NAPLES
NEURO CARE

Your Neurosurgery Appointment

Welcome to Naples Neuro Care. Your provider has requested a neurosurgery consultation regarding your condition. If you need to cancel or reschedule, we kindly ask that you call us 24 hours in advance. Our contact number is 239-944-5054.

At your first appointment, you will meet our Neurosurgeon or one of our Physician Assistants. Physician Assistants (PA) are healthcare professionals certified by the National Commission on Certification of Physician Assistants who practice medicine under the supervision of a Physician. PA's conduct physical exams, obtain medical history, diagnose, and treat illnesses, order and interpret tests, counsel on preventive healthcare, assist in surgeries, and prescribe medications.

Please gather any recent imaging studies that you have had of your brain or spine, such as X-Rays, CT scans, or an MRI. We will ***want to see the actual images on CD***, not just the written reports. Please ensure these studies are less than 6 months old.

Enclosed is your appointment details and your new patient packet. Please complete all the forms and bring them with you to your appointment. We will try to see you as promptly as possible. Occasionally our providers must leave clinic for emergencies or urgent situations in the hospital and in that case your clinic visit may be delayed. We will make every effort to be thorough and get you in and on your way as soon as possible.

We look forward to meeting you. Welcome to Naples Neuro Care.

Edison Valle, MD, FAANS

NAPLES NEURO CARE

MEDICATION REFILL POLICY

NNC– NEUROSURGERY

To ensure the safety of all patients, NNC has a comprehensive policy for medication refills. **It is very important to plan ahead.**

It takes 1-3 business days to refill your prescriptions. We must review your medical record, check for expiration dates, verify number of refills, and ensure refill eligibility. Please contact us at least 3 days before your medication is due to run out to request a refill. Please note that prescriptions are not refilled on weekends or after 4:30 pm on weekdays.

Refill requests can also be made through your pharmacy. The pharmacy will forward the information we need to our office and after confirmation, it is presented to the provider for final authorization. Certain medications require laboratory testing before they can be refilled.

- Strict controls are in place for medications containing opioids. Florida law prohibits opioids from being called into the pharmacy. Patients must be seen in the office for non-refillable pain medications to be refilled.
- The law requires a 3-day limit on opioid prescriptions for acute pain. It is very important for patients taking opioid medication to take them as prescribed by the provider.
- Refills on medications can only be authorized on medications that were prescribed by Dr. Edison Valle. Dr. Valle will not refill medications prescribed by any other providers.
- Prescriptions may not be mailed or shipped. Controlled substance prescriptions must be picked up in the office. All other medications may be sent in electronically to your pharmacy if they participate in electronic prescribing.
- Please understand that pain medications are prescribed for patients undergoing surgery or a procedure only. If you do not require either of these, you may be referred to pain management for pain control.
- If your pain persists for more than 2 months after your date of surgery, schedule an appointment with your provider to be evaluated for a possible referral to Pain Management.

Thank you for understanding and complying with the medication policies.

Patient Signature_____Date_____

SPINE SERVICES PATIENT INTAKE FORM: PATIENT SECTION

□ CLINIC NEW PATIENT □ CLINIC CONSULT – REQUESTED BY: _____

HISTORY:

What is your chief complaint?

_____

_____

In your own words, explain WHEN and HOW your symptoms began. _____

_____

_____

_____

Who has referred you to us? Name: _____

Address & Phone #: _____

Is this your Primary Care Physician? □ Yes □ no? If not, who is your Primary Care Physician?

Name: _____

Address & Phone #: _____

What diagnosis has your physician given you? _____

Describe the symptoms for which you are being referred?

□ low back pain □ leg pain □ right □ left □ back & leg pain □ muscle weakness

□ numbness &/or tingling □ neck pain □ arm pain □ neck & arm pain □ right arm □ left arm

□ balance problems □ Other: _____

How did your current symptoms begin?

