



SPINAL DECOMPRESSION THERAPY APPLICATION

(Please Print)

As you read through and fill out these questions, please understand that this is an application to Georgia Spine and Disc/ laser therapy center.

This is NOT a guarantee of acceptance. This Program is only for patients with severe/chronic back pain, herniated discs, bulging discs, spinal stenosis, and sciatica.

Today's Date:		Name:	
DOB:		Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Address:			
City:		State:	Zip:
Home Phone: ()		Work Phone: ()	Cell Phone: ()
Best Place to Reach You: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell		May we leave a message? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E-mail:		SS #	
Employer:		Occupation:	
Length of Employment:			
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Spouse's Name:	
PATIENT INFORMATION			
How serious do you think your problem is?		In reference to the severity, how would you rate it on a scale of 0-10? (circle one)	
		1 2 3 4 5 6 7 8 9 10	
What is your reason for prompting your request for a consultation with the doctor?			
Please check all of the areas where you are experiencing pain:			
<input type="checkbox"/> Head	<input type="checkbox"/> Hand	<input type="checkbox"/> Knee	
<input type="checkbox"/> Neck	<input type="checkbox"/> Fingers	<input type="checkbox"/> Leg	
<input type="checkbox"/> Shoulder	<input type="checkbox"/> Low Back	<input type="checkbox"/> Calf	
<input type="checkbox"/> Arm	<input type="checkbox"/> Buttock	<input type="checkbox"/> Ankle	
	<input type="checkbox"/> Hip	<input type="checkbox"/> Toes	
Have you been diagnosed with any of the following?			
<input type="checkbox"/> Disc Bulge	<input type="checkbox"/> Facet Syndrome	<input type="checkbox"/> Spondylolisthesis	
<input type="checkbox"/> Disc Herniation	<input type="checkbox"/> Sciatica	<input type="checkbox"/> Degeneration	
	<input type="checkbox"/> Stenosis	<input type="checkbox"/> Other _____	
Would you consider this problem (check one)...			
<input type="checkbox"/> MINIMAL (Annoying but causing NO limitations)		<input type="checkbox"/> MODERATE (Sometimes tolerable but definitely causing limitations)	
<input type="checkbox"/> SLIGHT (Tolerable but causing a little limitation)		<input type="checkbox"/> SEVERE (Causing significant limitations)	
		<input type="checkbox"/> 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:			
<input type="checkbox"/> Sitting Pain	<input type="checkbox"/> Decreased Activities	<input type="checkbox"/> Difficulty Lifting	
<input type="checkbox"/> Standing Pain	<input type="checkbox"/> Difficulty Reaching	<input type="checkbox"/> Decreased Focus and Energy	
<input type="checkbox"/> Decreased Grasping	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Difficulty Working at the Computer	
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Difficulty Driving	<input type="checkbox"/> Difficulty Taking Care of Myself	
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?			
Since your neck, shoulder, or back pain became this severe what three things has it caused you to miss the most?			

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

Diagnostic tests performed:

X-Rays : <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	MRI's : <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
CT Scan : <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:	Myelogram : <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
EMG/NCV : <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:		

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

Family MD : <input type="checkbox"/> Yes <input type="checkbox"/> No	Name:	Orthopedic Surgeon : <input type="checkbox"/> Yes <input type="checkbox"/> No	Name:
Chiropractor : <input type="checkbox"/> Yes <input type="checkbox"/> No	Name:	Physical Therapist : <input type="checkbox"/> Yes <input type="checkbox"/> No	Name:
Neurologist : <input type="checkbox"/> Yes <input type="checkbox"/> No	Name:		

What kind of treatments have you received?

Physical Therapy:	How Long:	When:
Medication:	What:	When:
Surgery:	Type:	When:

Do you have any permanent hardware as a result of surgery?

Other Treatments you have received:

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

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

What activities / movements are guaranteed to make it worse?

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

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

Are you considering neck, back, or shoulder Surgery? Yes No

On a scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following... (circle one)

The HIGHEST your pain gets WITHOUT medication:	1	2	3	4	5	6	7	8	9	10
The LOWEST your pain gets WITHOUT medication:	1	2	3	4	5	6	7	8	9	10
The HIGHEST your pain gets WITH medication:	1	2	3	4	5	6	7	8	9	10
The LOWEST your pain gets WITH medication:	1	2	3	4	5	6	7	8	9	10

In Reference to your MAIN PROBLEM How often are you Aware of This Problem?

Occasionally (25% of the time) Intermittently (50% of the time) Frequently (75% of the time) Constant (90-100% of the time)

Have you lost any time off work? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much time and what have you been unable to perform?
Have you lost any time from your family? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much time, and what tasks have been limited?
Have you lost any time from your obligations at home? <input type="checkbox"/> Yes <input type="checkbox"/> No	How much time, and what tasks have been limited?
Have you lost time from enjoying your leisure activities? <input type="checkbox"/> Yes <input type="checkbox"/> No	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?

