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Non Surgical Spinal Decompression Application

*As you read through and fill out these questions, understand that this is an application for the SpinalAid Centers of America non-surgical spinal decompression program. This is NOT a guarantee of acceptance. The doctor will be assessing your case and analyzing it for 5 criteria which will be reviewed with you. The program is only for patients with severe/chronic neck or back pain, herniated discs, bulging discs, spinal stenosis, and sciatica. The doctor **ONLY** works with patients who are tired of, or who don't want to take medications, those who want an alternative to dangerous injections, invasive, irreversible surgeries with questionable outcomes, or have had failed back surgeries. If you are not serious about finding a solution to your problem please be respectful of our time and we will do the same for you. _____ **Initial***

Date _____ Social Security # _____

Name _____ Married / Divorced / Separated / Widowed / Single
Last *First* *Middle Initial* *(Circle One)*

Address _____ City _____ St _____ Zip _____

Phone _____ Cell _____ Work _____ E-mail _____

Date of Birth _____ Age _____ ❑ M ❑ F Ht: ___ft. ___ in. Wt. _____ Referred By _____

Occupation _____ Shift _____ Employer _____ How Long _____

Spouse/Guardian _____ Spouse's Employer _____

List your **Major Complaints** in order of severity:

1. _____ 3. _____
2. _____ 4. _____

In order to understand your overall health status, please indicate if you have any difficulty with any of the following? (Check all that apply):

❑ Headaches	❑ Fainting or Seizures	❑ Diabetes	❑ Constipation
❑ Shooting Head Pains	❑ Loss of Balance	❑ High Blood Pressure	❑ Diarrhea
❑ Sinus Trouble	❑ Ringing of Ears or Ear Aches	❑ Low Blood Pressure	❑ Painful Menstruation
❑ Loss of Smell / Taste	❑ Hearing Difficulty	❑ Liver Trouble	❑ Irregular Menstruation
❑ Hayfever / Allergies	❑ Eye / Vision Trouble	❑ Anemia	❑ Arthritis
❑ Asthma	❑ Neck Muscle Spasm	❑ Acid Reflux or Ulcers	❑ Tailbone/Sacrum Pain
❑ Cancer	❑ Grating in Neck	❑ Abdominal Pain	❑ Painful Joints
❑ Throat Trouble	❑ Tightness in Shoulder Muscles	❑ Stomach Trouble	❑ Swollen Joints
❑ Infections	❑ Pain in Shoulders & Arms	❑ Indigestion	❑ Hip Pain
❑ Thyroid Trouble	❑ Pins & Needles in Arms & Hands	❑ Nerves, Nervousness	❑ Slipped Disc
❑ Sleeping Trouble	❑ Cold Hands	❑ Inner Tension	❑ Pinched Nerve in Back
❑ Facial Pain or Palsy	❑ Chest Pains or Rib Pains	❑ Irritability–Moodiness	❑ Pins & Needles in Legs
❑ Loss of Memory	❑ Shortness of Breath	❑ Prostate Trouble	❑ Swollen Ankles
❑ Chronic Fatigue	❑ Carpal Tunnel Syndrome	❑ Bladder Problems	❑ Cold Feet
❑ Depression / Anxiety	❑ Fibromyalgia	❑ Gall Bladder Problems	❑ Numbness in Legs
❑ Stress	❑ Heart Palpitation or Heart Trouble	❑ Kidney Trouble	❑ Knee Pain
❑ Dizziness / Vertigo	❑ Upper Back Pain	❑ Buttocks Pain	❑ Groin Pain
❑ Neck Pain	❑ Mid Back or Shoulder Blade Pain	❑ Low Back Pain	❑ Pain in Legs and Feet

List any **Accidents or Injuries** in the past year _____

in the past 1-10 years _____

in the past 10-20 years _____

List **all Surgeries** and when _____

List **all Medications** and what they're for _____

Is Your Condition a Result of Your: ❑ Employment ❑ Auto Accident ❑ Personal Injury ❑ Other _____

Previous Chiropractic care? ❑ Yes ❑ No When? _____ Where? _____

Name of **Primary/Family doctor** *(phone, address)* _____

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 non-surgical spinal decompression and also to determine if the doctor is willing to accept my case. It is also my understanding that the consultation is at no charge.

Patient Name_____

Check any MEDICATIONS you are taking, including Over-The-Counter (OTC) & Prescription (Rx):

(check all that apply)	OTC	Rx
Headaches	❑	❑
Pain	❑	❑
Muscle Relaxants	❑	❑
Arthritis	❑	❑
Steriods	❑	❑
Sinus/Allergy	❑	❑
Asthma/Bronchitis	❑	❑
Sleeping	❑	❑

(check all that apply)	OTC	Rx
Diabetes	❑	❑
Water Pills	❑	❑
Heart/Cardiovascular	❑	❑
Blood Pressure	❑	❑
Cholesterol	❑	❑
Ulcers	❑	❑
Depression/Anxiety	❑	❑
Psychological	❑	❑

