: 334-281-9725 Toll Free: 866-223-5533 www.alneurospine.com

PATIENT INFORMATION FORM

Name _____
Last First Middle
Birth Date _____ Age _____ Sex _____ Marital Status _____ S.S. Number _____
Address _____ City, ST Zip _____
Home Telephone _____ Email Address _____
Employer _____ Business Telephone _____ Ext _____
Address _____ City _____ State _____ Zip _____
Pharmacy Name _____ Pharmacy Phone Number _____
Contact Person Not Living With You _____ Telephone () _____
Referring Physician _____ Family Doctor _____
Name/Address
Have you ever been treated by John K. Peden, M.D.; Robert H. Bradley, M.D.; or F. Donovan Kendrick, M.D.? _____ When? _____

INSURANCE INFORMATION

Name of Company _____ Name of Insured _____ Birth Date _____
Contract Number _____ Group Number _____ Spouse DOB _____

I request that payment of authorized MEDICARE benefits be made on my behalf to Neurosurgery & Spine Associates of Central Alabama, P.C., for any services or items furnished to me by that supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

If Worker's Compensation/Name of Carrier _____
Name/Address
Telephone () _____ Contact Person _____

No Insurance (Self Pay)

I authorize the release of any medical information necessary to process any claim attached with this authorization. I hereby understand that I am financially responsible to the physician for charges. I request that insurance payments be made directly to Neurosurgery & Spine Associates of Central Alabama, P.C.

Signed _____ Date Signed _____

NEUROSURGERY & SPINE ASSOCIATES OF CENTRAL ALABAMA, P.C.

Physical Medicine & Rehabilitation
Parker Pavilion
2065 East South Blvd., Suite 204
Montgomery, AL 36116-2463

MEDICAL RELEASE FORM

Effective April 14, 2003 (due to federal guidelines under HIPAA) we are now required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please list below the names, relationship, and phone numbers of any authorized individuals (spouse, family members, friends, caregivers, etc.) that we may discuss your medical or financial information with.

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>PHONE NUMBER</u>
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

May we leave medical information on your "home" answering machine?

Yes _____ No _____ Phone Number: _____

Patient Name: _____ Date of Birth: _____

Signature of Patient/Parent _____ Date: _____

OR

If you do not want any of your medical or financial information discussed with anyone other than yourself, please sign here.

Patient Name: _____ Date of Birth: _____

Signature of Patient/Parent _____ Date: _____

The above information is private and confidential and will be placed in your medical chart.
The information on this form will remain valid until we are notified otherwise.

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Date of Appointment: ___/___/___

Chart # _____

NAME _____

Referring Physician _____

SOCIAL SECURITY # _____

City, State _____

DATE OF BIRTH _____ AGE _____

Family Physician _____

OCCUPATION _____

Other Physicians _____

MEDICAL HISTORY/CONSULTATION

CURRENT PROBLEMS

1. What is your main symptom? _____
2. When did it begin? _____
3. Is this problem related to your job? No Yes Describe if other than injury _____
4. Is your current problem related to an accident? No Yes If so, please describe it in detail (date, place, cause, injuries received, ER visits). Use the back of this page if needed. _____

5. Were any of your symptoms present before your accident? No Yes Which ones? _____
6. What other symptoms do you have and when did they begin? _____

7. What test (electrical studies, x-rays, MRI, CT scan, myelogram, bone scan) have you had for these problems? (may circle) Other _____

8. Have you had physical therapy for this problem? No Yes Same Better Worse after
9. Have you had any spine injections for this problem? No Yes
If so, what type (trigger point, epidural, nerve root blocks)
when? _____ What Physician? _____ Same Better Worse after
10. What other treatments have you had for this problem? Circle: (bed rest, chiropractor, massage, TENS unit, home traction, ice, heat, ointments) Other: _____
11. What medications are you currently taking for this problem? _____
12. Is your problem getting better, worse, or is it unchanged? _____
13. Have you had any other accidents or injuries that contributed to this problem? No Yes Describe _____
14. Are you working currently? No Yes Usual Position Light Duty
15. What dates have you missed from work because of this problem? _____
16. Have you hired an attorney regarding this problem? No Yes N/A

Neurosurgery & Spine Associates of Central Alabama, P.C.

PATIENT HISTORY SHEET

Patient: _____

DOB: _____

For patients with pain: please circle any of the following that describe your symptoms.

Location – Head, Face, Neck, Back (upper, middle, lower), Arm, Leg, left, right, both, Other _____

Quality – Sharp, Dull, Throbbing, Stabbing, Burning, Constant, Intermittent

Severity – Mild, Moderate, Severe, Varies

Timing – At night, awakens from sleep, with activity, when awakening in the morning

Circle any of the following that make your symptoms **WORSE**: Sitting, Standing, Walking, Twisting, Bending, Lifting, Work, Cough, Sneeze, Strain, Other _____

Circle any of the following that make your symptoms **BETTER**: Sitting, Lying Down, Standing, Medication, Ice, Heat, Other _____

SYSTEM REVIEW: Please check any of the following symptoms that you have experienced in the past six months, or check none at the end of each category.

