Application For Admission

The Restorative Health Care DRX Severe Back Pain Solution Program

If you have received these forms you have qualified for a *consultation* with Dr. Heather at no charge. 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 and B) Your condition is serious enough to warrant your case being accepted for treatment. In the event your condition IS serious enough to warrant being considered for acceptance and Dr. Heather is UNAVAILABLE to treat you; your case will be referred to another clinic.

Today's Date _____

Name _____ Age _____ Birthday _____ Sex M F

Address _____

City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No

Employer _____ Occupation_____ Length of Employ_____

Marital Status S M W D Spouses Name _____ SS# _____

Nearest Relative: _____ Telephone: _____

I (signature) _____consent to allow Dr. Heather 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 she is willing to accept my case. It is also my understanding that BOTH the consultation AND examination (if necessary) are at no charge.

How Did You Hear About Restorative Health Care? _____
How Serious Do You Think Your Problem Is? _____

What Is Your Main Problem/Symptom Prompting Your Request For A Consultation With The Doctor?
_____

Would You Consider This Problem(circle one).... MINIMAL (Annoying but causing NO limitations)
SLIGHT (Tolerable but causing a little limitation)
MODERATE (Sometimes tolerable but definitely causing limitations)
SEVERE (Causing Significant limitations)
EXTREME (Causing near constant (>80% of the time) limitations)

1. 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?

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2. What are you hoping happens today as a result of your consultation with the Doctor?

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

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3. How long have you been like this?

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4. How has your life changed since your back became a problem?

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5. What activities are you limited in?

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6. What kinds of treatments have you received?

Epidural:	How Many _____	When(approx) _____
Physical Therapy:	How Long _____	When(approx) _____
Medication:	_____	When(approx) _____
Surgery:	Type_____	When(approx) _____

Other_____

7. When did you receive these treatments and for how long?

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

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

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10. What activities/movements are guaranteed to make it worse?

11.Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

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12. Is it worse in the morning or is it worse as the day progresses?

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13. If you cannot find a solution to this problem what do you think will happen to you?

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14. What are you hoping Dr. Heather tells you today?

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15. Describe what you hope or think she might be able to do for you.

16.Describe what will be different in your life if you can get better.

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17. When is the VERY FIRST time you recall having this problem? ----------
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List 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?_____
4._____ How Long Have You Had This?_____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This Problem? (circle one)
Occasionally (25% of the time)
Intermittently (50% of the time)
Frequently (75% of the time)
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 Your Leisure Activities? (Hobbies, Travel, Sports, etc...)
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 being unbearable, 0 being No Pain or Discomfort) 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 _____
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. (Mark C for Current. X for in last 12 mos.)

GENERAL
Chills ____ Convulsions ____ Dizziness ____ Fainting ___ Fatigue ____ Fever ____ Headache ____ Loss of Sleep ____
Allergy ____ (to what_____) Loss of Weight ____ Nervousness ____ Wheezing ____ Bronchitis ____
Numbness in BOTH hands AND feet ____

CARDIOVASCULAR
High Blood Pressure ____ Low Blood Pressure ____ Pain over heart ____ Poor Circulation ____ Rapid Heartbeat ___
Previous Heart Problem ____ (Describe _____) Slow Heartbeat ____ Stroke ____ TIA ____
Swollen Ankles ____ Varicose Veins ____ Aortic Aneurysm ____ Bruise Easily ____

DISEASES/CONDITIONS
Appendicitis ____ Anemia ____ Arthritis ____ Alcoholism ____ Abdominal Surgery ____ Bleeding Disorder ____
Blood Clot(s) ____ Breathing Difficulty ____ Cancer ____ Cholesterol High ____ Colon Problems ____ Diabetes ____
Depression ____ Epilepsy ____ Eczema ____ Eating Disorder ____ Glaucoma ____ HIV + ____ Heart Disease ____
Hernia ____ Headaches ____ Influenza ____ Kidney Disease ____ Liver Disease ____ Low back Pain ____
Mental Illness ____ Measles ____ Mumps ____ Pleurisy ____ Pneumonia ____ Polio ____ Prostate Problems ____
Hyperthyroid ____ Hypothyroid ____ 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 ____ Hemorrhoids ____
Liver Trouble ____ Nausea ____ Stomach Ache ____ Poor Appetite ____ Poor Digestion ____ Vomiting ____
Vomiting Blood ____ Rectal Bleeding ____ Bloating ____

GENITO-URINARY
Blood in Urine ___ Frequent Urination ___ Inability to control urine ____ Kidney Infection ____ Painful Urination ____
Prostate Trouble ____ Painful Urination ____

FOR MEN ONLY
Lump in testicles ____ Penis discharge ____

FOR WOMEN ONLY
Menstrual Cramps ____ Excessive menstrual flow ____ Hot Flashes ____ Irregular Cycle ____ Painful periods ____
Birth Control Pills ____ Abnormal Pap Smear ____

MUSCLE/JOINT/BONE
Backache ____ Foot Trouble ___ Pain 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 ____