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

Date:

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

If there is an effective and affordable procedure to treat your condition, are you ready to start treatment? Yes No

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?

HEALTH HISTORY

Have you had ANY of the following in the last 12 months or currently?

Please mark P for Past and C for Current. P = Past C = Current

GENERAL

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Fever | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Headache | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Allergy (to what _____) | <input type="checkbox"/> Numbness in BOTH hands AND feet |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Weight | |

CARDIOVASCULAR

- | | | |
|--|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Previous Heart Problem
(Describe: _____) | <input type="checkbox"/> Swollen Ankles |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Slow Heartbeat | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Pain over heart | <input type="checkbox"/> Stroke | <input type="checkbox"/> Aortic Aneurysm |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> TIA | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Rapid Heartbeat | | |

DISEASES / CONDITIONS

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Low Back Pain |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Abdominal Surgery | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> HIV+ | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Blood Clot(s) | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hyper Thyroid |
| <input type="checkbox"/> Cholesterol – High | <input type="checkbox"/> Influenza | <input type="checkbox"/> Hypo Thyroid |
| <input type="checkbox"/> Colon Problems | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rectal Surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | |

EARS / EYES / NOSE / THROAT

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Deafness | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Sinus Problem |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Sore Throat |

GASTRO-INTESTINAL

- | | | |
|--|---|--|
| <input type="checkbox"/> Gas | <input type="checkbox"/> Liver Trouble | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Colon Trouble | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting Blood |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Stomach Ache | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Rectal Bleeding |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Poor Digestion | <input type="checkbox"/> Bloating |

GENITO-URINARY

- | | | |
|---|---|--|
| <input type="checkbox"/> Blood in Urine | <input type="checkbox"/> Inability to Control Urine | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Prostate Trouble |

FOR MEN ONLY

- | | |
|---|--|
| <input type="checkbox"/> Lump in Testicle | <input type="checkbox"/> 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

Breathing

- Coughing/Spitting Blood

I, _____ consent to allow the doctor to speak with me and perform an examination (if necessary) in order to determine if I am a good Difficult Candidate for non-surgical spinal decompression and also to determine if the clinic doctors will accept my case.

SPINAL DECOMPRESSION EXCLUSION CRITERIA

- A. METASTATIC CANCER
- B. SEVERE OSTEOPOROSIS
- C. SPONDYLOLITHESIS (UNSTABLE)
- D. COMPRESSION FRACTURE OF CERVICAL OR LUMBAR SPINE BELOW L1 (RECENT)
- E. PATHOLOGIC AORTIC ANEURYSM
- F. PELVIC OR ABDOMINAL CANCER
- G. DISC SPACE INFECTIONS
- H. SEVERE PERIPHERAL NEUROPATHY
- I. HEMIPLEGIA, PARAPLEGIA, OR COGNITIVE DYSFUNCTION

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

Patient/Guardian signature

Date

POLICIES AND PRACTICES

PRIVACY PRACTICES ACKNOWLEDGMENT

I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I clearly understand that I am ultimately responsible for payment to Georgia Spine and Disc, for any and all services rendered to me at the time of my visit. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable.

I accept full responsibility for treatment and I release Georgian spine and disc and its doctors/employees from any and all liability in the unlikely event that a problem occurs from my treatment.

I, the undersigned, affirm and certify that the above information is complete and accurate to the best of my knowledge and is true and correct, and consent to chiropractic care in this office.

NOTICE OF PRIVACY PRACTICE

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully. Protecting our patients' privacy has always been important to this practice. A new state and federal law, the Health Insurance Portability and Accountability Act (HIPAA), went into effect on April 14, 2003 and requires us to inform you of our policy. At Georgia Spine and Disc, we are very careful to keep your health information secure and confidential. This new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice. The law permits us to use or disclose your health information to those involved in your treatment; for example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company. We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone. In an emergency, we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your health information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request. You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you prefer. You have the right to transfer copies of your health information to another practice. You have the right to see or receive a copy of any of your health information. You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.

You have the right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F Washington, D.C. 20201. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact Diamond Disc Institute.

VERIFICATION OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge the Practice has provided me a copy of the Notice Of Privacy Practices, via the website www.georgiaspineanddisc.com or hard copy on the file at the office at 203 Woodpark Place Suite B100, Woodstock, GA 30188 which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

I understand and acknowledge the above statements with my signature below.

Patient

Date

If under the age of 18, a parent or guardian must sign below:

Parent/Guardian signature

Date