DRX^{9000} Registration Form

You have been qualified for a consultation with the doctor. This however does NOT mean that your case has been accepted. Your consultation today will determine if:
A) You are a legitimate candidate for this program
B) Your condition is serious enough to warrant your case being accepted for this treatment

Name: _____ Age: _____

Birthday: (MMDDYYYY) _____ Sex: _____

Address: _____

_____

Home Phone: (____)_____

Work Phone: (____)_____ Best place to reach you:

Cellular Phone: (____)_____ Home Work Cellular

May we leave a voice mail message for you? Yes No

Employer: _____ Occupation:_____

Marital Status: Single Married Divorced Widowed

Spouse's Name: _____ Your SIN#: _____

I consent to allow the doctor to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for non-surgical spinal decompression and also to determine if he is willing to accept my case. Signature: _____

How did you hear about Spinal Decompression? _____

How serious do you think your problem is? (Scale 1-10. 1= feeling good. 10= extremely bad)

← 1 2 3 4 5 6 7 8 9 10 →

What is your main problem/symptom prompting your request for a consultation with the doctor? Back Neck Other _____

Would you consider this problem:

- o MINIMAL (annoying but causing NO limitations)
- o SLIGHT (tolerable but causing little limitation)
- o MODERATE (sometimes tolerable but definitely causing limitations)
- o SEVERE (causing significant limitations)
- o EXTREME (causing near constant [>80% of the time] limitations)

In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion, what do you think the real problem is? _____

_____

_____

What are you hoping happens today as a result of your consultation with the doctor? _____

_____

_____

Since your back pain became this sever what three things has it caused you to miss the most?

_____

_____

_____

How long have you been like this for? _____

How has your life changed since your back and/or neck became a problem? _____

_____

_____

What activities are you limited in? _____

_____

_____

What kinds of treatments have you received?

- o Epidural: How Many _____ When (approx) _____
- o Physical Therapy: How Long _____ When (approx) _____
- o Medication: Type _____ When (approx) _____
- o Surgery: Type _____ When (approx) _____
- o Other: _____

In general, when did you received these treatments and for how long? _____

_____

Did any of these treatments work? If so, which one(s)? For how long? _____

_____

Is there anything that you can do that makes it feel better? _____

What activities/movements are guaranteed to make it worse? _____

_____

Please describe the quality of the pain. (sharp, dull, achy, toothache, shooting, stabbing, numb, tingling, etc…) _____

_____

Is it worst in the morning or is it worse as the day progresses? _____

_____

If you cannot find a solution to this problem, what do you think will happen to you? _____

_____

What are you hoping the doctor tells you today? _____

Describe what you hope or thing he might be able to do for you? _____

_____

Describe what will be different in your life if you can get better? _____

_____

When is the VERY FIRST time you recall having this problem? _____

_____

In reference to your main problem, how often are you aware of this problem? _____

- o Occasionally (25% of the time)
- o Intermittently (50% of the time)
- o Frequently (75% of the time)
- o Constant (90-100% of the time)

Due to your main problem …

Have you lost any time from work? Yes No

How much time and what tasks have been limited? _____

Have you lost any time from your chores/tasks at home? Yes No

How much time and what tasks have been limited? _____

Have you lost any time from your family? Yes No

How much time and what tasks have been limited? _____

Have you lost any time from you leisure activities? (hobbies, travel, sports, etc.) Yes No

How much time and what tasks have been limited? _____

Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe? _____

On a scale of 0-10 (10 bring unbearable, 0 being no pain or discomfort) please rate the following…

The HIGHEST your pain gets WITHOUT medication	0	1	2	3	4	5	6	7	8	9	10
The LOWEST your pain gets WITHOUT medication	0	1	2	3	4	5	6	7	8	9	10
The HIGHEST your pain gets WITH medication	0	1	2	3	4	5	6	7	8	9	10
The LOWEST your pain gets WITH medication	0	1	2	3	4	5	6	7	8	9	10

List any surgeries that you have had and the corresponding dates.

_____

_____

_____

_____

_____

Have you had ANY of the following in the last 12 months or currently?

Please mark C for current, X for last 12 months.

GENERAL

- o Chills
- o Convulsions
- o Dizziness
- o Fainting
- o Fatigue
- o Fever
- o Headache
- o Loss of sleep
- o Numbness in BOTH hands & feet
- o Loss of weight
- o Nervousness
- o Wheezing
- o Bronchitis
- o Allergy [to what _____]

CARDIOVASCULAR

- o High blood pressure
- o Low blood pressure
- o Pain over heart
- o Poor circulation
- o Rapid heartbeat
- o Slow heartbeat
- o Previous heart problem [please describe: _____]
- o Stroke
- o TIA
- o Swollen ankles
- o Varicose veins
- o Aortic aneurysm
- o Bruise easily

DISEASES/CONDITIONS

- o Appendicitis
- o Anaemia
- o Arthritis
- o Alcoholism
- o Abdominal surgery
- o Bleeding disorder
- o Blood clot(s)
- o Breathing difficulty
- o Cancer
- o Cholesterol high
- o Colon problems
- o Diabetes
- o Depression
- o Epilepsy
- o Eczema
- o Eating disorder
- o Glaucoma
- o HIV+
- o Heart disease
- o Hernia
- o Headaches
- o Influenza
- o Kidney disease
- o Liver disease
- o Low back pain
- o Mental illness
- o Measles
- o Pneumonia
- o Hyperthyroid
- o Hypothyroid
- o Rectal surgery

EARS/ EYES/ NOSE/ THROAT

- Asthma
- Crossed eyes
- Double vision
- Blurred vision
- Difficulty swallowing
- Deafness
- Hearing loss
- Ear pain
- Thyroid problem
- Nose bleeds
- Sinus problems
- Sore throats

GASTRO-INTESTINAL

- Gas
- Colon trouble
- Constipation
- Diarrhea
- Gallbladder trouble
- Haemorrhoids
- Liver trouble
- Nausea
- Stomach ache
- Poor appetite
- Poor digestion
- Vomiting
- Vomiting blood
- Rectal bleeding
- Bloating

FOR WOMEN ONLY

- Menstrual cramps
- Excessive menstrual flow
- Hot flashes
- Irregular cycle
- Painful periods
- Birth control pills
- Abnormal pap smear

GENITO-URINARY

- Blood in urine
- Frequent urination
- Inability to control urine
- Kidney infection
- Painful urination
- Prostate trouble

FOR MEN ONLY

- Lump in testicles
- Penis discharge

MUSCLE/ JOINT/ BONE

- Backache
- Foot trouble
- Bain between shoulders
- Painful tailbone
- Stiff neck
- Spinal curvature
- Swollen joints

NEUROLOGIC

- Seizures
- Dizziness
- Hand trembling
- Weakness
- Difficulty with speech
- Loss of memory
- Loss of coordination

RESPIRATORY

- Chest pain
- Chronic cough
- Difficulty breathing
- Coughing/spitting blood