Clinics of: FEDERAL INJURY GROUP

DOL New Patient Information:

Please select a clinic location Federal Injury Treatment Center of Florida (Dunedin)

Today's Date: Wednesday, September 17, 2025

Full Legal Name: Your First Name Your Last Name

Date of Birth: Wednesday, January 1, 2025

Date of Injury: Wednesday, January 1, 2025

Social Security Number: 123-45-6789

Patient Case Number, if known Enter Case Number

Home Phone Number: (123) 456-7890

Cell Phone Number: (123) 456-7890

Email: example@example.com

What is your current address? Enter Street Address
Enter City, Enter State, Enter Zip

Patient's Spouse, Significant Other or Emergency Contact Name: Enter Contact Name

Patient's Spouse, Significant Other or Emergency Contact Number: (123) 456-7890

How Did You Hear About Us? Tell us how you heard about us!

Injured Body Area(s):
Please describe your work-related injury or injuries

Employer (Agency): Ex. USPS

Employee ID Number (EIN):
Enter ID Number

Employer's Phone Number:
(123) 456-7890

Employer's Address: Enter Employer's Address
Enter City, Enter State, Enter Zip

Supervisor's Name: Enter Supervisor's First Name Enter Supervisor's Last Name

What is your Craft? Ex. Mail Carrier

Have you filed out a CA-1 or CA-2? If so, please provide a copy at the time of your appointment.

Completed both CA-1 and CA-2.

Did your supervisor give you a CA-17 (Duty Status Report)? If so, please provide a copy at the time of your appointment.

Yes

Did your supervisor give you a CA-16 (Authorization for Examination/Medical Treatment)? If so, please provide a copy at the time of your appointment.

Yes

Have you been to an Emergency Room or other medical provider for this injury??

No

If so, where and when?

Please list if yes.

Have you had any previous therapy for this or any other issue?

No

If so, at which doctor's office or facility did you receive your therapy?

Please list if yes.

Have you had any surgery?

No

If so, when?

Please list if yes.

Do you have any other work-related injuries we can help you with?

Please describe any other work-related injuries we can help you with.

Do you have any other concerns or questions we can help you with?

Please describe any other concerns or questions we can help you with.

Medical Evaluation Questionnaire:

1. What is your full legal name? Your First Name Your Last Name

2. Date of Birth: Wednesday, January 1, 2025

4. When is the date of your injury? Wednesday, January 1, 2025

3. Are you: Right-handed

5. Have you ever had any previous problems or injuries, including any other work, recreational, or motor vehicle accidents?

Yes

If yes, please describe:
Please list if yes.

6. Have you ever had any difficulties prior to the date of your injury which were similar to those you are now experiencing?

Yes

If yes, please describe:
Please list if yes.

7. Please describe how your current work-related injury occurred.
Please describe how your current work-related injury occurred.

8. What problems did you have following your current work-related injury?
Please describe any problems did you have following your current work-related injury.

9. What did you do following the work-related injury?
Please describe the steps you took following the work-related injury.

10. Have you had any additional WORK or NON-WORK injuries related since the date of injury in question #4?
Please list any additional work or non-work related injuries since the date of your initial injury.

11. What is your greatest concern at this time?
Please describe your greatest concern at this time.

If you are not having difficulty with pain, please proceed to question #18.

12. Where if your pain located? Ex. Shoulder

13. How would you describe your pain? (achy, burning, sharp, dull, tingling, etc) Ex. Achy

14. What makes your pain worse? Ex. Lifting things

15. What makes your pain better? Ex. Ice

16. How frequent is your pain? Constant (present 75% of the time or more)

17. For the following questions, please do your best to rate your current pain on a scale from 0 (no pain) to 10 (excruciating pain):

17a. What number would you put on your pain at this time? 5 / 10

17b. During the past month, what has it averaged? 5 / 10

17c. During the past month, what is the highest it has been? 5 / 10

17d. During the past month, what is the lowest it has been? 5 / 10

Please proceed to question #18.

18. Are you having any other difficulties (numbness, weakness, headaches, anxiety, etc)?

Yes

If yes, please describe the difficulties in detail.

Please list, if yes.

Tasks: Please answer the following questions to the best of your ability.

19. Are there any tasks that are difficult for you to perform?

Yes

If yes, please describe the tasks which are most difficult for you.

Please list, if yes.

How much can you lift occasionally? (lbs) Ex. 5 lbs

Can you lift a gallon of milk?

No

Can you lift a heavy bag of groceries?

Yes

Can you lift a pail of water?

No

How long can you sit for at one time? Ex. 45 minutes

How long can you stand for at one time? Ex. 10 minutes

How long can you walk for at one time? Ex. 15 minutes

20. Who were you employed by when you were injured? Ex. USPS

21. How long had you been working there? Ex. 5 years

22. What was your job title? Ex. Mail Carrier

23. What activities did this job involve?

Please describe what activities your job involved

24. What type of work have you performed previously?

Please describe what type of work you've done in the past.

25. Have you had any other jobs since your injury? Yes

If yes, please describe.

Please list, if yes.

26. Are you working now? Yes

If yes, please describe your current job. If no, when did you last work?

Please list, if yes.

27. Has your doctor, or anyone, prescribed any work restrictions? Yes

If yes, please describe those restrictions.

Please list, if yes.

28. Where do you live? Enter city, state

29. Describe your current household. Who lives with you? Do you have any dependents who rely on your care?

Ex. Myself, my partner, 3 children and 1 grand-parent. 3 children and 1 grand-parent rely on my care.

30. Please describe your typical day.

Please describe your typical day.

31. Are you currently involved in any significant physical activities or recreational pursuits? Yes

If yes, please describe. Please list, if yes.

32. Have you ever been involved in any significant physical activities or recreational pursuits? Yes

If yes, please describe. Please list, if yes.

33. Do you smoke/vape? Yes

If yes, how many packs a day? Please list, if yes.

34. How many alcoholic beverages do you have per week? 5-7

35. Have you had any medical (not surgical) hospitalizations?

Yes, No, Not Sure (If yes, please describe)

36. Have you had any surgical operations?

Yes

If yes, who was your surgeon or medical group that performed the surgery?

Ex. TGH

37. Are you taking any prescribed medications?

Yes, No, Not Sure (If yes, please describe)

38. Are you allergic to any medications?

Yes, No, Not Sure (If yes, please describe)

39. Have you had any other medical problems?

Yes, No, Not Sure (If yes, please describe)

40. Do you have any history of disease in your family?

Yes, No, Not Sure (If yes, please describe)

41. Please provide any other comments which may assist us in understanding your situation.

Please provide any other comments which may assist us in understanding your situation.

Where is your pain now?

Mark the areas on your body where you feel the sensations described below using the appropriate symbol. Mark the areas where the pain is radiating as well as the source of the pain. Include all affected areas.

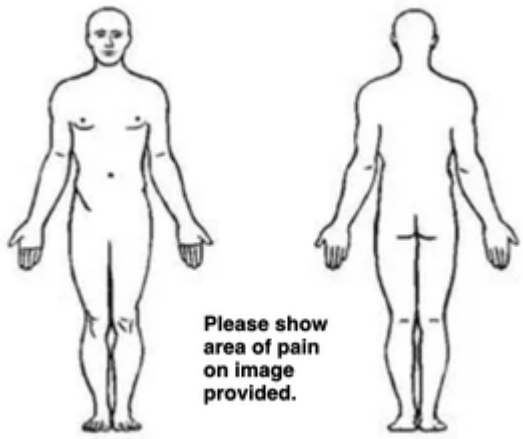
SYMBOLS

▲ Aching ■ Burning

= Numbness | Stabbing

● Pins and Needles **X** Other

Draw on Image



For the privacy of all patients, I will refrain from using my cell phone or earbuds during treatment and physical therapy sessions.

