Application for Admission to
Tysons Corner Chiropractic VAX-D Solution Program

Welcome. Our office only accepts patients that he feels will greatly benefit from his care. Not everyone is accepted. Your consultation today will determine if: (a) you are a legitimate candidate for this program and (b) your case is serious enough to warrant your case being accepted for treatment.

Name _____ **Date:** _____ **Date of Birth**_____ **Soc.Sec.** _____

Address_____

Phone Number: Home_____ **Cell** _____ **Email Address** _____

Please circle the number to best reach you...May we leave a voice mail message for you? (Yes) (No)

Sex: (M) (F) **Marital Status: (S) (M)** **Employer:**_____

Occupation:_____ **Length of Employ:**_____ **(months) (years)**

Work injury [Please circle] **Yes** **No**

Disability [Please circle] **Yes** **No** **Dates** _____

I (signature)_____consent to allow Tysons Corner Chiropractic to speak with me and perform an examination (if necessary) in order to determine if I am a candidate for non-surgical spinal decompression and also to determine if they are willing to accept my case. It is also my understanding that BOTH the consultation AND examination (if necessary) are at no charge.

MEDICAL HISTORY

How long have you been having back problems?_____

How serious do you think your problem is? 0—1—2—3—4—5—6—7—8—9—10 (severe)

When did this episode begin? _____

The pain is: [Please circle] **Constant** **Intermittent**

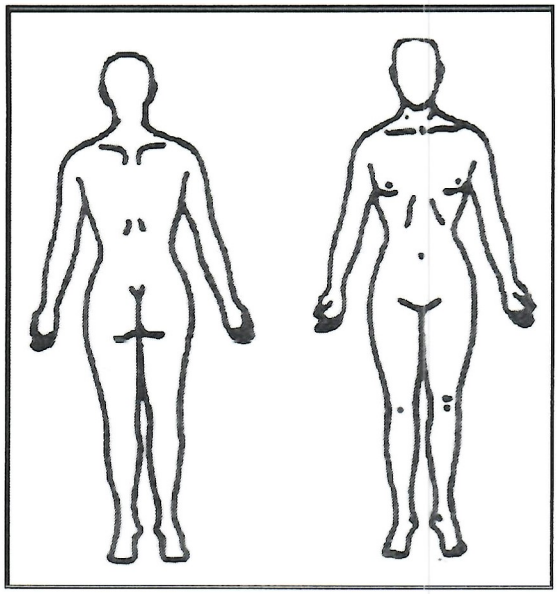
Pain index:

Without Medication		**With medication** [Please circle]	
0	I have no pain	**0**	I have no pain
1	The pain is very mild	**1**	The pain is very mild
2	The pain is moderate	**2**	The pain is moderate
3	The pain is fairly severe	**3**	The pain is fairly severe
4	The pain is very severe	**4**	The pain is very severe
5	The pain is the worst pain pain imaginable	**5**	The pain is the worst imaginable

Disability index [Please circle]

- **0** I can look after myself normally without causing extra pain
- **1** I can look after myself normally but it causes extra pain
- **2** It is painful to look after myself and I am slow and careful
- **3** I need some help but manage most of my personal care
- **4** I need help every day in most aspects of self-care
- **5** I do not get dressed, I wash with difficulty and stay in bed

Where is the pain located? [Please circle]



Which is worse? [Please circle] back pain leg pain

What started this episode of pain? [Please circle] bending, twisting, lifting, sustained after a fall, motor vehicle accident, no reason, other_____

_____

Is there anything that you can do to make the pain feel better? [Please circle] sitting, standing, lying, rising from a seated position, bending, walking

_____

What activities/movements are guaranteed to make the pain worse? [Please circle] sitting, standing, lying, rising from a seated position, walking, bending, twisting, cough or sneeze

_____

Is the pain worse in the morning, or as the day progresses? (please circle)

If you cannot find a solution to this problem, what do you think/feel will happen to you?

_____

Is your sleep disturbed yet? Yes No If so, is it: Getting to or Staying Asleep (please circle)

Has bowel or bladder function been affected yet? [Please circle] yes no

Treatment[s] for current condition that have failed to work [Please circle] manipulation, exercises, traction, physical therapy, surgery, trigger point injections, epidurals, hydrotherapy , other ____

_____

What medications are you presently taking?_____

_____

What medications have you used in the past for this problem?_____

_____

Do you have osteoporosis? [Please circle] **Yes No Don't Know**

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/feel the real problem is?

_____

_____

What are you hoping happens today as a result of your consultation with the doctor?

_____

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

1)
2)
3)

Describe what will be different in your life if you can get better: _____

_____

PAST MEDICAL HISTORY

List in order of importance all OTHER health problems NOT included in your main problem above:

_____ **How long have you had this?** _____

_____ **How long have you had this?** _____

_____ **How long have you had this?** _____

_____ **How long have you had this?** _____

Have you had back problems or sciatica in the <u>past</u>? [Please circle] Yes No

Is it similar to what you are experiencing now? [Please circle] Yes No Briefly explain _____

Which leg was affected by sciatica? [Please circle] R L

The pain was [Please circle] Constant Episodic

What was the frequency of the episodes? [Please circle] Daily Weekly Monthly

Every 2-3 months Every 3-6 months 1-2 times per year Constant

Did it interfere with your daily activities? [Please circle] Yes No **Which ones and how so:**_____

_____

Did you lose time from work? Yes No **From your leisure activities?** Yes No

How much time, and from what activities? _____

What non-surgical treatments did you receive?_____

Would you consider the treatment a success? [Please circle] Yes No

Surgical treatment [Please circle] Yes No

What type of back surgery did you have? [Please circle]

Laminectomy	Date[s] _____	Level[s] _____
Discectomy	Date[s] _____	Level[s] _____
Fusion	Date[s] _____	Level[s] _____
Percutaneous Discectomy	Date[s] _____	Level[s] _____
Chymopapain	Date[s] _____	Level[s] _____

Would you consider the surgery a success? [Please circle] Yes No

Please list any past or current medical conditions _____

Please list any medications or treatments you are taking for the above conditions .

Please list all surgeries you have had, include dates when possible.

_____**Date**_____

_____**Date**_____

_____**Date** _____

Do you use alcohol [Please circle] Yes No How much? _____

Do you smoke [Please circle] Yes No 1ppd 2ppd >2ppd

Are you employed outside the home? [Please circle] Yes No

Are you currently seeking or receiving disability compensation or other financial compensation for your back condition? [Please circle] Yes No

Are you presently in litigation with respect to your back? [Please circle] Yes No

What stage of litigation are you in: _____

Have you had ANY of the following in the last 12-months or currently? (Mark C for current and X for last 12-months)

General: Chills_____ Fainting_____ Fever_____ Loss of Sleep_____ Nervousness_____

Wheezing_____ Convulsions_____ Fatique_____ Headache_____ Weight Loss_____

Numbness in hands and/or feet_____ Allergies...to what_____

Cold Hands/Feet_____ Sweaty Hands/Feet_____ Panic Attacks_____ Racing Mind_____

Cardiovascular: High Blood Pressure_____ Low Blood Pressure_____ TIA_____

Rapid Heartbeat_____ Slow Heartbeat_____ Aortic Aneurysm_____ Stroke_____

Easily Bruise_____ Poor Circulation_____ Pain Over Heart_____

Diseases/Conditions: Appendicitis_____ Breathing Difficulty_____ Eczema_____ Arthritis_____

Influenza_____ Kidney Disease_____ Pleurisy_____ Pneumonia_____ Polio_____ HIV+_____

Anemia_____ Cancer_____ High Cholesterol_____ Eating Disorder_____ Liver Disease_____

Mental Illness_____ Alcholism_____ Colon Problems_____ Glaucoma_____ Headaches_____

Abdominal Surgery_____ Diabetes_____ Blood Clots_____ Depression_____ Epilepsy_____

Hernia_____ Measles_____ Mumps_____ Prostate Problems_____ Hyperthyroid_____

Hypothyroid_____ Surgery...where/for what_____

Ears/Nose/Throat: Asthma_____ Blurred Vision_____ Deafness_____ Sore Throats_____

Crossed Eyes_____ Difficulty Swallowing_____ Double Vision_____ Sinus Problems_____

Gastro-Intestinal: Gas_____ Diarrhea_____ Hemorrhoids_____ Stomach Ache_____

Poor Appetite_____ Liver Trouble_____ Gallbladder Trouble_____ Colon Trouble_____

Constipation_____ Irritable Bowel_____ Chron's_____

Genito-Urinary: Blood in Urine_____ Inability to Control Bladder_____ Kidney Infection_____

Prostate Trouble_____ Painful Urination_____ Frequent Urination_____

For Men Only: Lump in Testicles_____ Cancer—where_____ Discharge_____

For Women Only: Menstrual Cramps_____ Hot Flashes_____ Irregular Cycles_____

Painful Periods_____ Birth Control Pills_____ Abnormal Pap_____ Cramps_____

Muscle/Bone/Joint: Backache_____ Pain Between Shoulders_____ Painful Tailbone_____

Spinal Curvature_____ Swollen Joints_____ Stiff Neck_____ Foot Trouble_____

Neurologic: Seizures_____ Trembling_____ Difficulty with Speech_____ Dizziness_____

Hand Weakness_____ Loss of Memory_____ Loss of Coordination_____

Respiratory: Chest Pain_____ Chronic Cough_____ Difficulty Breathing_____ Coughing Blood_____

Other: _____