

Application For Admission

The Scatena Chiropractic DRX9000 Severe Back Pain Solution Program

If you are reading this you have been fortunate enough to qualify for a *consultation* with Dr. Scatena at no charge.

This however does NOT mean that your case has been accepted.

Your consultation today will determine if

A) You are a legitimate candidate for this program and B) Your condition is serious enough to warrant your case being accepted for treatment. In the event your condition IS serious enough to warrant being considered for acceptance and Dr. Scatena is UNAVAILABLE to treat you, your case will be referred to another clinic.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____
City _____ State _____ Zip _____ Email Address _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No
Employer _____ Occupation _____ Length of Employ _____
Marital Status S M W D Spouses Name _____ Your SS# _____
How Did You Hear About Scatena Chiropractic? _____
Family Medical Phycsian: _____ Date of Last Visit: _____ May we contact? Y N
List all Prescription Drugs you are currently taking: _____

List all Vitamins or Supplements you are currently taking: _____

When was the last time you were in a Auto Accident? _____

I (signature) _____ consent to allow Dr. Scatena 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. It is also my understanding that the consultation, examination, and Xrays(if necessary) are at no charge.

How Serious Do You Think Your Problem Is? _____

What Is Your Main Problem/Symptom Prompting Your Request For A Consultation With The Doctor?

- Would You Consider This Problem(circle 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)

1. In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back 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 today as a result of your consultation with the Doctor?

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

4. How long have you been like this?

5. How has your life changed since your back became a problem?

6. What activities are you limited in?

7. What kinds of treatments have you received?

Epidural:	How Many _____	When(approx) _____
Physical Therapy:	How Long _____	When(approx) _____
Medication:	_____	When(approx) _____
Surgery:	Type _____	When(approx) _____
Other	_____	

8. When did you receive these treatments and for how long?

9. Did any of these treatments work? If so which one(s)? For how long?

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

11. What activities/movements are guaranteed to make it worse?

12. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

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

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

15. What are you hoping Dr. Scatena tells you today?

16. Describe what you hope or think he might be able to do for you.

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

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

List In Order Of Importance 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? (circle one)

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

Due To Your Main Problem.....

Have You Lost Any Time From Work? Yes No

How Much Time and What Tasks Have Been Limited? _____

Have You Lost Any Time From Your Chores/Tasks At Home? Yes No

How Much Time and What Tasks Have Been Limited? _____

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 Leisure Activities? (Hobbies, Travel, Sports, etc...)

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?

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.

Please check (✓) EVERYTHING that you have EVER had - now OR in the past. Circle L, R, or B for Left, Right, or Both

HEAD

- Sinus (allergy) headache
- Entire head headache
- Back of head headache
- Forehead headache
- Side of head (temple) headache (L - R - B)
- Migraine headache
- Head feels heavy
- Loss of memory
- Light-headedness
- Fainting
- Light bothers eyes
- Blurred vision
- Double vision
- Loss of vision (L - R - B)
- Loss of taste
- Loss of balance
- Loss of hearing (L - R - B)
- Pain in ears (L - R - B)
- Ringing in ears (L - R - B)
- Buzzing in ears (L - R - B)
- Dizziness

NECK

- Pain in neck
- Neck pain with movement
- Bending head forward
- Bending head backward
- Turning head to the left
- Turning head to the right
- Bending head to the left
- Bending head to the right
- Pinched nerve in neck
- Neck feels out of place
- Muscle spasm in neck
- Grinding sounds in neck
- Popping sounds in neck
- Arthritis in neck

SHOULDERS

- Pain in shoulder joint (L - R - B)
- Pain across shoulders
- Bursitis in shoulder (L - R - B)
- Arthritis in shoulder (L - R - B)
- Can't raise arm above shoulders (L - R - B)
- Can't raise arm over head (L - R - B)
- Tension in shoulders (L - R - B)
- Pinched nerve in shoulder (L - R - B)
- Muscle spasm in shoulders (L - R - B)

ARMS & HANDS

- Pain in upper arm (L - R - B)
- Pain in elbow (L - R - B)
- Moving aggravates the pain
- Tennis elbow (L - R - B)
- Pain in forearm (L - R - B)
- Pain in hands (L - R - B)
- Pain in fingers (L - R - B)
- Pins & needles in arms (L - R - B)
- Pins & needles in fingers (L - R - B)
- Arms are numb / go to sleep (L - R - B)
- Fingers are numb / go to sleep (L - R - B)
- Hands cold (L - R - B)
- Arthritis/swelling in hands/fingers (L - R - B)
- Loss of grip strength (L - R - B)

MIDDLE BACK

- Middle Back Pain
- Pain between shoulder blades
- Pain from front to back
- Muscle spasms
- Pain in kidney area (L - R - B)

CHEST

- Chest pain
- Shortness of breath
- Pain around ribs
- Breast pain
- Dimpled or orange peel breast
- Irregular heartbeat

ABDOMEN

- Nervous stomach
- Can't eat certain foods
- Nausea
- Gas
- Constipation
- Diarrhea
- Hemorrhoids

LOW BACK

- Upper low back pain
- Lower low back pain
- Sacroiliac (SI) or hip pain (L - R - B)
- Slipped, bulging or herniated disk
- Low back feels out of place
- Muscle spasm
- Arthritis

HIPS, LEGS & FEET

- Pain in buttocks (L - R - B)
- Pain in hip joint (L - R - B)
- Pain down leg (L - R - B)
- Knee pain (L - R - B)
- Leg cramps (L - R - B)
- Foot cramps (L - R - B)
- Pins & needles feeling (L - R - B)
- Numbness in leg (L - R - B)
- Numbness in foot (L - R - B)
- Numbness in toes (L - R - B)
- Cold feet (L - R - B)
- Swollen feet (L - R - B)
- Swollen ankle (L - R - B)
- Arthritis

WOMEN ONLY

- Menstrual pain
- Cramping
- Irregularity
- Cycle _____ days
- Birth control type _____
- Hysterectomy

MEN ONLY

- Trouble starting urination
- Excessive night urination
- Prostate pain or swelling
- Frequent urination

GENERAL

- Nervousness
- Irritable
- Depressed
- Fatigue
- Generally feel run-down
- Normal sleep _____ hours
- Loss of sleep _____ hours
- Loss of weight _____ pounds
- Gain weight _____ pounds
- Coffee _____ cups per day
- Tea _____ cups per day
- Cigarettes _____ pack per day
- Diabetes
- Hypoglycemia

MY PAIN IS WORSE WHEN:

- Working
- Lifting
- Stooping
- Standing
- Sitting
- Bending
- Coughing
- Lying down (sleeping)
- Walking
- Other _____

MY PAIN IS BETTER WHEN I:

- Rest
- Use ice
- Use heat
- Stretch
- Move around
- Work
- Stand
- Sit
- Get adjusted by a Chiropractor
- Get it massaged
- Lay down
- Walk
- Take drugs: _____
- Rub on a cream / salve / ointment
- Take time off of work
- Other: _____

OTHER REMARKS BELOW:
