Application for Admission Into Our Treatment Program:

Welcome to our office. This is an application we offer to individuals who may be a candidate for one of our treatment programs. However, your acceptance for care will be determined by the doctor upon your consultation and examination. If you are reading this you have qualified for a consultation with the Doctor. Your consultation today will determine if:
A) You are a candidate for one of our treatment programs and if
B) Your condition is serious enough to warrant your case being accepted for treatment. There are certain criteria that must be met in order for the doctor to be able to accept your case for treatment, which the doctor will go over with you.

All Questions Must Be Answered Completely To Begin The Consultation

Today's Date: _____
Name: _____ Age: ____ Date of Birth: _____ Sex: M F
Address: _____ City: _____
State: _____ Zip: _____ Email: _____
Home Phone: _____ Work Phone: _____
SS#: _____ Marital Status: M/S/D/W Children: _____
Spouse Name: _____
Best Place to Reach You (circle one) Home / Work / Cell May we leave a message? Yes/No
Employer: _____ Occupation: _____
Person To Contact In Case of Emergency: _____ Phone: _____
I (signature) _____ 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 their treatment protocols and also to determine if he/she is willing to accept my case.

1. What is your main concern or problem that brought you in to see the Doctor today?
_____

2a. When did your problem begin? _____
2b. Was there a significant event or trauma that brought your condition? Please explain:
_____

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

4. What seems to make you feel worse? _____

5. Describe your pain: Dull / Achy / Sharp / Stabbing / Numbness / Tingling / Radiating Pain

6. Your pain is worse in the: Morning / Afternoon / At Night and I have difficulty sleeping

7. How has your life changed since your condition became a problem?
Difficulty waking up, getting out of bed /Performing my daily routine / Being able to do my job/ Care for my family/ Provide for myself/ Other _____

8. What kinds of treatments have you received for this or other health conditions?
   a. Epidural: How Many? _____ Approximate Date: _____
   b. Physical Therapy: How Long? _____ Approximate Date: _____
   c. Medication: Name: _____ Approximate Date: _____
   d. Surgery: Type: _____ Approx. Date: _____
   e. Other _____

9. Daily Habits (Please give short answers, for example. . . for coffee if you drink 2 cups of coffee a day put 2 cups/day. Your honesty allows the Doctor to better treat your case).

Coffee _____
Soda (diet or regular) _____
Alcohol _____
Cigarettes _____

On a Scale of 0-10 (10 being unbearable) Please rate the following.....

The HIGHEST your pain gets WITHOUT medication ____
The LOWEST your pain gets WITHOUT medication ____
The HIGHEST your pain gets WITH medication _____
The LOWEST your pain gets WITH medication _____

In Order of Importance all OTHER Health problems/concerns NOT including your main problem above

1. _____ How long have you had this? _____
2. _____ How long have you had this? _____
3. _____ How long have you had this? _____

10. How have others been affected by your health condition?
    a. No one is affected b. Haven't noticed any problem c. They tell me to do something
    d. People avoid me.

11. What are you afraid this might be (or beginning) to affect (or will affect)?
    a. Job b. Kids c. Future Abilityd. Marriage e. Sleep
    f. Self- Esteem g. Time h. Finances i. Freedom

12. What would be different/better without this problem? (please be specific)

_____

13. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

_____

14. How did you hear about this Program and/or Doctor? (Circle one) Newspaper / Direct Referral / Seminar, or other.

_____

CURRENT MEDICAL DOCTOR'S INFORMATION:
(This information is very important and is used to co-ordinate your case. If you do not have the information with you, its is imperative that you bring it in with you on your next visit).

Doctor's Name: _____Address: _____
City: _____ State: ___ Zip Code: _____ Phone: _____

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Any additional comments that may help the doctor understand your condition?

_____

PAIN DIAGRAM:

In this diagram, please mark accordingly the areas of pain related to your chief complaint: