

The Saville Spine Institute  
Dr. Phil Saville, M.D P.A.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ DOB: \_\_\_\_\_ MR# \_\_\_\_\_

Why are you here today? \_\_\_\_\_

**Review of Systems:** Please check (✓) off any symptoms you **currently** have.

<b>Constitutional</b> <input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Malaise <input type="checkbox"/> Night sweats <input type="checkbox"/> Weakness <input type="checkbox"/> Weight loss <input type="checkbox"/> Weight gain	<b>Gastrointestinal</b> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Constipation <input type="checkbox"/> Black tarry stools <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn <input type="checkbox"/> Yellowing of skin <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	<b>Psychiatric</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia	<b>Hematologic</b> <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising  <b>Metabolic</b> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Hair Loss <input type="checkbox"/> Heat intolerance	<b>Cardiovascular</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Bluing <input type="checkbox"/> Heart murmur <input type="checkbox"/> Leg swelling <input type="checkbox"/> Fainting <input type="checkbox"/> Irregular heart beat/ Palpitations
<b>HEENT</b> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Ear drainage <input type="checkbox"/> Headache <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Vertigo <input type="checkbox"/> Vision loss	<b>Genitourinary</b> <input type="checkbox"/> Painful urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Blood in urine <input type="checkbox"/> Urge incontinence <input type="checkbox"/> Urinary incontinence	<b>Integumentary</b> <input type="checkbox"/> Contact allergy <input type="checkbox"/> Itchy skin <input type="checkbox"/> Rash <input type="checkbox"/> Skin infections <input type="checkbox"/> Skin lesion	<b>Immunologic</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Contact dermatitis <input type="checkbox"/> Environmental allergies <input type="checkbox"/> Food allergies	<b>Neurological</b> <input type="checkbox"/> Difficulty walking <input type="checkbox"/> Dizziness <input type="checkbox"/> Poor coordination <input type="checkbox"/> Memory loss <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Numbness <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors
<b>Respiratory</b> <input type="checkbox"/> Chest pain (in lungs) <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Recent infection <input type="checkbox"/> Known TB Exposure <input type="checkbox"/> Wheezing	<b>Musculoskeletal</b> <input type="checkbox"/> Back pain <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Neck Pain <input type="checkbox"/>	<b>Other</b>		

0 1 2 3 4 5 6 7 8 9 10

No Pain Mild Moderate Severe Very Severe Worst Pain Possible

0 1-3 4-6 7-9 10

PLEASE INDICATE YOUR PAIN LEVEL RIGHT NOW \_\_\_\_\_

WHAT IS YOUR **WORST** PAIN LEVEL? \_\_\_\_\_

WHAT IS YOUR **BEST** PAIN LEVEL? \_\_\_\_\_

**Medications:** List all medications you are taking (prescribed and over the counter)

Medication Name	Dosage	How often?

**Allergies: List all known allergens including medications, food, and other.**

Allergen description	Severity (Mild, Moderate, Severe)	Reaction
<b>(circle):</b> Sulfites/Red Wine or Eggs, Contrast or Shellfish		

**Social History: Please complete.**

Have you <b>ever</b> used tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If you answered yes:</b> What type? _____ Daily? <input type="checkbox"/> Yes <input type="checkbox"/> No How much per day? _____ For how long? _____ Age started: _____ Age stopped: _____ (if applicable)
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If you answered yes:</b> What type? _____ How often? _____ How much? _____ When was your last drink? _____
Do you drink/consume caffeine? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If you answered yes:</b> What type? _____ How much? _____

