DIAMOND DISC INSTITUTE FOR SPINAL CARE

SPINAL DECOMPRESSION THERAPY APPLICATION

(Please Print)

As you read through and fill out these questions, please understand that this is an application to The Diamond Disc Institute. 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: ☐ Male ☐ Female
Address:		
City:	State:	Zip:
Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )
Best Place to Reach You: ☐ Home ☐ Work ☐ Cell	May we leave a message? ☐ Yes ☐ No	
E-mail:	SS #	
Employer:	Occupation:	
Length of Employment:		
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ 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:

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

Have you been diagnosed with any of the following?

- ☐ Disc Bulge
- ☐ Disc Herniation
- ☐ Facet Syndrome
- ☐ Sciatica
- ☐ Stenosis
- ☐ Spondylolisthesis
- ☐ Degeneration
- ☐ Other _____

Would you consider this problem (check 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:

- ☐ Sitting Pain
- ☐ Standing Pain
- ☐ Decreased Grasping
- ☐ Difficulty Sleeping
- ☐ Decreased Activities
- ☐ Difficulty Reaching
- ☐ Difficulty Walking
- ☐ Difficulty Driving
- ☐ Difficulty Lifting
- ☐ Decreased Focus and Energy
- ☐ Difficulty Working at the Computer
- ☐ 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 : ☐ Yes ☐ No	Date:	MRI's : ☐ Yes ☐ No	Date:
CT Scan : ☐ Yes ☐ No	Date:	Myelogram : ☐ Yes ☐ No	Date:
EMG/NCV : ☐ Yes ☐ No	Date:		
Previous treatment for neck, shoulder, or low back pain performed by:			
Family MD : ☐ Yes ☐ No	Name:	Orthopedic Surgeon : ☐ Yes ☐ No	Name:
Chiropractor : ☐ Yes ☐ No	Name:	Physical Therapist : ☐ Yes ☐ No	Name:
Neurologist : ☐ Yes ☐ 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? ☐ Yes ☐ No	How much time and what have you been unable to perform?
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 obligations at home? ☐ Yes ☐ No	How much time, and what tasks have been limited?
Have you lost any time from enjoying your leisure activities? ☐ Yes ☐ 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

__ 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
__ Hyper Thyroid
__ Hypo Thyroid
__ 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
__ Diarrhea
__ Gallbladder Trouble
__ Hemorrhoids
__ Liver Trouble
__ Nausea
__ Stomach Ache
__ Poor Appetite
__ Poor Digestion
__ Vomiting
__ Vomiting Blood
__ Constipation
__ 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
__ Irregular Cycle
__ Painful Periods
__ Birth Control Pills
__ Abnormal Pap Smear

__ Hot Flashes

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

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 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 ACKNOWLEDEGMENT

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 The Diamond Disc Institute, 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 Diamond Disc Institute 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 The Diamond Disc Institute, 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 The 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.diamonddiscinstitute.com or hard copy on the file at the offices at 12670 Lake Blvd., Lindstrom MN 55045 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 of18, a parent or guardian must sign below:

Parent/Guardian signature *Date*