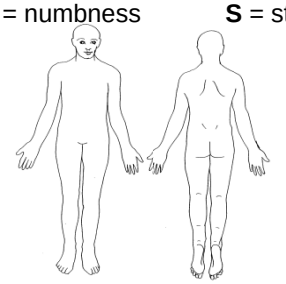
(check all that apply)	OTC	Rx
Bowels/Laxative	❑	❑
Hormones	❑	❑
Thyroid	❑	❑
Antibiotics	❑	❑
Birth Control		❑
Heartburn/Stomach	❑	❑
Other _____	❑	❑
NOT TAKING Medications	❑	❑

Do you have difficulties with any of the following ACTIVITIES? (check all that apply)

- ❑ Pushing
- ❑ Pulling
- ❑ Laundry
- ❑ Standing
- ❑ Sitting
- ❑ Reclining
- ❑ Prolong Standing
- ❑ Carry objects
- ❑ Lifting
- ❑ Bowling
- ❑ Golfing
- ❑ Concentrating
- ❑ Drying Hair
- ❑ Combing Hair
- ❑ Washing Face
- ❑ Walking
- ❑ Stooping
- ❑ Squatting
- ❑ Prolong sitting
- ❑ Leaning
- ❑ Twisting
- ❑ Jogging
- ❑ Dancing
- ❑ Driving car
- ❑ Brushing Teeth
- ❑ Making Bed
- ❑ Putting on shirt
- ❑ Kneeling
- ❑ Reaching
- ❑ Bending forward
- ❑ Prolonged walk
- ❑ Bathing
- ❑ Showering
- ❑ Swimming
- ❑ Washing dishes
- ❑ Going to toilet
- ❑ Put on shoes
- ❑ Tying shoes
- ❑ Put on pants
- ❑ Bending
- ❑ Climbing
- ❑ Skiing
- ❑ Prolong kneel
- ❑ Exercise upper
- ❑ Exercise lower
- ❑ Ice Skating
- ❑ Roller skating
- ❑ Preparing meal

* On the drawing below, mark where you have pain or altered sensation.

P = pain / soreness **T** = tingling
A = aching **B** = burning
N = numbness **S** = stiffness



REVIEW OF SYSTEMS (check all that apply)

General
- ❑ Chills
- ❑ Fainting
- ❑ Fever
- ❑ Forgetfulness
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Sweats

Genito-Urinary
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination

Eyes
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Vision - Flashes
- ❑ Vision - Halos
- ❑ Blurred vision

Ears/Nose/Throat
- ❑ Earache
- ❑ Ear Discharge
- ❑ Loss of hearing
- ❑ Nose bleeds
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Persistent cough

Respiratory
- ❑ Cough
- ❑ Congestion
- ❑ Distress
- ❑ Sputum
- ❑ Shortness of breath

Endocrine
- ❑ Weight gain
- ❑ Weight loss
- ❑ Hoarseness
- ❑ Heat Intolerance
- ❑ Cold Intolerance
- ❑ Breast Changes
- ❑ Hair Changes
- ❑ Extreme Thirst

Gastrointestinal
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel changes
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting no blood
- ❑ Vomiting with blood

Cardiovascular
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

Men only
- ❑ Breast lumps
- ❑ Erection difficulties
- ❑ Lump in testicles
- ❑ Penis discharge
- ❑ Sore on penis
- ❑ Prostate Problem
- ❑ Other _____

Women Only
- ❑ Abnormal pap smear
- ❑ Bleeding between periods
- ❑ Breast lumps
- ❑ Miscarriage
- ❑ Extreme menstrual pain
- ❑ Hot flashes
- ❑ Nipple discharge
- ❑ Painful intercourse
- ❑ Vaginal discharge
- ❑ Vaginal Infections
- ❑ Date of last menstrual period _____
- ❑ Date of last pap smear_____
- ❑ Have you had a mammogram? _____
- ❑ Are you pregnant? ___
- ❑ Number of children ___
- ❑ Other _____

Integumentary (skin)
- ❑ Bruise easy
- ❑ Hives
- ❑ Change in moles
- ❑ Sores that won't heal
- ❑ Itching
- ❑ Unusual swelling
- ❑ Sores/ulcers
- ❑ Rash
- ❑ Scars

Neurological
- ❑ Seizures
- ❑ Vertigo
- ❑ Dizziness
- ❑ Hand Trembling
- ❑ Loss of Sensations
- ❑ Loss of facial expression
- ❑ Weak Grip
- ❑ Paralysis
- ❑ Difficulty of Speech
- ❑ Tingling
- ❑ Numbness
- ❑ Un-coordination

Psychiatric
- ❑ Hyperventilation
- ❑ Insecurity
- ❑ Trouble Sleeping
- ❑ Irritable
- ❑ Undecidedness
- ❑ Timid
- ❑ Hallucinations
- ❑ Loss of Memory
- ❑ Alcoholism
- ❑ Drug Addiction
- ❑ Drug Dependency
- ❑ Extreme Worry
- ❑ Sexual Problems
- ❑ Suicidal Thoughts

Conditions
- ❑ AIDS
- ❑ Alcoholism
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Bleeding Disorders
- ❑ Breast Lumps
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Hernia
- ❑ Herpes
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Measles
- ❑ Migraine Headaches
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pneumonia
- ❑ Polio
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Fever
- ❑ Ulcers
- ❑ Venereal Disease
- ❑ Other _____