**Medical History: Please check (✓) off any symptoms you have or have had in the past.**

<input type="checkbox"/> Aids	<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Anemia
<input type="checkbox"/> Angina	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Chicken Pox
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> COPD	<input type="checkbox"/> Coronary artery disease
<input type="checkbox"/> Deep Vein Thrombosis (DVT)	<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes; Non-insulin dependent	<input type="checkbox"/> Diabetes – Insulin dependent	<input type="checkbox"/> Drug abuse
<input type="checkbox"/> Elevated lipids	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Gout	<input type="checkbox"/> Headache, migraine	<input type="checkbox"/> Heart attack
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Valve Disease	<input type="checkbox"/> Hepatitis, liver disease
<input type="checkbox"/> Herpes	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Inflammatory bowel disease	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lyme disease	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pace Maker
<input type="checkbox"/> Parkinson disease	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Seizure disorder/epilepsy	<input type="checkbox"/> Shingles
<input type="checkbox"/> Sleep apnea	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Vaginal Infection
<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

**Surgical History: Please list any surgical interventions and procedures you have had.**

Surgery or procedure	Description, Side, or Note	Date	Outcome

MR# \_\_\_\_\_

**Family History:** Please fill in any known health information about your relatives.

Relationship	Condition/diagnosis	Age of Onset	Was this the cause of death? (if applicable)
Mother <input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes Age? ____
Father <input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes Age? ____
Other _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes Age? ____
Other _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes Age? ____
Other _____ <input type="checkbox"/> Alive <input type="checkbox"/> Deceased			<input type="checkbox"/> Yes Age? ____

**Therapeutic History:** Please place a check (✓) by any therapy you are undergoing or have undergone for your neck and/or back complaints.

Treatment/Therapy	Description of treatment (duration of treatment, location of treatment, dose, outcome, etc.)
<input type="checkbox"/> Anti-inflammatory medications	
<input type="checkbox"/> Activity modification	
<input type="checkbox"/> Chiropractic care	
<input type="checkbox"/> Exercises	
<input type="checkbox"/> Ice/heat	
<input type="checkbox"/> Injections	
<input type="checkbox"/> Pain medications	
<input type="checkbox"/> Physical therapy	
<input type="checkbox"/> Other	

**Spinal History:** (Office Use Only)

<input type="checkbox"/> Neck pain	<input type="checkbox"/> Mid-back pain	<input type="checkbox"/> Low back pain

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omission that I may have made in the completion of these forms.

Patient Name (Print): \_\_\_\_\_ Date \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**The Saville Spine Institute  
Dr. Philip Saville, M.D. P.A  
300 Village Square Xing Ste 202  
Palm Beach Gardens, FL 33410  
561-630-3870  
561-630-3680 FAX**

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

The Saville Spine Institute will need to call you regarding your healthcare and account. By completing the information below you are giving us authorization to contact you and to leave a message or send a text reminder of your appointment.

- ☐ Home Phone: \_\_\_\_\_  
☐ Cell Phone: \_\_\_\_\_  
☐ Work Phone: \_\_\_\_\_  
☐ Email: \_\_\_\_\_  
☐ Fax: \_\_\_\_\_  
☐ Other: **By checking this box I choose to opt out of The Saville Spine Institute Email correspondences.**

I hereby authorize the continuous release of all my medical records/films/x-rays, and billing statements to the following persons. This authorization is in full force and effect unless and until revoked by me in writing. (Examples: Spouse, Children, Attorney, Employer etc.)

NAME	PHONE/FAX/EMAIL	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Who should we contact in case of an emergency?**

NAME: \_\_\_\_\_  
RELATIONSHIP: \_\_\_\_\_  
PHONE: \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE**

I acknowledge that I am entitled to the Spine Center's Privacy Notice upon my request.

**Patient Signature** \_\_\_\_\_ **Print Name** \_\_\_\_\_

**Date** \_\_\_\_\_

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DOB: \_\_\_\_\_

**CONSENT FOR THE RELEASE OF MEDICAL RECORDS**

By signing below, I agree that Philip Saville, M.D., P.A. has the right to request any and all previous medical records. I understand that my health or medical information may be used or released for purposes of treatment, payment or health care operations.

