Winter Park Spine & Injury, *5502 Lake Howell Rd., W.P., 32792*

Non-Surgical Spinal Decompression (NSSD) Patient Information Form (Please Print)

This is an application to Dr. Roffler's Core Pain Relief Program; this is NOT a guarantee of acceptance. Dr. Roffler will be assessing your case and analyzing it for 5 criteria which he will review with you. This Program is only for patients with severe or chronic back or neck pain, herniated discs, bulging discs, stenosis, and sciatica. Dr. Roffler ONLY works with patients who are tired of, or who don't want to take medications, those who want an alternative to dangerous injections or invasive surgeries.

Name_____ Today's date _____
Last First Middle Initial

Street or Mailing Address:_____ Apt#_____

City:_____ State:_____ Zip:_____ SS#_____

Phones: H: (____)_____ W:(____)_____ Ext:_____ Cell:(____)_____ Email:_____

Age:_____ Birth Date:_____ M F Marital: Married Single Widowed Divorced Number of children: _____

Your Employer:_____ Occupation:_____

Type of work activities: _____

Spouse's Name:_____ Spouse's work phone :(____)_____ Ext._____

Spouse's Employer:_____ Spouse's Occupation: _____

Patient's Nearest Relative (other than spouse):_____ Relation:_____

Address:_____ Phone: ( )_____

How did you hear about Winter Park Spine & Injury and or Dr. Roffler? _____

FEMALE: Are you pregnant? YES / NO

I consent to allow Dr. Roffler to speak with me and perform an examination & x-rays (if necessary) in order to determine if I am a good candidate for non-surgical spinal decompression and also to determine if he is willing to accept my case.

(Signature)_____ (Date) _____

In a reference to the severity how would you rate your pain on a scale of 1 – 10 (With 10 most severe)_____.

On a scale of 1 – 10, how committed are you to getting rid of your pain? (With 10 most committed)_____.

How do you view your Problem (circle one)….

MINIMAL (Annoying but causing NO limitation)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitation)
SEVERE (Causing significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

What percentage of time are you aware of your main problem?

OCCASIONALLY	(25% of the time)
INTERMITTENTLY	(50% of the time)
FREQUENTLY	(75% of the time)
CONSTANT	(90 – 100% of the time)

1. What is your main reason/primary symptom prompting your request for a consultation with Dr. Roffler? _____

2. What are you hoping happens today as a result of the Dr. Roffler spending time with you? _____

3. Since your Primary symptom became this severe what three things has it caused you to miss the most? _____

4. What changes/modifications have you had to make and how has your lifestyle changed since your back/neck problems? _____

5. What actions or activities do you have troubles with or have limitations in? _____

6. Mechanism of Trauma (how did initial injury occur) _____

7. Location/Radiation (down leg/arm): _____

8. Duration: Sudden / Gradual / Insidious (circle one) Onset (date)_____ Length of time you have had it? _____

9. Quality: Aching/ Burning/ Cramping/ Tingling/ Dull/ Numbness/ Sharp/ Stabbing/ Shooting/ Squeezing/ Tearing/ Throbbing/ Spasm/ Can't Describe / Other (please circle) _____

10. Have you received any of the following treatments?

Surgeries (back/neck) How Many _____ Approx. Date _____

Injections: How Many _____ Approx. Date _____ How Long _____

Drugs/Pharmaceuticals: How Many _____ Approx. Date _____ How Long _____

Physical Therapy: # Times_____ Approx Date_____ How Long _____

11. Did any of these treatments seem to work in helping your pain? If so which one(s) and for how long? _____

_____

12. Have you had (please circle)? MRI's, C/T Scan's, or NCV's, approximate date_____ and the results: _____

_____

13. What actions can you take that temporarily decrease the pain? _____

14. What activities/movements increase/worsen your condition? _____

15. Is it worse in the morning or the evening? _____

16. What do you think will happen to you if you cannot find a solution to your pain/problem? _____

_____

17. What are you hoping Dr. Roffler will tell you today? _____

18. Describe what will be different in your life if you can get better? _____

List in Order of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above:

1. _____ How Long? _____

2. _____ How Long? _____

Due to your Main Problem:

Have you lost time from work? YES / NO How much time and what have you been unable to perform? _____

Have you lost time from your obligations at home? YES / NO How much time and what tasks have been limited? _____

Have you lost any time from the family? YES / NO How much time and if so what? _____

Have you lost any time from enjoying your Leisure activities (Hobbies, Travel, Sports, etc.)? YES / NO How much time and which activities?

