

Lordex Spine Center Application For Admission

Non surgical Spinal Care for Severe Neck, Shoulder, Low Back & Leg Pain

If you are reading this you have been fortunate enough to qualify for a *consultation* with the Doctor 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 the Doctor is UNAVAILABLE to treat you, your case will be referred to another clinic.

Today's Date _____
Name _____ Age _____ DOB _____ 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 message for you? Y N
Employer _____ Occupation _____
Length of Employment _____
Marital Status S M W D Spouse's Name _____ SS# _____

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 he 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 the Lordex Spine Center? _____

Please circle all of the areas where you are experiencing pain:

Head Neck Shoulder Arm Hand Fingers Low Back Buttock Hip Knee Leg Calf Ankle Toes

What is your main problem/symptom prompting your request for a consultation with the Doctor?

Have you been diagnosed with any of the following? (Please circle)

Disc Bulge Disc Herniation Facet Syndrome Sciatica Stenosis Spondylolisthesis Degeneration Other

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)

The pain has affected your quality of life by limiting your daily activities in the following ways: (Circle)

Sitting Pain	Difficulty Sleeping	Difficulty Walking	Decreased Focus and Energy
Standing Pain	Decreased Activities	Difficulty Driving	Difficulty working at the computer
Decreased Grasping	Difficulty Reaching	Difficulty Lifting	Difficulty taking care of myself

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

2. Since your neck, shoulder, or back pain became this severe what three things has it caused you to miss the most?

3. How long has this pain been affecting your quality of life?

4. Diagnostic tests performed:

Y	N	X-rays	Date:	_____
Y	N	MRI's	Date:	_____
Y	N	CT scan	Date:	_____
Y	N	Myelogram	Date:	_____
Y	N	EMG/NCV	Date:	_____

5. Previous treatment for neck, shoulder, or low back pain performed by:

Y	N	Family MD	Name:	_____
Y	N	Orthopedic Surgeon	Name:	_____
Y	N	Chiropractor	Name:	_____
Y	N	Physical Therapist	Name:	_____
Y	N	Neurologist	Name:	_____

6. What kind of treatments have you received?

Epidural (Injection):	How Many	_____	When (approx.)	_____
Physical Therapy:	How Long	_____	When (approx.)	_____
Medication:		_____	When (approx.)	_____
Surgery:	Type	_____	When (approx.)	_____
Do you have any permanent hardware as a result of surgery?: _____				
Other _____				

7. Did any of these treatments work? If so which one(s)? How long did it last?

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

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

10. Please describe the quality of the pain. (sharp, dull, achy, toothache, shooting, stabbing, numb, tingling, burning, catching, weakness, etc.)

11. Is it worse in the morning, as the day progresses, or end of the day?

12. Are you considering neck, back, or shoulder surgery? Yes No

13. 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_____

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)

14. When is the VERY FIRST time you recall having this problem?

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

16. If there is an effective and affordable procedure to treat your condition, are you ready to start treatment?
YES NO

17. Do you have any questions we can answer for you?

List In Order Of Importance all OTHER Health Challenges/ Concerns NOT including Your Main Health Challenge.

- | | |
|----------|-----------------------------------|
| 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? _____ |

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 Problem___ Sore Throat___

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___

FOR MEN ONLY

Lump in testicle___ 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___

OFFICE USE ONLY:

.TRHDC.

LORDEX EXCLUSION CRITERIA

- A. PREGNANCY**
- B. PRIOR LUMBAR FUSION**
- C. METAL IMPLANT SURGERY (CAGES, SCREWS, ETC.)**
- D. METASTATIC CANCER**
- E. SEVERE OSTEOPOROSIS**
- F. SPONDYLOLITHESIS (unstable)**
- G. COMPRESSION FRACTURE OF CERVICAL OR LUMBAR SPINE
BELOW L1 (recent)**
- H. PARS DEFECT**
- I. PATHOLOGIC AORTIC ANEURYSM**
- J. PELVIC OR ABDOMINAL CANCER**
- K. DISC SPACE INFECTIONS**
- L. SEVERE PERIPHERAL NEUROPATHY**
- M. HEMIPLEGIA, PARAPLEGIA, OR COGNITIVE DYSFUNCTION**

I HAVE READ THE ABOVE LIST OF EXCLUSIONS FOR RECEIVING LORDEX DECOMPRESSION AND UNDERSTAND THAT BY SIGNING BELOW I AM STATING THAT I DO NOT HAVE ANY OF THE ABOVE LISTED EXCLUSIONS.

Name: _____

Signature: _____

Date: _____