

Application for Admission
Evolution DT Severe Back/ Neck Pain Solution Program

We will be determining if you qualify for this elective procedure. Please fill in this application so that we can determine:

- a) If you are a legitimate candidate for this program based upon your medical history, and
- b) If your condition is serious enough to warrant your case being accepted for treatment.

Today's Date: _____

Name: _____

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 he is willing to accept my case.

How did you hear about us? _____

How serious do you think your problem is?

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

Would you consider this problem is:

- MINIMAL (annoying but causing NO limitations)
- SLIGHT (tolerable but causing a little limitations)
- MODERATE (sometimes tolerable but definitely causing limitations)
- SEVERE (causing significant limitations)
- EXTREME (causing near constant 80% or more limitations)

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

2. What are you hoping happens as a result of your consultation?

3. Since your back/neck pain became this severe what three things has it caused you to miss the most ?

- 1. _____
- 2. _____
- 3. _____

4. How long have you been like this?

- | | | | |
|--------|---------|----------|-----------------|
| 1 week | 1 month | 3 months | 6 months |
| 1 year | 2 years | 5 years | 6 years or more |

Name: _____

5. What kinds of treatments have you received?

			Results:
Epidural:	How many: _____	When (approx) _____	Good, Fair, Poor
Physical Therapy:	How long: _____	When (approx) _____	Good, Fair, Poor
Chiropractic:	How long: _____	When (approx) _____	Good, Fair, Poor
Medication:	How long: _____	When (approx) _____	Good, Fair, Poor
Surgery:	How long: _____	When (approx) _____	Good, Fair, Poor
Acupuncture:	How long: _____	When (approx): _____	Good, Fair, Poor
Massage Therapy:	How long: _____	When (approx): _____	Good, Fair, Poor
Other:	_____		

6. Did any of these treatments work? If so, which treatment and for how long?

7. List all other physicians you have had evaluate for this condition?

1. Name: _____ Type of Doctor: _____

Phone #: _____ Address: _____

2. Name: _____ Type of Doctor: _____

Phone #: _____ Address: _____

3. Name: _____ Type of Doctor: _____

Phone #: _____ Address: _____

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, etc).

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

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

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

Name: _____

List in order of important all other health problems/concerns not including 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?

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

Due to your MAIN PROBLEM...

1. Have you lost any time from work? YES NO - How much time and what tasks have been limited?
WSIB Yes No

2. Have you lost any time from your chores/tasks at home? NO – YES How much time and what tasks have been limited?

3. Have you lost any time from your family? NO – YES How much time and the events lost.

4. Have you lost any time from your leisure activities (hobbies, travel, sports, etc...)? NO – YES How much time and what tasks have been limited?

5. Considering the amount of pain/discomfort you've had this week, how long has your problem been this severe?

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;

