

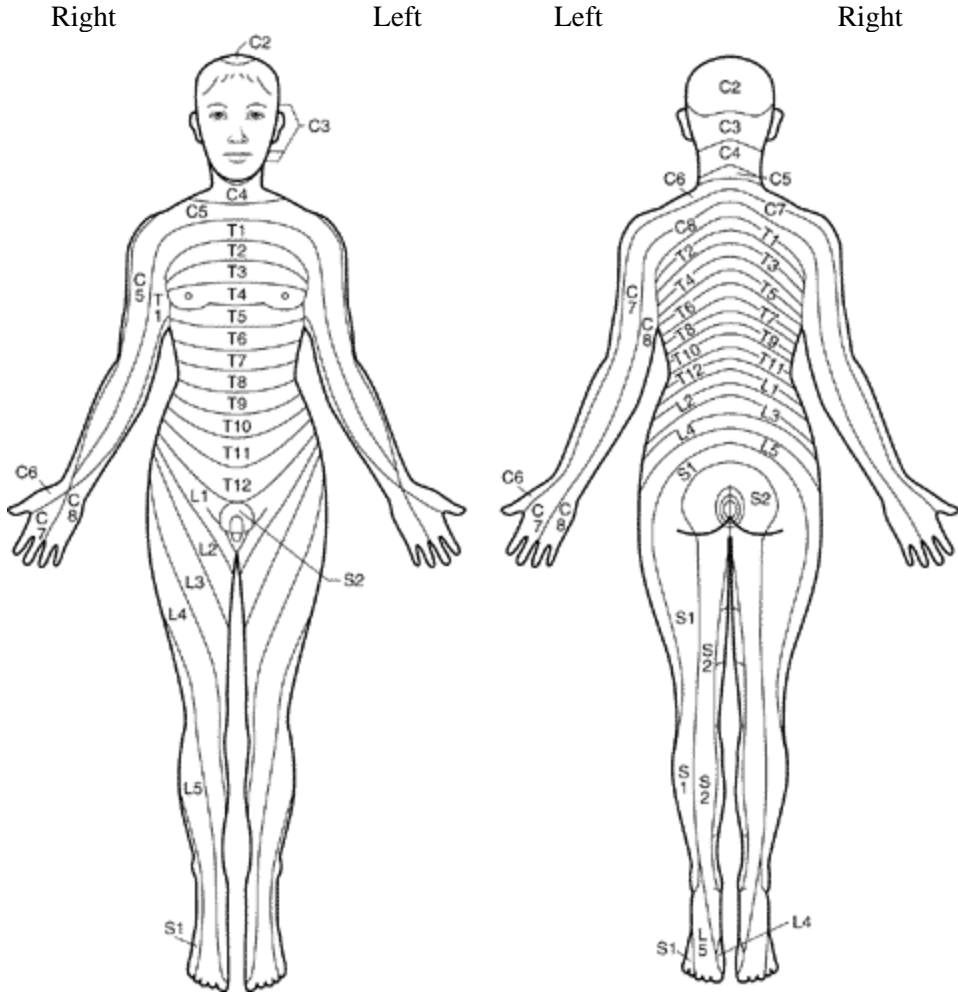
FLORIDA ORTHOPAEDIC INSTITUTE

Steven A. Barna, MD Interventional Spine New Patient Intake Form

Name _____
Primary Care M.D. _____

Date _____
Referring Provider _____

1) Pain Location



2) Onset

- a) when started _____
- b) how started, initiating trauma, motor vehicle accident etc _____

3) Intensity (put a cross where your pain level is)

- a) Now 0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10
no pain worst pain imaginable
- b) average
0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10
- c) at the best
0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10
no pain worst pain imaginable
- d) worst pain
0 ___ 1- ___ 2- ___ 3- ___ 4- ___ 5- ___ 6- ___ 7- ___ 8- ___ 9- ___ 10

4) Description of pain (circle)
aching throbbing sharp burning dull
pins and needles shooting stabbing pressure sore discomfort
cramping electric shocks

5) Weakness (circle) yes no

6) Numbness (circle) yes no

7) Bladder or bowel changes – incontinence (circle) yes no

8) What makes pain worse _____

9) What makes pain better _____

10) Interference with activities of daily life (no interference 0 -- max interference 10)

a) sleep _____

b) activity _____

c) work _____

d) mood _____

e) interaction with family, friends, co-workers _____

11) Previous treatments and did they help?

a) Physical therapy _____

b) Chiropractic _____

c) Massage _____

d) Acupuncture _____

e) Heat/Cold _____

f)

Pain Medication	Dose	Duration	Side Effects	Benefit
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1) _____

2) _____

3) _____

4) _____

5) _____

g) Procedures (epidural, facet, etc) _____

h) TENS

i) Psychologist (including biofeedback, cognitive therapy) _____

12) Surgical evaluation (orthopedic/ neurosurgeon) yes no

13) Neurologist yes no

14) Diagnostic radiological (x-ray, MRI) yes no

Where done _____

Past Medical History

Past Surgical History

Allergies and Effects

Do you take any antibiotics for medical/dental procedures?

Yes

No

Dr. Barna's Policies and Procedures

The mission of the Florida Orthopaedic Institute is to provide high quality, safe, and accessible care. The aim is to decrease pain and increase function through consultation, coordination of care, and diagnostic and therapeutic interventions.

The purpose of this form is to give patients information to assist in the success of their treatment and outline expectations:

1. Please set up appointments for visits in advance. Due to the physician's full schedule, he/she may not be able to see walk-ins.
2. Please call at least 48 hours in advance if you cannot keep your scheduled appointment.
3. Please understand that chronic pain is different from acute pain. There is not always "immediate" relief from chronic pain. It may require several treatments to provide adequate pain relief.
4. This clinic does not write prescriptions for opioids (narcotics). If opioid pain medication is clearly indicated, the physician will make appropriate recommendations to your referring physician.
5. Please comply with all treatment plans set up for you by your physician. Pain management is multidisciplinary and pain relief is often due to a combination of treatments.
6. Emergency—Please go to the emergency room if you are unable to contact your doctor here or your primary care physician.

I have read and understand the above policies.

Please sign: _____

Date: _____