Non-Surgical Spinal Decompression Intake Form

As you read through and fill out this questionnaire, please understand that this is an application to *Pinhook Chiropractic Clinic's* Non-Surgical Spinal Decompression and Spinal Hygiene Programs. This is NOT a guarantee of acceptance. Our Doctors will be assessing your case and analyzing it for 5-criteria, which will be reviewed with you. This program is only for patients with severe/chronic back and/or neck pain, herniated disc, bulging disc, spinal stenosis, radicular pain and sciatica. *Pinhook Chiropractic Clinic* works ONLY with patients who are trying to limit or avoid the overuse of medications, those who want an alternative to dangerous injections, invasive surgeries, or have had Failed Back Surgery Syndrome. 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.

Personal Information:

Name_____ Date of Birth_____ Email_____
Address_____ City_____ State_____ Zip_____
Cell Phone (___)_____ Home Phone (___)_____
SS#_____ Employer_____ Occupation_____

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 candidate for non-surgical spinal decompression and also to determine if the clinic doctors will accept my case. It is also my understanding that the consultation is at no charge.

How did you hear about our office? _____
How serious do you think your problem is?_____
In reference to the severity, how would you rate it on a scale of 0-10? (10 being the worse**) _____**
What is your reason for prompting your request for a consultation with the doctor? _____
_____

How do you view your problem (circle one)	MINIMAL	(Annoying but causing NO limitations)
	SLIGHT	(Tolerable but causing a little limitation)
	MODERTATE	(sometimes tolerable but causing limitations)
	SEVERE	(Causing Significant limitations)
	EXTREME	(Causing near constant limitations)

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

_____

What are you hoping happens today as a result of the doctor spending time with you?

_____

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

_____

How long have you been like this?_____

Please describe in detail the very first time you recall having this problem and what it felt like?

_____

_____

What changes or modifications have you had to make to your lifestyle sine your back problem?

_____

_____

What actions or activities do you have trouble with, or have limitations to?

_____

_____

What kind of treatments have you received? {Limit to Lower Back & Neck only}

Surgeries _____ How Many _____ When_____ How long did effects last _____

Injections _____ How Many _____ When_____ How long did effects last _____

Chiropractic Care _____ When_____ How long did effects last _____

Physical Therapy _____ When_____ How long did effects last _____

Drugs/Pharmaceuticals_____ When _____ How long did effects last _____

Other:_____

Did any of these treatments seem to work in helping your pain?

If so which one(s) and for how long?_____

_____

What actions can you take that temporarily decrease the pain?_____

_____

What activities or movements are guaranteed to increase your pain and worsen your condition?

_____

What does the pain feel like (sharp, dull, achy, toothache, shooting, stabbing, numb, tingling, etc…) and where?_____

_____

What does if feel like when you wake up compared to the rest of the day?_____

Is it worsen in the morning or the evening?_____

What are you hoping the doctor will tell you today?_____

_____

Please express what you hope or imagine this state-of-the-art program and knowledge might be able to accomplish for you?_____

_____

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

_____

List in order of importance all other health problems or concerns NOT including you main problem.

1._____ **How Long** _____

2._____ **How Long**_____

3._____ **How Long** _____

What percentage of the time are you aware of your main 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 problem …

Have you lost any time from work? Yes No
How much time and what have you been? _____
Have you lost any time from your obligations at home? Yes No
How much time and what chores have been limited at home? _____
Have you lost any time from your family? Yes No
How much time and what tasks have been limited? _____
Have you lost any time enjoying you leisure activities? Yes No
How much time and what tasks have been limited? _____
How long has your problem been this severe? _____

On a scale 1-10 (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:

_____
_____
_____
_____