<p>GENERAL</p> <input type="checkbox"/> Weakness <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> NONE <p>SKIN</p> <input type="checkbox"/> Rash <input type="checkbox"/> Cancer <input type="checkbox"/> Itching <input type="checkbox"/> NONE <p>HEAD</p> <input type="checkbox"/> Headache <input type="checkbox"/> Trauma <input type="checkbox"/> Dizziness <input type="checkbox"/> Vertigo <input type="checkbox"/> NONE <p>EYES</p> <input type="checkbox"/> Double Vision <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Visual Loss <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> NONE <p>EARS</p> <input type="checkbox"/> Ringing <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Drainage <input type="checkbox"/> NONE	<p>NOSE</p> <input type="checkbox"/> Bloody Nose <input type="checkbox"/> Discharge <input type="checkbox"/> Loss of Smell <input type="checkbox"/> Facial Pain <input type="checkbox"/> NONE <p>THROAT</p> <input type="checkbox"/> Sore Throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> NONE <p>NECK</p> <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Mass <input type="checkbox"/> NONE <p>HEART</p> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Irregular Beat <input type="checkbox"/> NONE <p>EXTREMITIES</p> <p style="text-align: center;"><u>Numbness</u> <u>Weakness</u></p> <p>Arm <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R</p> <p>Leg <input type="checkbox"/> L <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> R</p> <input type="checkbox"/> Ankle Swelling <input type="checkbox"/> Blood Clot <input type="checkbox"/> Arthritis <input type="checkbox"/> Injury <input type="checkbox"/> NONE	<p>LUNGS</p> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Wheezing/Asthma <input type="checkbox"/> Frequent Cough <input type="checkbox"/> COPD/Emphysema <input type="checkbox"/> NONE <p>GI</p> <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Reflux <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood in Stool <input type="checkbox"/> Loss of Bowel Control <input type="checkbox"/> NONE <p>GU</p> <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Loss of Bladder Control <input type="checkbox"/> Blood in Urine <input type="checkbox"/> NONE <p>BACK</p> <input type="checkbox"/> Pain <input type="checkbox"/> Stiffness <p>BREAST</p> <input type="checkbox"/> Masses <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> NONE	<p>NEURO/PSYCH</p> <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Weakness <input type="checkbox"/> Tingling <input type="checkbox"/> Seizures <input type="checkbox"/> Balance Problems <input type="checkbox"/> Frequent Falls <input type="checkbox"/> Coordination Problems <input type="checkbox"/> Difficulty Concentrating <input type="checkbox"/> Poor Memory <input type="checkbox"/> Excess Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Difficulty Speaking <input type="checkbox"/> NONE <p>BLOOD</p> <input type="checkbox"/> Anemia <input type="checkbox"/> Easy Bleeding <input type="checkbox"/> On Blood thinner <input type="checkbox"/> NONE <p>ENDOCRINE</p> <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Heat/Cold Intolerance <input type="checkbox"/> NONE
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NEUROSURGERY & SPINE USE ONLY: Reviewed by _____ Date _____

Neurosurgery & Spine Associates of Central Alabama, P.C.

PATIENT HISTORY SHEET

Patient: _____

DOB: _____

PAST MEDICAL HISTORY: Please check any of the following problems that you have experienced in the past or now

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> TIA |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lupus | <input type="checkbox"/> Ulcer Disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mental Problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy (Seizure) | <input type="checkbox"/> Osteoporosis | _____ |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> None of These |

SURGICAL HISTORY:

Have you had previous neck or lower back surgery? ___NO ___YES Surgeon _____ When _____
 What other operations have you had? _____

Any problems with anesthesia? ___NO ___YES Describe _____
 Have you had any other accidents or injuries in the past? ___NO ___YES Describe _____

MEDICATIONS: Please list all of your current medications and dosages. NONE
 Please include all over-the-counter medications such as Advil, Tylenol, herbal, vitamin, and weight-loss supplements.

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

ALLERGIES: Please list all medication or dye allergies and your reaction to each. NO KNOWN ALLERGIES

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

FAMILY HISTORY: Please check any of the following diseases affecting your blood relatives.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lupus | <input type="checkbox"/> None of These |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mental Problems | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy (Seizure) | <input type="checkbox"/> Muscular Dystrophy | |

Are there any other problems that seem to run in your family? _____

SOCIAL HISTORY:

Last grade completed in school ___ 1-8 ___ 9-12 ___ College ___ Post graduate Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Use of Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Moderate <input type="checkbox"/> Daily – Amount/Type _____ Use of Tobacco: <input type="checkbox"/> Never <input type="checkbox"/> Previously, but quit <input type="checkbox"/> Currently ___packs/day How long ___years Recreational Drugs: <input type="checkbox"/> Never <input type="checkbox"/> Yes Type/Frequency _____	Have you applied for or are you on Social Security Disability <input type="checkbox"/> Yes <input type="checkbox"/> No
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VOCATIONAL HISTORY:

<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled <input type="checkbox"/> Work Full-time <input type="checkbox"/> Work Part-time
Employer _____ How long? _____
Usual job duties _____
Type: <input type="checkbox"/> Heavy Labor (up to 100lbs.) <input type="checkbox"/> Medium (up to 50lbs.) <input type="checkbox"/> Light (up to 20lbs.) <input type="checkbox"/> Sedentary (up to 10lbs.)
Last date you worked ___ / ___ / ___

NEUROSURGERY & SPINE USE ONLY: Reviewed by _____ Date _____