Patient Application for Care

Willow Bend Spinal Decompression Center

Specialists for the DRX Spinal Pain & Laser Solution Program

If you are reading this you have been qualified for a ***consultation*** with Dr. Hafen. 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. Hafen is UNAVAILABLE to treat you, your case will be referred to another clinic.

P a t i e n t I n f o r m a t i o n

Name: (First Last)	Today's Date:	Birth Date: (Mo/day/Yr)	
Street Address:	City:	State:	Zip Code:
Height: Ft In	Weight:	E-mail Address:	Home Phone:
Place of Employment:	Job Description:		Work Phone:

W h a t B r o u g h t Y o u i n T o d a y

What problems or symptoms motivated you to visit us today...please explain:

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

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

1.
2.
3.

Please mark the areas of pain on the figures below.

How long has your problem been like this?

What activities are you limited in?

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

What kinds of treatments have you received?

Physical Therapy-How Long?___________ When (approx)______________________

Medication_________________________ When (approx)______________________

Surgery-Type________________________ When (approx)______________________

Other____

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

Have you become tolerant to the pain? Yes No

What activities/movements are guaranteed to make it worse?

Is there anything that you do that makes it better?

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

On a Scale 1-10, (1= Mild & 10 = Very Bad) Where would you rank your discomfort? **RIGHT NOW?**	Where would you rank your discomfort? **ON AVERAGE?**	Where would you rank your discomfort? **AT IT'S WORST?**
1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10	1 2 3 4 5 6 7 8 9 10

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)

What are you hoping Dr. Hafen tells you today?

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

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

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?

____

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) **Constantly** (90-100% of the time)

How did you hear about us?

If you were referred to Willow Bend, to whom should we thank?

B r i e f H e a l t h H i s t o r y

Have you had any Major surgeries/ Operations? If so, please explain:

Are there any major diseases that you have diagnosed with?

Have you had any major accidents or falls? If so, please explain:

What medications are you currently taking and what are they for?

Y o u r C o n s e n t

For Women

Are you pregnant? Yes No

If so, what month? ______________

Are you taking birth control? Yes No

I have been informed that x-rays can be hazardous to an unborn child. To the best of my knowledge, I am not pregnant. I do consent to having x-rays taken if deemed necessary.

Signature:______________________

I consent to allow Dr. Hafen to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for a treatment plan and also to determine if he is willing to accept my case.

______________________ ______________
Patient's Signature Date

______________________ ______________
Consent to Treat a Minor Date

______________________ ______________
Guardian or Spouse's Signature Authorizing Care Date