_____

On a Scale of 0 – 10 (10 being unbearable, 0 being No Pain) Please rate the following:

The HIGHEST your pain gets WITHOUT medication _____ The LOWEST your pain gets WITHOUT medication _____

The HIGHTEST your pain gets WITH medication _____ The LOWEST your pain gets WITH medication _____

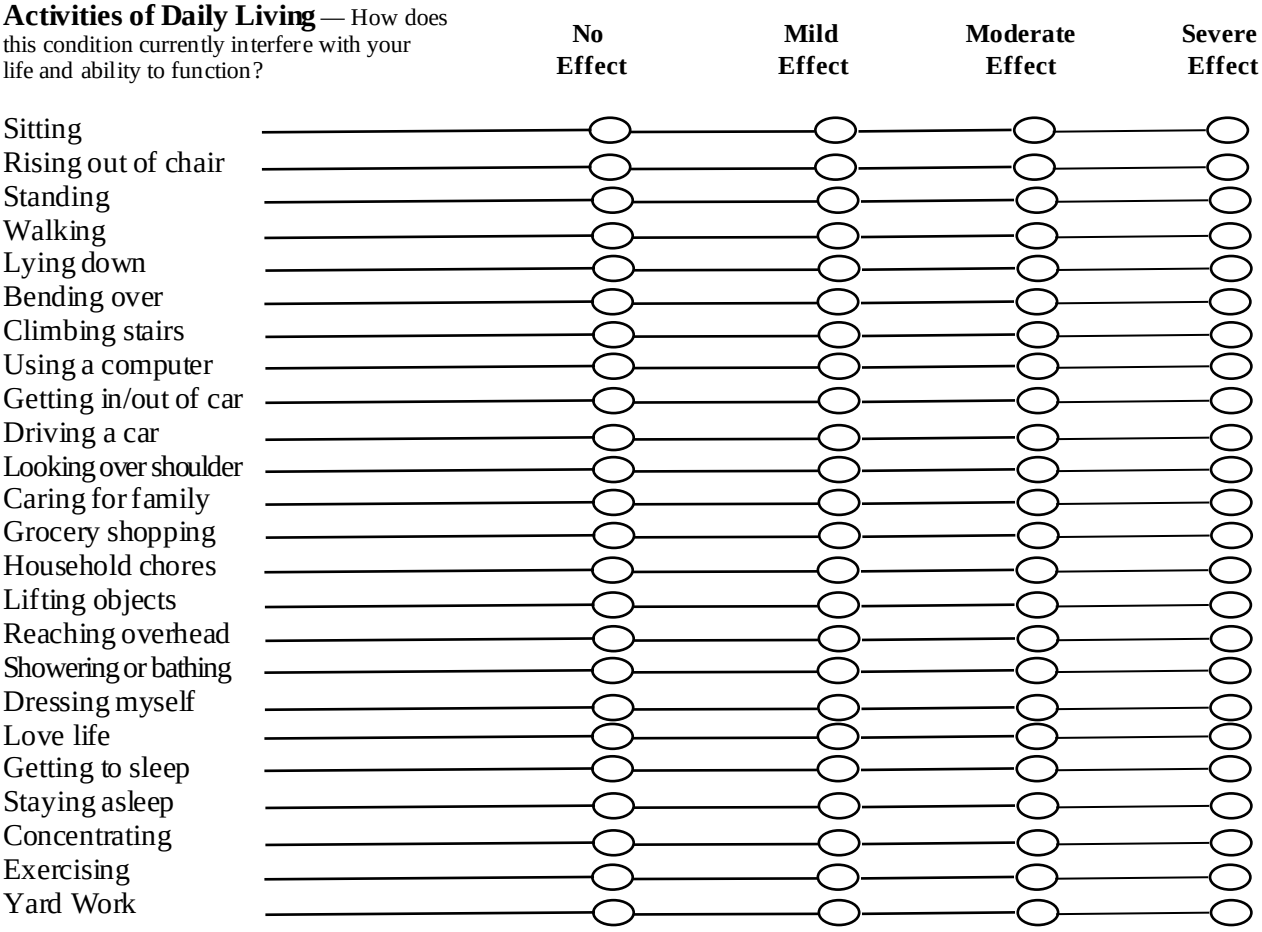
IS THERE ANYTHING ELSE YOU WANT Dr. Roffler to know about your condition? _____

_____

_____

_____

Activities of Daily Living — How does this condition currently interfere with your life and ability to function?



Initial Each	
_____	If I am a candidate for Non-surgical spinal decompression, I instruct Dr. Roffler to deliver the care that, in his professional judgement, can best help me in the restoration of my health condition.
_____	I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.
_____	I understand that all services are due and payable at the time of service, unless other arrangements have been made.
_____	To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my heath concern(s).

_____ _____ _____

Patient (or Guardian) Signature Date (MM/DD/YYYY) Doctor Initial

DOCTOR COMMENTS ONLY

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