Timothy A. Holt, M.D.
Montgomery Spine Center
257 Winton Blount Loop
Montgomery, AL 36117
(334) 396-1886

Marital Status S M D W

PLEASE PRINT

Patient Name ______________________________ Sex Male Female

Address ______________________ City ______________ State ______ Zip ________

Home Phone ______________ SSN ______________ DOB __________ Age ______

Employer/Address ______________________ Work Phone ______________

Emergency Contact Person & Number ______________________________

Parent or Spouse Name ______________________ Address ______________________

Employer/Address ______________________ Work Phone ______________

Reason for Visit ______________________________

Referring Physician ______________________ Family Physician ______________

Is Condition Related to: Accident Job Injury Motor Vehicle Other Date of Accident ____________

Place & Details of Accident ______________________________

____

Name and address of Responsible Party for Accident ______________________________

____

Is this a Worker's Comp Claim: Y N Company Name ______________________

Company Address ______________________________ Phone ______________

Carrier Address ______________________________ Phone ______________

Contact Person ______________________________ Phone ______________

Is this in litigation? Y N Attorney

MEDICAL INSURANCE INFORMATION

Name of Primary Ins. Co. ______________ Group # ____________ Policy # ____________

Cardholder's Name ______________ DOB __________ Relationship to Cardholder __________

Name of Secondary Ins. Co. ______________ Group # ____________ Policy # ____________

Cardholder's Name ______________ DOB __________ Relationship to Cardholder __________

Method of Payment Cash Check Credit Card Other ______________________

PLEASE READ BEFORE SIGNING

I/we, the undersigned, authorize and consent to the rendering of emergency care, including diagnostic procedures, and medical treatment, by Timothy A. Holt, M.D. or authorized members of our staff, as may in their professional judgement be necessary for the above patient. I acknowledge that no guarantees have been made as to the effect of such examinations or treatment. Authorization is hereby given to release such information as may be necessary for the completion of my hospital/medical claims. I further agree to pay all medical expenses incurred resulting from this treatment and authorization, and I assign any insurance benefits applicable. I waive any right which I may have according to the Constitution and Laws of Alabama, or any other state, to claim exemption as to personal property as to this obligation, and if this obligation is not paid in full when due, I agree to pay all costs of collecting it, including a reasonable attorney's fee. I understand and agree to pay Timothy A. Holt, M.D. for medical services and supplies provided that are not covered under PMD, HMO, or any other programs.

Signature of Patient or Legal Guardian ______________________________ Date ______________

Montgomery Spine Center, P.C.

Timothy A. Holt M.D.

Assignment of Benefit Form

Financial Responsibility
All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our practice's financial counselor. Necessary forms will be completed to help expedite insurance carrier payments. However, YOU ARE responsible for all fees, regardless of insurance coverage.

Assignments of Benefits
I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plans to issue payment check(s) directly to Timothy A. Holt, M.D. for medical services rendered to myself and/or my dependents. Regardless of my insurance benefits, if any, I understand that I am responisble for any amount not covered by insurance.

Authorization to release Information
I hereby authorize Timothy A. Holt, M.D. to furnish and/or release any information necessary, to insurance carriers, concerning my illness and treatments, to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by writing, by me.

I have requested medical services from Timothy A. Holt, M.D. on behalf of myself and for my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the authorized treatment. I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges not covered by insurance in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I will pay fees for today's charges by: ☐ CASH ☐ CHECK ☐ VISA/MC

Patient/Responsible Party Signature Date

Witness Date

Montgomery Spine Center, P.C.

Timothy A. Holt M.D.