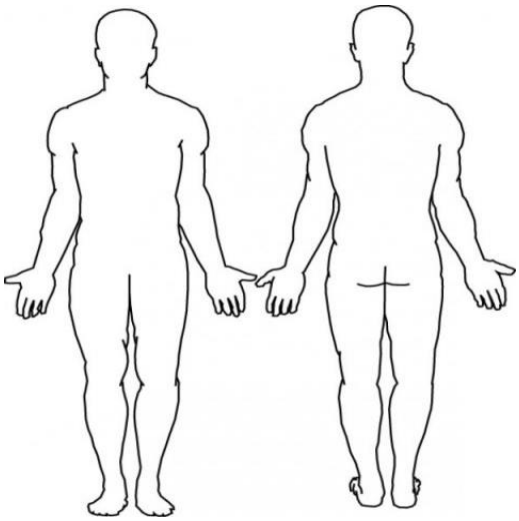
□ suddenly □ gradually □ lifting / twisting / pulling / bending □ injury at work □ fall

□ motor vehicle accident □ sports injury □ no apparent cause □ Other: _____

PAIN DRAWING – Where is your pain now?

Mark the areas on your body where you feel the sensation described below using the appropriate symbol.
Mark the areas of radiation. Include all affected areas. To complete the picture, please draw in your face.

Aching	*Numbness*	*Pins & Needles*	*Burning*	*Stabbing*
^^^	===	ooo	XXX	///



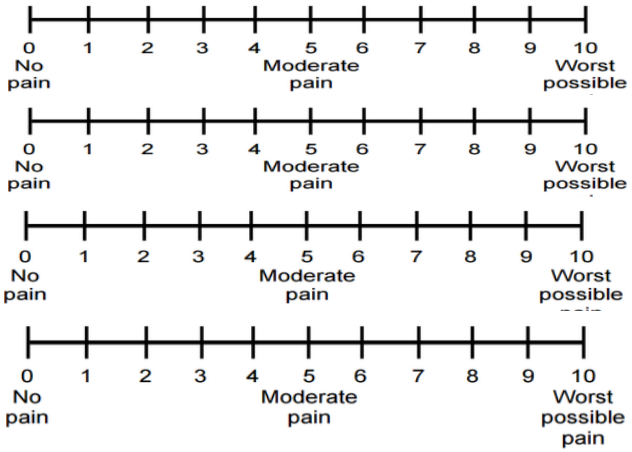
SPINE SERVICES PATIENT INTAKE FORM: PATIENT SECTION

On a scale of 0 – 10, mark the level of **LEG** pain/discomfort, with 0 being none and 10 being unbearable (mark only one)

On a scale of 0 – 10, mark the level of **BACK** pain/discomfort, with 0 being none and 10 being unbearable (mark only one)

On a scale of 0 – 10, mark the level of **ARM** pain/discomfort, with 0 being none and 10 being unbearable (mark only one)

On a scale of 0 – 10, mark the level of **NECK** pain/discomfort, with 0 being none and 10 being unbearable (mark only one)



How would you describe your pain?

☐ sharp ☐ dull ☐ deep ☐ superficial ☐ constant ☐ intermittent ☐ Other:_____

How long have you had your symptoms?

☐ 1-7 days ☐ 8-14 days ☐ 15-21 days ☐ 22-28 days ☐ 1 month ☐ 2 months ☐ 3 months
☐ 6 months ☐ 9 months ☐ more than 1 year - # years _____

What makes your symptoms worse?

☐ lying down ☐ sitting ☐ standing ☐ walking ☐ bending forward ☐ bending backward
☐ coughing ☐ neck flexion ☐ neck extension ☐ neck rotation ☐ never worsens
☐ Other: _____

What makes your symptoms better?

☐ lying down ☐ sitting ☐ standing ☐ walking ☐ leaning on shopping cart ☐ nothing
☐ manipulation (PT, chiropractic, massage) ☐ narcotics ☐ anti-inflammatory / aspirin
☐ neck flexion ☐ neck extension ☐ neck rotation ☐ Other:

_____

Has there been any change in your bowel and bladder habits?

☐ no ☐ yes – Describe: _____

What other treatments have you had for your spine problem? Please explain any "yes" answers in the space below

Chiropractic treatment for this illness or injury? ☐ Yes ☐ No
Physical therapy? ☐ Yes ☐ No
Have you ever received an epidural steroid injection for this problem? ☐ Yes ☐ No
Have you ever received a Medrol (steroid) dose pack for this problem? ☐ Yes ☐ No
Taken prescription medication for this problem? ☐ Yes ☐ No
Have you ever had any neck or back surgery? ☐ Yes ☐ No ☐ If yes, how many? _____
Have you ever been hospitalized for any illness or trauma? ☐ Yes ☐ No
Ever been treated for depression, anxiety or mental health issues? ☐ Yes ☐ No
Would you be willing to consider both surgical and non-surgical treatment options for your symptoms?
☐ Yes ☐ No

NAPLES NEURO CARE

SPINE SERVICES PATIENT INTAKE FORM: PATIENT SECTION

Do you currently have any of these symptoms? Please check "Yes" or "No" for each symptom.

Yes	No	Constitutional Symptoms
		Fever
		Night Sweats
		Generalized Weakness or Fatigue
		Weight Gain
		Weight Loss

Yes	No	Cardiovascular
		Shortness of Breath
		Chest Pain
		Irregular Heartbeat
		Palpations

Yes	No	Respiratory
		Coughing up Blood
		Chronic Cough
		Wheezing

Yes	No	Gastrointestinal
		Blood in Stool
		Black or Discolored Stool
		Abdominal Pain
		Difficulty Swallowing
		Nausea or Vomiting
		Diarrhea
		Constipation
		Abdominal Distention
		Abdominal Mass or Lumps

Other: _____
_____
_____
_____
_____
_____

Yes	No	Genito-urinary
		Burning with Urination
		Dark or Discolored Urine
		Difficulty Starting or Ending Urine Stream
		Poor Bladder Control
		Loss of Genital Sensation
		Any Type Sexual Dysfunction

Yes	No	Skin/Breast
		Dry Skin
		Body Rash or Hives
		Nipples Discharge
		Breast Lump
		Problems with Wound Healing
		Change in a Mole
		Dimpling of Skin
		Change in Color or Temperature of Skin

Yes	No	Hematologic / Lymphatic
		Easily Bruises or Bleeds
		Nose Bleeds

Yes	No	Musculoskeletal
		Masses or Lumps
		Swelling
		Inability to Feel Hot or Cold
		Poor Coordination
		Loss of Control of Arms or Legs
		Loss of Muscle Mass
		Abnormal Arm or Leg Sensations
		Neck Pain
		Back Pain
		Numbness
		Tingling
		Muscle Spasms

Yes	No	Neurological
		Poor Vision
		Blurry Vision
		Double Vision
		Loss of Hearing
		Ringing in Ears
		Numbness in Face
		Loss of Sense of Smell
		Loss of Sense of Taste
		Droopy Face or Eye
		Hoarseness
		Difficulty Speaking
		Difficulty Swallowing
		Slurred Speech
		Headache
		Dizziness
		Seizures
		Unsteady Gait

Yes	No	Endocrine
		Poor Appetite
		Cold Intolerance
		Excessive Thirst
		Loss of Body Hair

		Psychosocial
		Depression
		Hallucinations
		Anxiety
		Mood Swings

NAPLES NEURO CARE

Have you ever had any of the following medical conditions? Please check yes or no to all the following.

MEDICAL HISTORY: **YES** **NO**

Hypertension (high blood pressure) _____ □ □
Dyslipidemia (high or low cholesterol) _____ □ □
Diabetes (too much sugar in bloodstream) ____ □ □
Diabetes type: controlled / uncontrolled
Peripheral Vascular Disease
(blocked blood vessel in legs) _____ □ □
TIA / Stroke _____ □ □
Heart Disease _____ □ □
Syncope (fainting) _____ □ □
Kidney Disease _____ □ □
BPH (enlarged prostate gland) _____ □ □
GI Ulcer _____ □ □
Asthma / Lung Disease _____ □ □
Anemia _____ □ □
Lupus/Rheumatoid Arthritis/ □ □
Ankylosing Spondylitis
Cancer _____ □ □
Date_____ Type_____
Other: _____
_____
_____

SURGICAL HISTORY – Please list any prior surgeries
_____
_____
_____
_____
_____
_____

FAMILY HISTORY

Relationship	Medical History	Cause of Death (if applicable)
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

