

# Application For Treatment

## ***PRIETO CHIROPRACTIC & SPINAL DECOMPRESSION CENTER***

This application is the first step in assisting the doctor in determining if you are a candidate for our specialized treatment system utilizing Non-Surgical Spinal Decompression. Please answer the following questions honestly and to the best of your knowledge.

Applicant's Name \_\_\_\_\_ Date \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F Marital Status: S M W D

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_

How Did You Hear About Us?  Newspaper  TV  Patient Newsletter  MD Referral  
 Chiropractor Referral  Physical Therapist Referral  
 Radio  Event Booth  Other \_\_\_\_\_

If you were referred, whom can we thank for referring you? \_\_\_\_\_

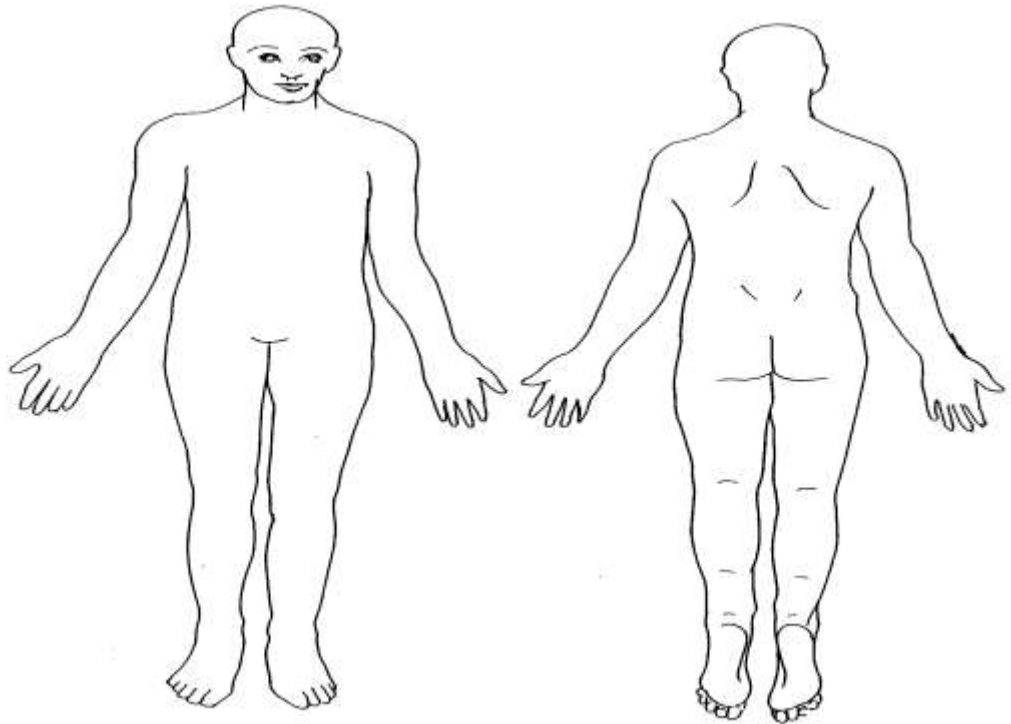
Medical Doctor Name? \_\_\_\_\_ Phone \_\_\_\_\_

M.D. Address \_\_\_\_\_

- What Is Your Main Problem / Symptom Prompting Your Request For A Consultation With Our Doctor? \_\_\_\_\_
- 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 limitations)
- Since your problem began, what three things has it caused you to miss out on the most?  
1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_
- On a scale of 1 – 10 (**10** being **unbearable pain**, **0** being **NO Pain** or Discomfort) Please rate the following:  
The **HIGHEST** level of pain **WITHOUT** medication \_\_\_\_\_  
The **LOWEST** level of pain **WITHOUT** medication \_\_\_\_\_  
The **HIGHEST** level of pain **WITH** medication \_\_\_\_\_  
The **LOWEST** level of pain **WITH** medication \_\_\_\_\_
- What kind of treatments have you received for your problem/pain?  
 Physical Therapy  Chiropractic  Acupuncture  Pain Medications  
Which Meds Are You Taking: \_\_\_\_\_  
 Spinal Injections How Many? \_\_\_\_\_ Date of Last Injection \_\_\_\_\_  
 Spinal Surgery: Surgery Type and Dates \_\_\_\_\_

- Using the key below mark the drawing in the location(s) you have pain or altered sensation, with the letter that best describes what you are feeling:

- |                           |
|---------------------------|
| <b>A</b> = Ache           |
| <b>B</b> = Burning        |
| <b>D</b> = Dull           |
| <b>N</b> = Numbness       |
| <b>S</b> = Stiffness      |
| <b>SH</b> = Sharp Pain    |
| <b>ST</b> = Stabbing Pain |
| <b>T</b> = Tingling       |
| <b>TH</b> = Throbbing     |



- Does your pain wake you up at night?  Yes  No How Often? \_\_\_\_\_
- What activities/movements guarantee to make your problem worse? \_\_\_\_\_  
\_\_\_\_\_
- During a typical day, when is your pain the worst? \_\_\_\_\_
- What position do you sleep in at night?  Flat on Back w/out leg support  
 Side Lying Fetal Position w/out leg support  
 Side Lying Fetal Position with leg support  
 On Your Stomach
- Due To Your Main Problem;
  - a) Have You Lost Any Time From Work (If Applicable)?  Yes  No  
Average Lost Work Time? \_\_\_\_\_  
What Work Tasks Have Been Limited? \_\_\_\_\_
  - b) Any Specific Chores or Tasks At Home You Are Limited In or Can No Longer Do?  
Please List \_\_\_\_\_
- Have you ever had a surgical repair of an abdominal aortic aneurysm?  Yes  No
- Have you ever fractured your spine or pelvis?  Yes  No  
If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_
- Have you ever been diagnosed with osteoporosis?  Yes  No  
If yes, did you receive a bone density test?  Yes  No
- If you cannot find a solution to this problem what would concern you the most? \_\_\_\_\_  
\_\_\_\_\_

*The last section of this application is the General Health History Section. Please complete the section on the next page, thoroughly and answer to the best of your knowledge.*

## HEALTH HISTORY

Mark “C” if you are **CURRENTLY** experiencing or “X” if you’ve experienced any of the following in the last 24 months?

### **GENERAL**

Chills \_\_\_\_\_ Convulsions \_\_\_\_\_ Dizziness \_\_\_\_\_ Fainting \_\_\_\_\_ Fatigue \_\_\_\_\_ 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 Problem \_\_\_\_\_ 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 \_\_\_\_\_ Surgical Repair of Adominal Aortic Aneurysm \_\_\_\_\_

### **EARS/EYES/NOSE/THROAT**

Asthma \_\_\_\_\_ Crossed Eyes \_\_\_\_\_ Double Vision \_\_\_\_\_ Blurred Vision \_\_\_\_\_  
Difficulty Swallowing \_\_\_\_\_ Deafness \_\_\_\_\_ Hearing Loss \_\_\_\_\_ Ear Pain \_\_\_\_\_  
Thyroid Problem \_\_\_\_\_ Nose Bleeds \_\_\_\_\_ Sinus Problems \_\_\_\_\_ Sore Throats \_\_\_\_\_

### **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 \_\_\_\_\_ Painful Urination \_\_\_\_\_

### **FOR MEN ONLY**

Lump in Testicles \_\_\_\_\_ Penis Discharge \_\_\_\_\_

### **FOR WOMEN ONLY**

Menstrual Cramps \_\_\_\_\_ Excessive Mentrual 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 \_\_\_\_\_ Scoliosis/Spinal Curvature \_\_\_\_\_ Swollen Joints \_\_\_\_\_

*Continued on next page>>>*

Mark "C" for Currently or "X" if experienced in the last 24 months

**NEUROLOGIC**

Seizures \_\_\_\_\_ Dizziness \_\_\_\_\_ Hand Trembling \_\_\_\_\_ Muscle Weakness \_\_\_\_\_ Difficulty With  
Speech \_\_\_\_\_ Loss of Memory \_\_\_\_\_ Loss of Coordination \_\_\_\_\_

**RESPIRATORY**

Chest Pain \_\_\_\_\_ Chronic Cough \_\_\_\_\_ Difficulty Breathing \_\_\_\_\_ Coughing/Spitting Up Blood \_\_\_\_\_

I (signature) \_\_\_\_\_ consent to allow Dr. Prieto and staff to consult with me and perform an examination (if necessary) in order to determine if I am a clinical candidate for non-surgical spinal decompression on the DRX 9000. I understand that completing this application does not automatically guarantee that I have been accepted as a patient for treatment. It is also my understanding that the initial consultation and examination are being provided to me at NO CHARGE.

-----OFFICE USE ONLY-----

Notes:

Case Accepted \_\_\_\_\_ Case Not Accepted \_\_\_\_\_

Case Referred Out For Further Evaluation \_\_\_\_\_

Consulting Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_