I authorize Philip Saville, M.D., P.A., to release copies of my records as necessary to process claims, obtain reimbursement or payment from an insurance company, HMO, or other third party payer or attorney. I further authorize Philip Saville, M.D., P.A., to furnish information from my medical records to other treating physicians, other medical care facilities, hospitals, home health agencies, ancillary service providers or other health care providers for my continued care and treatment. I understand that my health information and medical records may be transmitted to me, my insurers or other health care providers by telephone, regular mail, email or facsimile.

**ASSIGNMENT OF BENEFITS, INSURANCE AUTHORIZATION, AND PAYMENT**

I, the patient hereby authorize any and all of my insurance company to make medical benefit payments otherwise payable to me for services rendered by Philip Saville, M.D., P.A., but not to exceed the charges of those services payable to and mailed directly to: Philip Saville, M.D., P.A. Furthermore I hereby IRREVOCABLY ASSIGN to Philip Saville, M.D., P.A., the rights and benefits under any insurance, indemnity agreement, or any other collateral source as defined in Florida Statutes for any service and or charges provided by Philip Saville, M.D., P.A..

I direct payment of the benefits I am entitled to under the provision of my insurance policy directly to Philip Saville, M.D., P.A. I understand that I am fully responsible for any balance not paid by my insurance including co-payments, deductibles, and out of pocket network disallowments.

I agree that if my insurance company pays me for any services provided by Philip Saville, M.D., P.A.; I will forward any payments in full within 5 days of the explanation of benefits to Philip Saville, M.D., P.A. I understand that failure to forward any payments made for services rendered by Philip Saville, M.D., P.A., will be considered insurance fraud and I will be responsible for the cost to recover these payments including collection fees, attorney fees, and all legal fees involved in collecting this debt.

I understand that I am fully responsible for any balance not paid by my insurance, and I agree to pay any outstanding balance including co-payments and deductible amounts. If my account has to be referred to a collection agency or an attorney, I will pay all costs of the collection, including reasonable attorney's fees and costs.

I will also be financially responsible for any scheduled appointments not cancelled 24 hours prior to appointment time. There is a 24-hour cancellation policy for all office visits. If any appointment is not cancelled or if I fail to show, I understand that my account will be charged as follows: Follow up, New Patient, and X-Ray appointments will be charged the full fee of the visit. MRI appointments will be charged \$750.00.

**LIMITED POWER OF ATTORNEY**

I hereby appoint Philip Saville, M.D., P.A. and any of its duly authorized agents to be my agent and attorney-in-fact for the limited purpose of endorsing and depositing, for the benefit Philip Saville, M.D., P.A., any and all checks and/or paperwork received for payment of services rendered up to the amount of my bill. This appointment means that Philip Saville, M.D., P.A., or its authorized agents may deposit any and all checks or other financial instruments received from my insurer or any person as payment for my treatment services without my endorsement.

I have read and fully understand the conditions listed above with respect to the release of information, assignment of benefits, and financial responsibility. I understand that this form will remain in effect for so long as I am being treated by Philip Saville, M.D., P.A., unless it is revoked by me in writing.

Signature of Patient \_\_\_\_\_

Print Name \_\_\_\_\_

Witness signature \_\_\_\_\_

Date \_\_\_\_\_

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**Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **MR#** \_\_\_\_\_

Please answer the questions below by choosing the ONE answer that describes your typical NECK PAIN, and/or limitations within the last week or two.

**Section 1 - Pain intensity**

- ☐ I have no pain at the moment. 0
- ☐ The pain is mild at the moment. 1
- ☐ The pain is moderate at the moment. 2
- ☐ The pain is fairly severe at the moment. 3.
- ☐ The pain is very severe at the moment. 4
- ☐ The pain is the worst imaginable at the moment. 5

**Section 2 - Personal Care**

(Washing, Dressing etc.)

- ☐ I can look after myself without causing extra pain. 0
- ☐ I can look after myself normally but it causes extra pain. 1
- ☐ It is painful to look after myself and I am slow and careful. 2
- ☐ I need some help, but manage most of my personal care. 3
- ☐ I need help every day in most aspects of self-care. 4
- ☐ I cannot get dressed or wash without assistance, and am bedridden. 5

**Section 3 - Lifting**

- ☐ I can lift heavy weights without extra pain. 0
- ☐ I can lift heavy weights, but it causes extra pain. 1
- ☐ Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table. 2
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. 3
- ☐ I can lift very light weights. 4
- ☐ I cannot lift or carry anything at all. 5

**Section 4 - Reading**

- ☐ I can read as much as I want with no pain in my neck. 0
- ☐ I can read as much as I want with slight pain in my neck. 1
- ☐ I can read as much as I want with moderate pain in my neck. 2
- ☐ I cannot read as much as I want because of moderate pain in my neck. 3
- ☐ I cannot read as much as I want because of severe pain in my neck. 4
- ☐ I cannot read at all. 5

**Section 5 - Headache**

- ☐ I have no headaches at all. 0
- ☐ I have slight headaches which come infrequently. 1
- ☐ I have moderate headaches which come infrequently. 2
- ☐ I have moderate headaches which come frequently. 3
- ☐ I have severe headaches which come frequently. 4
- ☐ I have headaches almost all the time. 5

**Section 6 - Concentration**

- ☐ I can concentrate fully when I want to with no difficulty. 0
- ☐ I can concentrate fully when I want to with slight difficulty. 1
- ☐ I have a fair degree of difficulty in concentrating with I want to. 2
- ☐ I have a lot of difficulty in concentrating when I want to. 3
- ☐ I have a great deal of difficulty in concentration when I want to. 4
- ☐ I cannot concentration at all. 5

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**Section 7 - Work**

- ☐ I can do as much work as I want to. 0
- ☐ I can only do my usual work, but no more. 1
- ☐ I can do most of my usually work, but no more. 2
- ☐ I cannot do my usual work. 3
- ☐ I can hardly do any work at all. 4
- ☐ I cannot do any work at all. 5

**Section 8 - Driving**

- ☐ I can drive my car without neck pain. 0
- ☐ I can drive my care as long as I want with slight pain in my neck. 1
- ☐ I can drive my car as long as I want with moderate pain in my neck. 2
- ☐ I cannot drive my car as long as I want because of moderate pain in my neck. 3
- ☐ I can hardly drive my care at all because of severe pain in my neck. 4
- ☐ I cannot drive my car at all. 5

**Section 9 - Sleeping**

- ☐ I have no trouble sleeping. 0
- ☐ My sleep is slightly disturbed (less than 1 hour sleepless). 1
- ☐ My sleep is mildly disturbed (1-2 hours sleepless). 2
- ☐ My sleep is moderately disturbed (2-3 hours sleepless) 3
- ☐ My sleep is greatly disturbed (3-5 hours sleepless) 4
- ☐ My sleep is completely disturbed (5-7 hours sleepless). 5

**Section 10 - Recreation**

- ☐ I am able to engage in all recreational activities with no pain in my neck at all. 0
- ☐ I am able to engage in all recreational activities with some pain in my neck. 1
- ☐ I am able to engage in most, but not all recreational activities because of pain in my neck. 2
- ☐ I am able to engage in only a few of my usual recreational activities because of pain in my neck. 3
- ☐ I can hardly do any recreational activities because of pain in my neck. 4
- ☐ I cannot do any recreational activities at all. 5

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**Patient:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **MR#:** \_\_\_\_\_

Please answer the questions below by choosing the ONE answer that describes your typical LOW BACK PAIN, and/or limitations within the last week or two.

