Application for Admission
rehab*fx* *Severe Back/Neck Pain Program*

If you are reading this you have been fortunate enough to qualify for a ***consultation and/or an evaluation*** with the Doctor. This however does NOT mean that your case has been accepted. Your consultation and/or evaluation today may 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, options will be made available to you.

Today's Date ____________________ Email: ________________________________

Name _______________________________________ Age _________ Birthdate ____________ SS# ____________________

Address ____

City____________________________ State _________________ Zip ____________ Sex M F

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 Spouse's Name __________________________________

I (signature) _______________________________consent to allow rehabfx 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 they are 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 rehabfx? ____

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 or neck 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 or neck pain became this severe what three things has it caused you to miss the most?

4. How long have you been like this?

5. How has your life changed since your back or neck became a problem?

6. What activities are you limited in?

7. What kinds of treatments have you received?

Epidural Injections: How Many ______________________ When(approx) ________________________________

Physical Therapy: How Long ________________________ When(approx) ________________________________

Medication: ______________________________________ When(approx) ________________________________

Surgery: Type______________________________________ When(approx) ________________________________

Other____

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

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

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

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

12. Please describe the quality of the pain. (Sharp, Dull, Achy, Toothache, Shooting, Stabbing, Numb, Tingling, etc...)

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

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

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15. What are you hoping the Doctor tells you today?

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16. Describe what you hope or think the Doctor might be able to do for you.

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

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

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If your insurance carrier does not cover your treatment, are you willing to pay out of pocket to correct your condition? Yes or No

Have you had an MRI? Yes or No

Where and when did you have this MRI done?

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List In Order of Importance all OTHER Health Problems/Concerns NOT includng 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?

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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.

IN CASE OF EMERGENCY (Name of relative or close friend not living in your home):

Name:____________________________Home Phone (____)____________ Cell Phone: (____) ____________
Address:____

24-Hour Notice Policy: Appointments that are rescheduled or cancelled within 24 hours or failure to show may be subject to a $35.00 fee.

I, the undersigned, understand and agree to authorize Minors Chiropractic, Inc. (dba Rehab*fx)* and all employees to administer whatever examination and procedures they deem necessary. Fees are payable at the time of service unless other arrangements are made in advance. I agree that medical records may be transmitted to me or other health care providers via email, fax, or mail.

X Patient Signature___________________________________ Date____________________
X Signature of Authorizing Parent/Guardian (if minor)____

HIPAA GUIDELINES FOR REHAB*FX* ARE AVAILABLE FOR REVIEW UPON REQUEST