FLORIDA HOSPITAL
NEUROSCIENCE INSTITUTE

Florida Hospital Orlando Spine Center Client Intake Form

Today's Date_____

Last Name _____ First Name_____ Middle_____

Street Address_____ DOB_____
(Address, City, State, Zip Code)

First Contact # _____ Please Circle: Home Cell Other

Second Contact #_____ Please Circle: Home Cell Other

Social Security # _____ Email Address: _____

Spouse's Name _____ Spouse's Contact # _____

Nearest Friend or Relative (Name and Phone #)_____

Primary Care Physician (Name and Phone #)_____

Specialty Physician (Name, Phone # and Specialty)_____

Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Declined

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Do Not Wish to Disclose

Primary Insurance Company_____ Phone #_____

Insurance Company Address_____

Insured Person's Name_____

Insured Person's Social Security #_____ Insured Person's DOB_____

Relationship to Insured Person_____ Group #_____

Policy/ID #_____ Copayment Amount_____

Secondary Insurance Company_____ Phone #_____

Insurance Company Address_____

Insured Person's Name_____

Insured Person's Social Security #_____ Insured Person's DOB_____

Relationship to Insured Person_____ Group #_____

Policy/ID #_____ Copayment Amount_____

Is this an injury related to an auto/vehicular accident? Yes No

Is this an injury related to a Worker's Compensation case? Yes No

Florida Hospital Orlando Spine Center Patient

Symptoms: Please place a check next to the symptoms you have had in the past 6 months

Constitutional		***Ears, Nose and Throat***	
Fatigue		Recent Head Injury	
Body Aches		Thyroid Mass	
Fever		Vertigo	
Weight Loss		Sinus Pain	
Chills		Sore Throat	
Loss of Appetite		Nasal Congestion	
Eyes		***Cardiovascular***	
Eye Pain		Chest Pain	
Blurred Vision		Syncope	
Floaters		Lightheadedness	
Visual Hallucinations		Irregular Heart Beats	
Double Vision		Lower Extremity Edema	
Peripheral Vision Changes		Orthostatic Symptoms	
Sudden Vision Loss		Rapid Heart Rate	
Changes in Vision		Claudication	
Transient Visual Loss		***Respiratory***	
Integument		Shortness of Breath	
Rash		Hoarseness	
Itching		Wheezing	
Hair Growth Change		Cough	
Gastrointestinal		***Genitourinary***	
Nausea		Urgency	
Constipation		Urinary Retention	
Heartburn		Impotence	
Vomiting		Frequency	
Loss of Appetite		Difficulty Voiding	
Diarrhea		Possible Pregnancy	
Difficult Swallowing		Incontinence	
Abdominal Pain		Skipped Menstrual Cycle	
Endocrine		***Psychiatric***	
Loss of Hair		Anxiety	
Heat Intolerance		Feeling Confused	
Constipation		Depression	
Decreased Libido		Excessive Anger	
Increased Libido		***Heme-Lymph***	
Cold Intolerance		Easy Bleeding	
Nipple Discharge		Lymph Node Enlargement	
Neurologic		***Musculoskeletal***	
Muscular Weakness		Joint Pain	
Difficulty Concentrating		Limitation of Motion	
Seizures		Back Pain	
Falls		Joint Swelling	
Incoordination		Muscular Weakness	
Memory Difficulties		Muscle Pain	
Tremors		Muscle Cramps	
Head Injuries		Neck Pain	
Tingling or numbness		***Other***	
Speech Difficulties		Difficulty Sleeping	
Loss of Balance			

Please explain any current symptoms not listed above :_____

_____

_____

_____

Do you have pain? Yes No

If yes, where is your pain located?_____

Does it radiate? Yes No

If yes, where?_____

Describe your pain: _____

_____

	Please Circle One		
Are you Right Handed or Left Handed?	Right	Left	Ambidextrous
Are you pregnant?	Yes	No	
Could you be pregnant?	Yes	No	

Current Height: _____ Current Weight: _____

Past Medical History: (Please check all applicable boxes)

Anemia, Iron Deficiency		Hyperthyroidism	
Angina (Ischemic Chest Pain)		Hypothyroidism	
Arthritis		Increased Cholesterol	
Arthritis		Irritable Bowel Syndrome	
Asthma		Murmurs	
Bleeding Disorders		Peripheral Neuropathy	
Brain Mass: Intracranial Mass		Peripheral Vascular Disease	
Cardiovascular Disease		Seizures	
Congestive Heart Failure		Stroke	
COPD		Ulcers	
Diabetes		Fibromyalgia	
Gastric Reflux		Gout	
High Blood Pressure		Cancer (Please list details)	

Please explain all boxes checked above:

_____

_____

_____

Past Surgical History : (Please Complete All Applicable Boxes)

Past Tests/Treatments	Yes/No	Date	Facility or Physician
Physical Therapy			
Chiropractic Treatment			
EMG/Nerve Conduction			
Traction			
Epidural Injections			
Facet blocks			
Facet Rhizotomies			
Trigger Point Injections			

Have you taken any NSAIDs (Non steroidal anti inflammatory medications like Advil, Aleve, Tylenol, etc.)? If so, please list:

_____

_____

Please list all surgeries and major hospitalizations: (Date/Procedure)
If none, please check ☐

_____

_____

_____

If spine related, have you seen a spine specialist in the past? Yes No

If yes, physician name?_____ Phone No. _____

Have you seen a pain management doctor? Yes No

If yes, physician name?_____ Phone No. _____

Medications: List Name, Strength, and how often taken
☐ If None, please check.

Medication/Prescription Over the Counter	Dose	Frequency # Times/Day	Reason/Condition Treated	Prescribing Doctor	Current or Previous

****Attach list if you need additional space**

Family Medical History
Please list and explain any family illness(es)?

_____

_____

_____

Past Scans/Tests

		Date			Date
X-Rays			PET Scan		
MRI			CT Scan		
Sonogram			Nerve Tests		
Angiogram			Myelogram		
Fluid Analysis			Cisternogram		
Bone Scan			Laboratory Tests		
Vestibular Testing					

Date of Most Recent Scan _____ Facility: _____

Do you have CD/Films? Yes No

Social History
Do you smoke? Yes No

If so, how long have you smoked? _____

How much do you smoke and how often? _____

If you quit smoking, when did you quit?_____

Do you drink alcohol? Never On Occasion Moderately

Do you drink caffeinated beverages? Yes No Frequency: Daily Weekly Monthly