DR. HOLT'S PRESCRIPTION AND PAIN MEDICINE POLICY

1. Our first and foremost concern is the patient's well being. We understand that you are hurting. However, our worst nightmare would be to provide you with an addiction to a narcotic pain medicine. Therefore, pain medicine or pain management will be delivered in a decreasing dosage or tapering fashion.
2. Your pain medicines will last for a specific number of days and no medicine will be called in prior to this date.
3. Please read the label on the pain medicine in regards to how the medicine is to be taken and how often or how long the medicine will have to last.
4. Please be advised that no pain medicines or prescriptions will be phoned in during the weekends and after 4:00 in the afternoons.
5. If you find that you are unable to take a specific pain medicine that we give you, and you call requesting another pain medicine, you must bring the written prescription or the actual pain pills back into the office. These will be exchanged pill for pill.
6. Dr. Holt does not prescribe muscle relaxers.
7. Dr. Holt does not prescribe nerve medications.
8. Dr. Holt does not prescribe sleeping pills.
9. Please be advised that Dr. Holt is your physician and your surgeon, therefore, he manages your pain. It is imperative that you get no other pain medicine from any other doctor. This is a legal issue and in some places, it is a misdemeanor and/or felony.
10. Please be advised that we have laws and legal requirements that prevent us from prescribing too much pain medicine.
11. If you have more excruciating pain after hours or on the weekends, you always have the choice of going to the Emergency Room. This should be your last and final resort.

GENERAL POINT REGARDING THE APPROACH TO TREATING PAIN

There is no magic pain pill or pain medicine to make all of your pain go away. Through a combination of pain medicine, anti-inflammatories or Tylenol, ice for 15 minutes or ice massage for five to six minutes, you will receive relief. Rest, avoiding those activities that increase the pain or make the pain excruciating, and wear your brace as directed. These are a variety of different procedures used consistently together and daily over an extended period of time that are going to assist in controlling the pain to where it is tolerable.

Our continual and deep concern is for our patient's well being and care. Again we do not want to provide narcotic pain medicine addiction on top of already existing back or next problems.

Signature of Patient ____

Montgomery Spine Center, P.C.

Timothy A. Holt M.D.

Medical Release For: ____

Effective October 1, 2002 (due to federal guideline under HIPPA) we are now required to have and maintain in a patient's medical chart, medical release information on family members, friends, caregiver, etc. You must provide the names of those individuals who you wish to be given any or all of your medical or financial information. ANYONE calling for medical or financial information on you who is not listen on this sheet will be told that NO information can be released to him or her.

Please list names and phone numbers of the authorized individuals below.

1) If you DO NOT want your medical or financial information discussed with anyone other than yourself, please sign here:
   ________________________________ Date__________________

2) I (sign here) ____
   give authorization to the following individual(s) listed below to discuss my medical or financial information
   with your staff or the Doctor on my behalf.

	Name	Phone Number
1.	________________________	________________________
2.	________________________	________________________
3.	________________________	________________________

May we leave medical information on your "home" answering machine? (Circle)

Yes　　　　　No

The above information is private and confidential and will be placed in your medical chart. This information must be updated and a new form signed a year from the above date.

Phone: (334) 396-1886 • Fax: (334) 396-1887
257 Winton M. Blount Loop • Montgomery, AL 36117
P.O. Box 231509 • Montgomery, AL 36123

Montgomery Spine Center, P.C.

Timothy A. Holt M.D.

Name ________________________________ Age __________ Date _________________

Occupation ____________________ Race _______________ Right or Left Handed ______

Pulse ______ Blood Pressure _____________ Alcohol Use _______ Tobacco Use _______

Referred by:

1. Today's Problem:

2. Mechanism of Injury:

3. Date of Injury

4. What Makes It Worse:

5. What Makes It Better:

6. % of Pain per part:

7. How long can you:

Sit ___________

Stand _________

Walk __________

8. Treatment History:

A. Physical Therapy

Yes ____

No ____

How long & when _______

B. Injections

Yes ____

No ____

When _______

C. Chiropractor

Yes ____

No ____

How long & when _______

D. Anti-inflammatory

Advil/Ibuprofen ______

Naproxen/Aleve ______

Mobic ______

Celebrex ______

E. Pain Medication

Lortab _____________

Percocet ___________

Oxycontin __________

Ultram _____________

Other ______________

Past Medical History: Hypertension Diabetes Reflux CAD Thyroid problems

FAMILY HISTORY

A. Heart D. TB
B. Diabetes E. Bleeding disorders
C. Cancer F. Rheumatoid arthritis

OPERATIONS

Montgomery Spine Center, P.C.

Timothy A. Holt M.D.

Patient Medication Worksheet

Name:
Drug Allergies: ______________________________
Pharmacy Name: ______________________________
Phone #: ______________________________

Patient Instructions

Please list any medications that you are currently taking, including over-the-counter, dietary supplements and herbs

Name	Dose	Route	Frequency	Comments

Please complete this form and bring with you to your appointment

PERSONAL HISTORY: ***Please mark if you currently / recently have had any problems with any of the below. Please DO NOT write in gray area.***

HEAD / EYES / EARS / THROAT

_______ Hearing disorder
_______ Double vision
_______ Headaches
_______ Dizziness
_______ Glaucoma
_______ Detached retina
_______ Macular degeneration
_______ Sinus disorder
_______ Glasses
_______ Contacts
_______ Ringing in the ears
_______ Other: ____________________
❒ NONE

MOUTH

_______ Loose teeth/chipped teeth
_______ Caps
_______ Braces
_______ Gingivitis
_______ Crowns
_______ Bridges
_______ Dentures ❒ Upper ❒ Lower
_______ Partials ❒ Other ❒ NONE

NEUROLOGIC

_______ Seizure
_______ Stroke
_______ Unexplained Vision changes
_______ Numbness
_______ Weakness
_______ Memory Loss
_______ Fainting spells
_______ Migraine headaches
_______ Any neurologic disease
_______ Other: ___________ ❒ NONE

PSYCHIATRIC

_______ Depression
_______ Anxiety
_______ Other
_______ Comments: ________________
❒ NONE

CARDIAC / HEART

_______ Chest pain? ❒ Yes ❒ No
with rest? ❒ Yes ❒ No
exertion? ❒ Yes ❒ No
Heart Attack / Last Attack ___
_______ Congestive Heart Failure
_______ Pacemaker
_______ High Blood Pressure
_______ Circulation problems
_______ Irregular heart rate
_______ Heart palpitation
_______ Wake up short of breath
_______ Phlebitis
_______ Blood Clots
_______ Mitral valve prolapse
_______ Heart murmur
_______ Known heart disease
_______ Other: ___________ ❒ NONE

PULMONARY / LUNGS

_______ Asthma / Las attack _____
_______ Bronchitis
_______ Wheezing
_______ Cold, cough or respiratory infection in past 2 weeks?
_______ Known lung disease (COPD) (Emphysema)
_______ TB
_______ Other: ___________ ❒ NONE

URINARY / GENITAL

_______ Kidney / Bladder infection
Last problem: _________
_______ Kidney stone
_______ Kidney disease / Renal failure
_______ Dialysis (last treatment _______)
_______ If male / prostate problem
_______ If female / Menstrual problem
_______ Pregnant
_______ Other: ____________________
____
____
❒ NONE

METABOLIC

_______ Diabetes requiring pills ❒ Yes ❒ No
Insulin ❒ Yes ❒ No
Diet Controlled ❒ Yes ❒ No
_______ Thyroid problems
_______ Currently on Chemotherapy?
_______ Previous Cancer
Where? _________________________
_______ Other: ____________________
____
____
❒ NONE

GASTROINTESTINAL

_______ Heartburn
_______ Reflux
_______ Hiatal Hernia
_______ Cirrhosis
_______ Hepatitis
_______ Liver disease
_______ Gallbladder disease
_______ Blood in stool
_______ Stomach ulcer
_______ Bleeding ❒ NONE

SKELETAL

_______ Arthritis: Where? ____________
_______ Difficulty walking
_______ Unexplained back pain
_______ Inability to exercise
_______ Other: ____
❒ NONE

BLOOD

_______ Anemia
_______ Sickle cell
_______ Easy bruising
Blood transfusions in last 3 months?
Delivered ❒ Miscarried ❒ Other
within last three months? ❒ Yes ❒ No
Have you recieved Rhogam? ❒ Yes ❒ No
_______ Slow to stop bleeding after a cut
_______ HIV Positive / when: __________
_______ Thalassemia
_______ Other: ___________ ❒ NONE

Patient Signature: ______________________________________ Date: ____________________

Montgomery Spine Center, P.C.

