Application For Treatment

Prieto Chiropractic & Spinal Decompression Center

This application is the first step in assisting the doctor in determining if you are a candidate for our specialized treatment system utilizing Non-Surgical Spinal Decompression. Please answer the following questions honestly and to the best of your knowledge.

Applicant's Name _____ Date _____

Age _____ Date of Birth _____ Sex: ☐M ☐F Marital Status: _____

Address _____City_____ Zip _____

Home Phone _____ Alternate Phone _____

E-mail _____ Occupation _____

How Did You Hear About Us? ☐Newspaper ☐TV ☐ Patient Newsletter ☐MD Referral
☐Chiropractor Referral ☐ Physical Therapist Referral
☐Radio ☐ Event Booth ☐Other_____

If you were referred, whom can we thank for referring you?_____

Medical Doctor Name?_____Phone_____

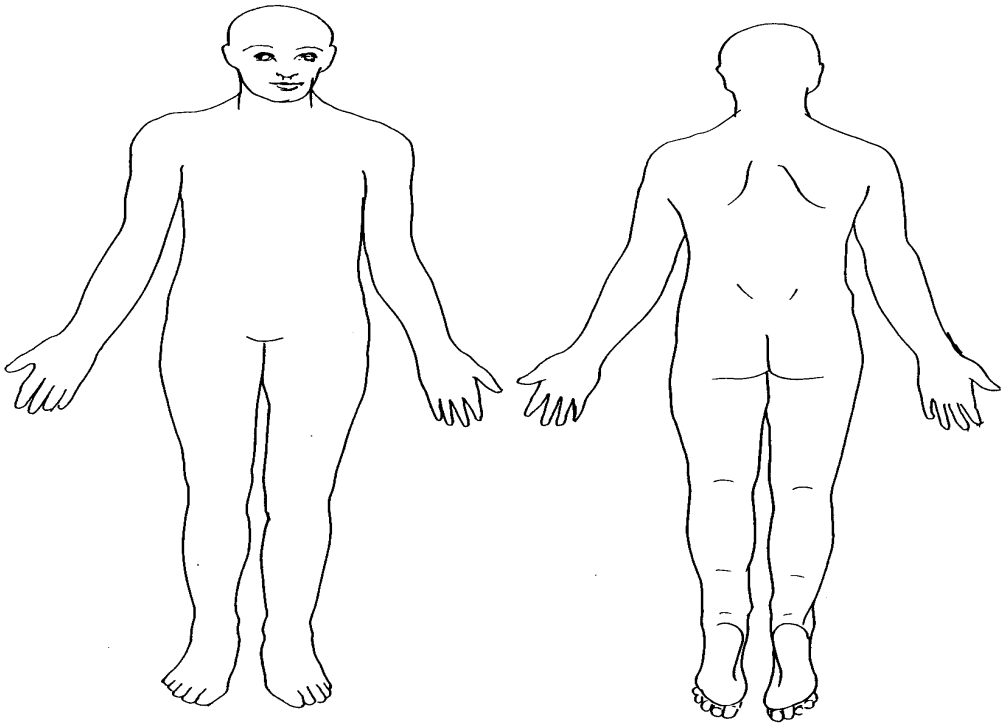
M.D. Address_____

- What Is Your Main Problem / Symptom Prompting Your Request For A Consultation With Our Doctor? _____
- Would You Consider This Problem (check one): ☐ MINIMAL (Annoying but causing NO limitations)
  ☐ SLIGHT (Tolerable but causing a little limitation)
  ☐ MODERATE (Sometimes tolerable but definetly causing limitations)
  ☐ SEVERE (Causing Significant limitations)
  ☐ EXTREME (Causing near constant limitations)
- Since your problem began, what three things has it caused you to miss out on the most?