**Section 1 - Pain Intensity**

- ☐ I have no pain at the moment. 0
- ☐ The pain is very mild at the moment. 1
- ☐ The pain is moderate at the moment. 2
- ☐ The pain is fairly severe at the moment. 3
- ☐ The pain is very severe at the moment. 4
- ☐ The pain is the worst imaginable at the moment. 5

**Section 2 - Personal Care**

(Washing, Dressing etc.)

- ☐ I can look after myself normally without causing extra pain. 0
- ☐ I can look after myself normally, but it causes extra pain. 1
- ☐ It is painful to look after myself and I am slow and careful. 2
- ☐ I need some help but manage most of my personal care. 3
- ☐ I need help every day in most aspects of self-care. 4
- ☐ I cannot get dressed or wash without assistance, and am bed ridden. 5

**Section 3 – Lifting**

- ☐ I can lift heavy weights without extra pain. 0
- ☐ I can lift heavy weights but it gives extra pain. 1
- ☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). 2
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. 3
- ☐ I can lift only very light weights. 4
- ☐ I cannot lift or carry anything at all. 5

**Section 4 – Walking**

- ☐ Pain does not prevent me walking any distance. 0
- ☐ Pain prevents me walking more than 1 mile. 1
- ☐ Pain prevents me walking more than ½ of a mile. 2
- ☐ Pain prevents me walking more than 100 yards. 3
- ☐ I can only walk using a stick or crutches. 4
- ☐ I am in bed most of time and must use a wheelchair to go to the bathroom. 5

**Section 5 – Sitting**

- ☐ I can sit in any chair as long as I like. 0
- ☐ I can only sit in my favorite chair as long as I like. 1
- ☐ Pain prevents me from sitting for more than 1 hour. 2
- ☐ Pain prevents me from sitting for more than 1/2 an hour. 3
- ☐ Pain prevents me from sitting for more than 10 minutes. 4
- ☐ Pain prevents me from sitting at all. 5

**Section 6 – Standing**

- ☐ I can stand as long as I want without extra pain. 0
- ☐ I can stand as long as I want but it gives me extra pain. 1
- ☐ Pain prevents me from standing for more than 1 hour. 2
- ☐ Pain prevents me from standing for more than 1/2 an hour. 3
- ☐ Pain prevents me from standing for more than 10 minutes. 4
- ☐ Pain prevents me from standing at all. 5

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**Section 7 – Sleeping**

- ☐ My sleep is never disturbed by pain. 0
- ☐ My sleep is occasionally disturbed by pain. 1
- ☐ Because of pain, I have less than 6 hours sleep. 2
- ☐ Because of pain, I have less than 4 hours sleep. 3
- ☐ Because of pain, I have less than 2 hours sleep. 4
- ☐ Pain prevents me from sleeping at all. 4

**Section 8 – Sex Life (if applicable)**

- ☐ My sex life is normal and causes no extra pain. 0
- ☐ My sex life is normal but causes some extra pain. 1
- ☐ My sex life is nearly normal but is very painful. 2
- ☐ My sex life is severely restricted by pain. 3
- ☐ My sex life is nearly absent because of pain. 4
- ☐ Pain prevents any sex life at all. 5

**Section 9 – Social Life**

- ☐ My social life is normal and causes no extra pain. 0
- ☐ My social life is normal but increases the degree of pain. 1
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports 2
- ☐ Pain has restricted my social life and I do not go out as often. 3
- ☐ Pain has restricted my social life to my home, and/or social media only. 4
- ☐ I have no social life because of pain. 5

**Section 10 – Traveling**

- ☐ I can travel anywhere without pain. 0
- ☐ I can travel anywhere but it gives extra pain. 1
- ☐ Pain is bad but I manage journeys of over two hours. 2
- ☐ Pain restricts me to journeys of less than 1 hour. 3
- ☐ Pain restricts me to short necessary journeys less than 30 minutes. 4
- ☐ Pain prevents me from traveling except to receive treatment. 5