

SPINAL DECOMPRESSION QUALIFICATION QUESTIONS

Name: _____ Birth Date: _____ Age _____ Weight _____ lbs

Home Tel: _____ Cell: _____ Work _____

Date: _____ Referred by: _____ CA Initial: _____

Qualification Questions for New Patient Consultation:

1. Are you seeking Pain Relief or Healing with Spinal Decompression Therapy or both?

2. Have you seen your physician about this? Yes or No (circle)
If yes what was the recommended treatment, what was the diagnosis?

How was this diagnosed? _____
3. Where is the pain located? _____
4. Are you concerned that you may need surgery?

5. When was your MOST RECENT MRI or CT Scan? _____ if within 2 years ask them to forward them to our office. Where was it performed?

6. Have you ever had surgery in the problem area? No Yes brief description

7. Do you have any breathing conditions? Yes No
If so what are they? _____
8. Do you have COPD or Asthma or Emphysema?

Any Questions that are answered yes from this point may automatically disqualify patients, but continue with questions. Circle corresponding answers.

9. Are you **pregnant**? No Yes
10. Are your legs/arms **paralyzed**? No Yes
11. Have you ever had a **surgical repair of an aortic aneurysm**? No Yes
12. Do you have a history of **strokes**? No Yes
13. Have you ever had a **fracture** or broken your neck or back? No Yes
14. Have you ever had **cancer**? No Yes
15. Have you ever had a **bone scan or bone density scan** No Yes, please bring in scan.
16. Have you ever been told you have **osteoporosis or osteopenia**? No Yes
17. Do you have any **congenital abnormalities of the spine**? No Yes
18. Have you been prescribed any **blood thinners or cortisone**? No Yes
(If there are any uncertainties about any questions, schedule anyway and will sort out during consultation)

I _____ confirm the statements above are true regarding my health history.

Signature _____ Witness _____

Accept Patient _____ Decline Patient _____ Doctor Signature _____

Comments _____