SOCIAL HISTORY

Tobacco **YES** **NO**
Currently Smoking _____ □ □
Quit Date: _____
Packs per day _____ Years _____
Illicit Drugs _____ □ □
Occasional _____ □ □
Drinks Per Week _____
Quit Date _____
Occupation _____
_____

MEDICATIONS

_____
_____
_____

ALLERGIES

_____
_____

WORK HISTORY

Are you able to perform your daily routine with these symptoms? □ Yes □ No

Are you able to work with your condition? □ Yes □ No

Have you ever filed a Worker's compensation claim related to a neck or brain injury? □ Yes □ No □ N/A

Have you been or will you be involved in a lawsuit because of your neck or back problem? □ Yes □ No

Is lawsuit settled? □ Yes □ No

Patient Signature **Date / Time**

_____

Nursing Staff Signature / Initials / Print Name **Date / Time**

_____

Physician Signature / Print Name **Date / Time**

NAPLES NEURO CARE

ODS: 0-4 none, 5-14 mild, 15-24 moderate, 25-34 severe, 35-50 complete

SECTION 1 - PAIN INTENSITY

- ☐ I can tolerate the pain I have without having to use painkillers.
- ☐ The pain is bad but I manage without taking painkillers.
- ☐ Painkillers give complete relief from pain.
- ☐ Painkillers give moderate relief from pain.
- ☐ Painkillers give very little relief from pain.
- ☐ Painkillers have no effect on the pain and I do not use them.

SECTION 2 - PERSONAL CARE (washing, dressing etc.)

- ☐ I can look after myself normally, without causing extra pain.
- ☐ I can look after myself normally, but it causes extra pain.
- ☐ It is painful to look after myself and I am slow and careful.
- ☐ I need some help, but manage most of my personal care.
- ☐ I need help every day in most aspects of self-care.
- ☐ I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 - LIFTING

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

SECTION 4 - WALKING

- ☐ Pain does not prevent my walking any distance.
- ☐ Pain prevents me walking more than 1 mile.
- ☐ Pain prevents me walking more than ½ of mile.
- ☐ Pain prevents me walking more than ¼ mile.
- ☐ I can only walk using a stick or crutches.
- ☐ I am in bed most of the time and have to crawl to the toilet.

SECTION 5 - SITTING

- ☐ I can sit in any chair as long as I like.
- ☐ I can sit in my favourite chair as long as I like.
- ☐ Pain prevents me sitting more than 1 hour.
- ☐ Pain prevents me from sitting more than ½ an hour.
- ☐ Pain prevents me from sitting more than 10 minutes.
- ☐ Pain prevents me from sitting at all.

SECTION 6 - STANDING

- ☐ I can stand as long as I want without extra pain.
- ☐ I can stand as long as I want but it gives me extra pain.
- ☐ Pain prevents me from standing for more than 1 hour.
- ☐ Pain prevents me from standing for more than 30 minutes.
- ☐ Pain prevents me from standing for more than 10 minutes.
- ☐ Pain prevents me from standing at all.

SECTION 7 - SLEEPING

- ☐ Pain does not prevent me from sleeping well.
- ☐ I can sleep well only by using tablets.
- ☐ Even when I take tablets, I have less than 6 hours sleep.
- ☐ Even when I take tablets, I have less than 4 hours sleep.
- ☐ Even when I take tablets, I have less than 2 hours sleep.
- ☐ Pain prevents me from sleeping at all.

SECTION 8 - SEX LIFE (If applicable)

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

SECTION 9 - SOCIAL LIFE

- ☐ My social life is normal and gives me no extra pain.
- ☐ My social life is normal, but increases the degree of pain.
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- ☐ Pain has restricted my social life and I do not go out as often.
- ☐ Pain has restricted my social life to my home.
- ☐ I have no social life because of pain.

SECTION 10 - TRAVELLING

- ☐ I can travel anywhere without extra pain.
- ☐ I can travel anywhere but it gives extra pain.
- ☐ Pain is bad but I manage journeys over 2 hours.
- ☐ Pain restricts me to journeys of less than 1 hour.
- ☐ Pain restricts me to short necessary journeys under 30 minutes.
- ☐ Pain prevents travel except to the doctor or hospital.