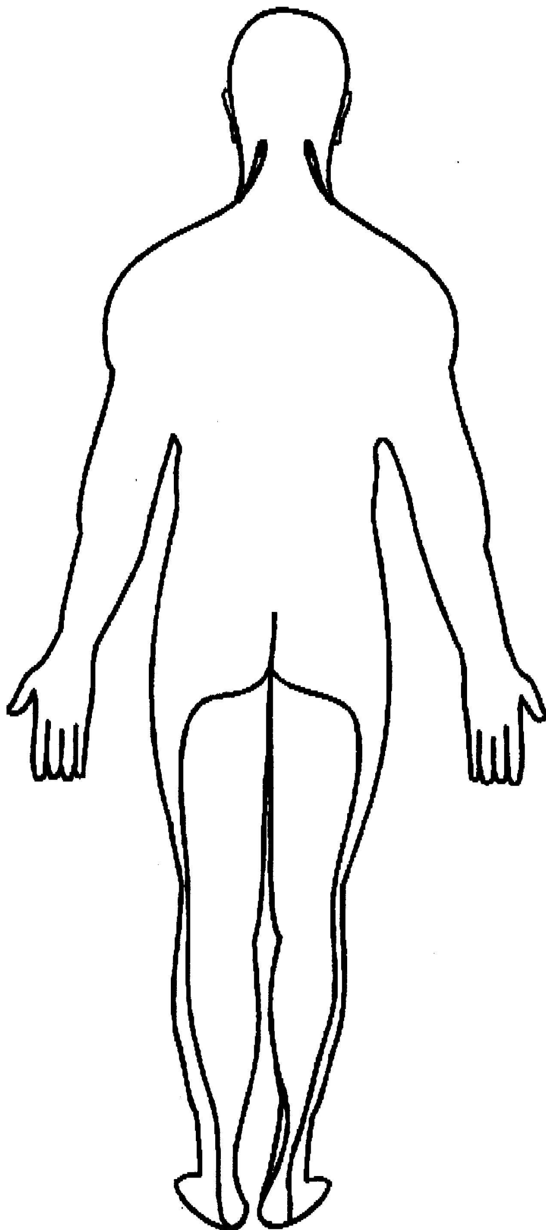
Timothy A. Holt M.D.

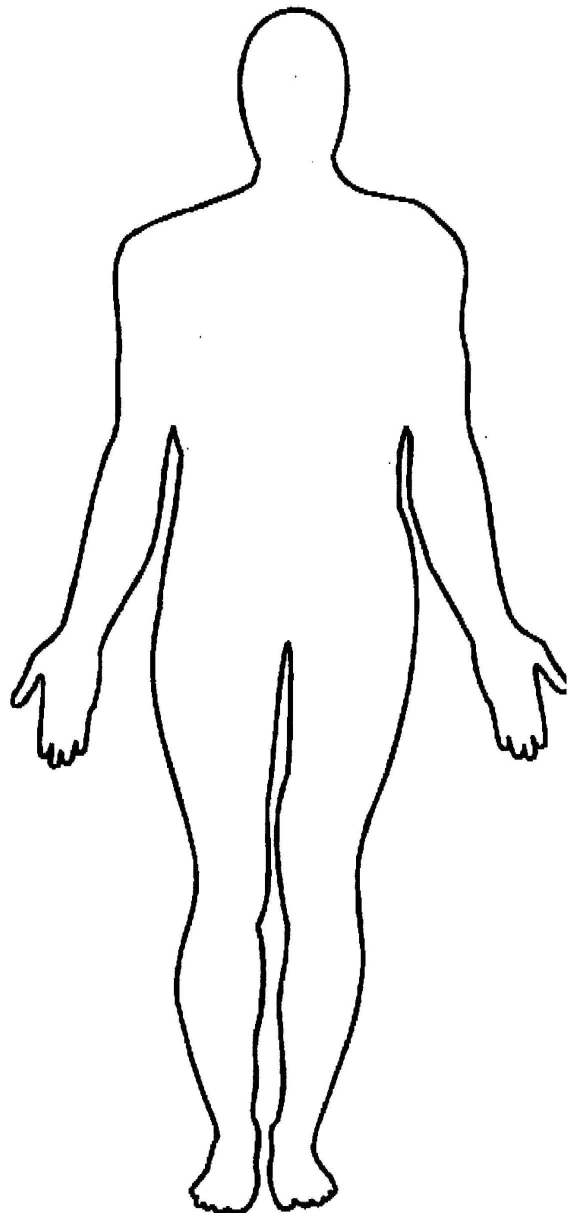
OSWESTRY FUNCTION TEST

PAIN

XXXX	Pins and Needles
OOOO	Sharp Pain
----	Numbness
////	Burning

BACK **FRONT**





Please use the appropriate symbol to describe your back and neck pain

Low Back / SI-Joint Clinical Outcomes

Patient Name: ___________________________ Assessment Date: _____ / _____ / _____

PLEASE READ: This questionnaire is designed to enable us to understand how much your back pain affected your everyday activities. In the event that two or more of the statements in a category may relate to you, please mark the one answer that most accurately describes your problem. Please describe your pain and/or limitations over the past week or so without pain medication.

Oswestry Disability Index (Version 2.0)

Section 1 - Pain Intensity

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

Section 2 - Personal Care

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

Section 3 - Lifting

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

Section 4 - Walking

- ☐ (0) Pain does not prevent me from walking any distance
- ☐ (1) Pain prevents me from walking more than 1 mile
- ☐ (2) Pain prevents me from walking more than 1/2 mile
- ☐ (3) Pain prevents me from walking more than 100 yards
- ☐ (4) I can only walk using a stick or crutches
- ☐ (5) I am in bed most of the time and have to crawl to the toilet

Section 5 - Sitting

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

Section 6 - Standing

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

Section 7 - Sleeping

- ☐ (0) My sleep is never disturbed by pain
- ☐ (1) My sleep is occasionally disrupted by pain
- ☐ (2) Because of pain, I sleep less than 6 hours at a time
- ☐ (3) Because of pain, I sleep less than 4 hours at a time
- ☐ (4) Because of pain, I sleep less than 2 hours at a time
- ☐ (5) Pain prevents me from sleeping at all

Section 8 - Sexual Activity (if applicable)

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

Section 9 - Social Life

- ☐ (0) My social life is normal and gives me no extra pain
- ☐ (1) My social life is normal but increases the degree of pain
- ☐ (2) Pain has no significan effect on my social life apart from limiting my more energetic interests (eg. sports, etc.)
- ☐ (3) Pain has restricted my social life and I do not go out as often
- ☐ (4) Pain has restricted my social life to my home
- ☐ (5) I have no social life because of pain

Section 10 - Traveling

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

RATE YOUR PAIN: Using a scale from 0-10 where 0 = No Pain and 10 = The Worst Pain Possible

____ LOW BACK _____ RIGHT LEG _____ RIGHT GROIN _____ RIGHT BUTTOCK

_____ LEFT LEG _____ LEFT GROIN _____ LEFT BUTTOCK

The Neck Disability Index

Patient Name: ______________________________ Date: ________________

PLEASE READ: This questionnaire is designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Plase answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.

Section 1 - Pain Intensity

- ☐ I have no pain at this moment
- ☐ The pain is very mild at the moment
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment

Section 2 - Personal Care

- ☐ 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 can 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 me extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently placed (eg. on a table)
- ☐ Pain prevents me from lifting heavy weights but I can manage light to medium weight if they are conveniently positioned
- ☐ I can lift very light weight
- ☐ I cannot lift or carry anything

Section 4 - Reading

- ☐ I can read as much as I want to, with no pain in my neck
- ☐ I can reas as much as I want to, with slight pain in my neck
- ☐ I can read as much as I want to, with moderate pain in my neck
- ☐ I can't read as much as I want, because of moderate pain in my neck
- ☐ I can hardly read at all, because of severe pain in my neck
- ☐ I cannot read at all

Section 5 - Headaches

- ☐ I have no headaches at all
- ☐ I have slight headaches that come infrequently
- ☐ I have moderate headaches that come infrequently
- ☐ I have moderate headaches that come frequently
- ☐ I have severe headaches that come frequently
- ☐ I have headaches almost all the time

Section 6 - Concentration

- ☐ I can concentrate fully when I want to, with no difficulty
- ☐ I can concentrate fully when I want to, with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to
- ☐ I have a great deal of difficulty in concentrating when I want to
- ☐ I cannot concentrate at all

Section 7 - Work

- ☐ I can do as much work as I want to
- ☐ I can do my usual work, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't work at all

Section 8 - Driving

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all

Section 9 - Sleeping

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☐ My sleep is moderately disturbed (2-3 hrs sleepless)
- ☐ My sleep is greatly disturbed (3-5 hrs sleepless)
- ☐ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10 - Recreation

- ☐ I am able to engage in all my recreation activities with no neck
- ☐ pain at all
- ☐ I am able to engage in all my recreation activities with some neck pain
- ☐ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in few of my recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all