  1)_____2) _____3)_____
- On a scale of 1 – 10 (**10** being **unbearable pain**, **0** being **NO Pain** or Discomfort) Please rate the following:
  The **HIGHEST** level of pain **WITHOUT** medication _____
  The **LOWEST** level of pain **WITHOUT** medication _____
  The **HIGHEST** level of pain **WITH** medication _____
  The **LOWEST** level of pain **WITH** medication _____
- What kind of treatments have you received for your problem/pain?
  ☐ Physical Therapy ☐ Chiropractic ☐ Acupuncture ☐ Pain Medications
  Which Meds Are You Taking:_____
  ☐ Spinal Injections How Many?_____ Date of Last Injection _____
  ☐ Spinal Surgery: Surgery Type and Dates _____

- Using the key below mark the drawing <u>in the location(s)</u> you have pain or altered sensation, with the letter that best describes what you are feeling:

A = Ache
B = Burning
D = Dull
N = Numbness
S = Stiffness
SH = Sharp Pain
ST = Stabbing Pain
T = Tingling
TH = Throbbing



- Height _____ Weight _____
- Does your pain wake you up at night? ☐ Yes ☐ No How Often? _____
- What activities/movements guarantee to make your problem worse? _____

  _____
- During a typical day, when is your pain the worst? _____
- What position do you sleep in at night? ☐ Flat on Back w/out leg support
  ☐ Side Lying Fetal Position <u>w/out</u> leg support
  ☐ Side Lying Fetal Position <u>with</u> leg support
  ☐ On Your Stomach
- Due To Your Main Problem**;**
  a) Have You Lost Any Time From Work (If Applicable)? ☐ Yes ☐ No
  Average Lost Work Time? _____
  What Work Tasks Have Been Limited? _____
  b) Any Specific Chores or Tasks At Home You Are Limited In or Can No Longer Do?
  Please List_____
- Have you ever had a surgical repair of an abdominal aortic aneurysm? ☐ Yes ☐ No
- Have you ever fractured your spine or pelvis? ☐ Yes ☐ No
  If yes, please explain: _____

  _____
- Have you ever been diagnosed with osteoporosis? ☐ Yes ☐ No
  If yes, did you receive a bone density test? ☐ Yes ☐ No
- If you cannot find a solution to this problem what would concern you the most? _____

  _____

The last section of this application is the General Health History Section. Please complete the section below, thoroughly and answer to the best of your knowledge.

HEALTH HISTORY

Mark "C" if you are CURRENTLY experiencing or "X" if you've experienced any of the following in the last 24 months?

GENERAL

Chills _____ Convulsions _____ Dizziness _____ Fainting _____ Fatigue _____ 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 Problem _____ 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 _____ Surgical Repair of Adominal Aortic Aneurysm _____ High BP ____ Stroke____

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 Mentrual Flow _____ Hot Flashes _____ Irregular Cycle _____
Painful Periods _____ Birth Control Pills _____ Abnormal Pap Smear _____ Pregnant? YES NO

MUSCLE/JOINT/BONE

Backache _____ Foot Trouble _____ Pain Between Shoulders _____ Painful Tailbone _____
Stiff Neck _____ Scoliosis/Spinal Curvature _____ Swollen Joints _____

Mark "C" if you are CURRENTLY experiencing or "X" if you've experienced any of the following in the last 24 months?

NEUROLOGIC

Seizures _____ Dizziness _____ Hand Trembling _____ Muscle Weakness _____ Difficulty With Speech _____ Loss of Memory _____ Loss of Coordination _____

RESPIRATORY

Chest Pain _____ Chronic Cough _____ Difficulty Breathing _____ Coughing/Spitting Up Blood _____

PLEASE LIST ANY OTHER SURGICAL PROCEDURES

_____

_____

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I (signature)_____consent to allow Dr. Prieto and staff to consult with me and perform an examination (if necessary) in order to determine if I am a clinical candidate for non-surgical spinal decompression on the DRX 9000. I understand that completing this application does not automatically guarantee that I have been accepted as a patient for treatment. It is also my understanding that the initial consultation and examination are being provided to me at NO CHARGE.

----------OFFICE USE ONLY----------

Notes:

Case Accepted _____ Case Not Accepted_____

Case Referred Out For Further Evaluation _____

Consulting Doctors Signature _____Date_____