Yes

Signature

Pain Disability Questionnaire:

Full Name: Your First Name Your Last Name

Date Wednesday, September 17, 2025

Instructions: These questions ask your views about how your pain now affects how you function in everyday activities. Please answer every question and choose ONE number on each scale that best describes how you feel.

1. Does your pain interfere with your normal work outside and inside the home? 5 / 10

2. Does your pain interfere with personal care (such as washing, grooming, dressing, etc.)? 5 / 10

3. Does your pain interfere with your traveling? 5 / 10

4. Does your pain affect your ability to sit or stand? 5 / 10

5. Does your pain affect your ability to lift overhead, grasp objects, or reach for things? 5 / 10

6. Does your pain affect your ability to lift things off the floor, bend down, stoop or squat? 5 / 10

7. Does your pain affect your ability to walk or run? 5 / 10

8. Has your income declined since your pain began? 5 / 10

9. Do you take pain medication every day to control your pain? 5 / 10

10. Does your pain force you to see doctors much more often than before your pain began? 5 / 10

11. Does your pain interfere with your ability to see the people who are important to you? 5 / 10

12. Does your pain interfere with recreational activities and hobbies that are important to you? 5 / 10

13. Do you need the help of your family or friends to complete everyday tasks (both outside and inside) because of your pain?	5 / 10
14. Do you now feel more depressed, tense, anxious, or worried than before your pain began?	5 / 10

Upper or Lower Limb Assessment:

The next section is broken out by upper or lower limb injuries. Please complete the Upper Limb Assessment if you are having issues with your arms and please complete the Lower Limb Assessment if you are having issues with your legs.

Full Name: Your First Name Your Last Name

Today's Date: Wednesday, September 17, 2025

Please indicate which assessment you will be completing: Both

Upper Limb Assessment:

Please complete this form if you are having issues with your arms

Please use the scale below to rate the amount of difficulty for the following questions:
1: No difficulty, 2: Mild Difficulty, 3: Moderate Difficulty, 4: Severe Difficulty, 5: Unable

1. Open a tight or new jar: 5 / 5

2. Do heavy household chores (wash walls, take out trash, wash floors, etc) 3 / 5

3. Carry a shopping bag, backpack or briefcase. 5 / 5

4. Wash your back or hair. 3 / 5

5. Use a knife to cut food. 5 / 5

6. Recreational activities in which you take some force or impact on your arm, shoulder, or hand (golf, tennis, volleyball, yard work, etc) 3 / 5

7. How much difficulty have you had sleeping because of the pain in your shoulder, arm or hand? 5 / 5

Please use the scale below to rate the severity of the following symptoms in the past week.
1: Not at all, 2: Slightly, 3: Moderately, 4: Quite a Bit, 5: Extremely

8. To what extent has your shoulder, arm, or hand problem interfered with your normal social activities with friends, family or neighbors? 3 / 5

9. Were you limited in your work or regular daily activities as a result of your shoulder, arm or hand pain? 5 / 5

Please use the scale below to rate the severity of the following symptoms in the past week.
1: None, 2: Mild, 3: Moderate, 4: Severe, 5: Extreme

10. Shoulder, arm or hand pain: 3 / 5

11. Tingling (pins and needles) in your shoulder, arm or hand: 5 / 5

Lower Limb Assessment:

Please use the scale below to rate the your ability to do the following activities for the in the last week for the following questions:

1. How stiff was your lower limb? 3 / 5

2. How swollen was your lower limb? 5 / 5

3. How difficult was it for you to put on socks, shoes or stockings? 3 / 5

4. Walking on flat surfaces: 5 / 5

5. Going up or down stairs: 3 / 5

Please use the scale below to rate the your pain in the last week for the following questions:

6: Laying in bed at night: 5 / 5

7. Which statement best describes your ability to get around most of the time during the past week? 3. Mostly used a crutch/cane

Patient Authorization for the Release of Medical Records

I, Your First Name Your Last Name , hereby authorize and direct the barer of any medical information on myself to
First Name Last Name

release any and all medical records, in their entirety, to the physician or facility indicated below. This includes all medical records, in their entirety, to the physician or facility indicated below. This includes all information (including X-rays, ER records, ambulance reports, IME's, peer review records, hospital records, consultations, second opinions, etc) for any disease, disorder, mental or physical afflictions which I may have been treated for in the past, from the start of treatment to the present, in accordance with Chapter 397.017 and 455.211. Facsimile and/or electronic transmissions of records will be deemed acceptable, proving the records are complete and legible. In consideration of the above, I hereby release from responsibility for any liability arising from disclosure to the captioned holder of information, physician, or hospital.

Today's Date:
Wednesday, September 17, 2025

Patient Phone Number:
(123) 456-7890

Patient Signature:

Patient's Date of Birth:
Wednesday, January 1, 2025

Date of Service:
Wednesday, January 1, 2025

Patient's Full Name:
Your First Name Your Last Name

Social Security Number (SSN):
1234

Florida Statutes: Chapter 395.017 Hospital Licensing and Registration. Chapter 455.241 Health Care Practitioner.
Any health care practitioner licensed pursuant to (Florida Statutes) who makes a physical or mental examination of, or administers treatment to any person, shall upon request of such person or their representative, furnish in a timely manner, without delay for legal reviews, copies of all such reports and records relating to such examination and treatment.

Holder of Information:

Physician or Hospital Name:
Ex. TGH

Physician or Hospital Address:
Enter Street Address
Enter City, Enter State, Enter Zip

Physician or Hospital Phone Number:
(123) 456-7890

Please release information to the following doctor(s) at the address listed above:
Dr. Bruce Kammerman, MD; Carmen Lynch, DC; Glenn Larsen, DC; Gennea Williams, DC, ND; Christopher Stenzel, DC; Paul Kalloghlian, DC; Alvaro "Varo" Betancourt, DC; J. Reinaldo Heredia, DC; Keegan Mente, DC; Michael P. Newman, DC

Federal Injury Group
Practice Manager: Yudit Turino, fitcofl@gmail.com
Phone: 727-600-8024, Fax: 727-600-8025

Selection of Physician:

I,Your First Name Your Last Name , as of, 09-17-2025, choose Dr. Bruce Kammerman, MD,
First Name Last Name Date

and a clinic of Federal Injury Group as my primary DOL doctor for my enter injury
describe injury

injury which occurred on 01-01-2025 .
Date

Signature

Patient Name: Your First Name Your Last Name

Please select a clinic of Federal Injury Group: Federal Injury Treatment Centers of FL: 2323 Curlew Road, Ste 2A, Dunedin, FL 34698

Dr. Bruce Kammerman, MD; Carmen Lynch, DC; Glenn Larsen, DC; Gennea Williams, DC, ND; Christopher Stenzel, DC; Paul Kalloghlian, DC; Alvaro "Varo" Betancourt, DC; J. Reinaldo Heredia, DC; Keegan Mente, DC; Michael P. Newman, DC

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Practice Manager: Yudit Turino, fitcofl@gmail.com
Phone: 727-600-8024, Fax: 727-600-8025

In-Person/Telehealth Consent Form:

1. I hereby authorize Health Care Services to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

Full Name: Your First Name Your Last Name

Terms and Conditions Accepted

Date Wednesday, September 17, 2025

Signature:

Upload Front & Back of Driver's License

Front of Driver's License Upload:

Back of Driver's License Upload:

Upload CA-1 or CA-2 Forms:

Which document will you be uploading?

I don't have either to upload.