

Application For Admission
The Hands on Health DRX Severe Back Pain Solution Program

If you are reading this you have been fortunate enough to qualify for a **consultation** with Dr. Van Horn DC 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. Van Horn is UNAVAILABLE to treat you, your case will be referred to another clinic.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Social Sec Number _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Best # To Reach You (circle one) Home / Work / Cell May we leave a message for you? Yes No
Employer _____ Phone _____
Occupation _____ Length of Employment _____
Marital Status S M W D Spouses Name _____

I (signature) _____ consent to allow Dr. Van Horn 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 she is willing to accept my case. It is also my understanding that BOTH the consultation AND examination (if necessary) are at no charge.

How Did You Hear About Hands on Health For Spinal Care? _____
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. Van Horn tells you today?

16. Describe what you hope or think she 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.

Have you had ANY of the following in the last 12 months or currently. (Mark C for Current. X for in last 12 mos.)

GENERAL

Chills ___ Convulsions ___ Dizziness ___ Fainting ___ Fatigue ___ Fever ___ Headache ___ Loss of Sleep ___
Allergy ___ (to what _____) Loss of Weight ___ Nervousness ___ Wheezing ___ Bronchitis ___
Numbness in BOTH hands AND feet ___

CARDIOVASCULAR

High Blood Pressure ___ Low Blood Pressure ___ Pain over heart ___ Poor Circulation ___ Rapid Heartbeat ___
Previous Heart Problem ___ (Describe _____) Slow Heartbeat ___ Stroke ___ TIA ___
Swollen Ankles ___ Varicose Veins ___ Aortic Aneurysm ___ Bruise Easily ___

DISEASES/CONDITIONS

Appendicitis ___ Anemia ___ Arthritis ___ Alcoholism ___ Abdominal Surgery ___ Bleeding Disorder ___
Blood Clot(s) ___ Breathing Difficulty ___ Cancer ___ Cholesterol High ___ Colon Problems ___ Diabetes ___
Depression ___ Epilepsy ___ Eczema ___ Eating Disorder ___ Glaucoma ___ HIV + ___ Heart Disease ___
Hernia ___ Headaches ___ Influenza ___ Kidney Disease ___ Liver Disease ___ Low back Pain ___
Mental Illness ___ Measles ___ Mumps ___ Pleurisy ___ Pneumonia ___ Polio ___ Prostate Problems ___
Hyperthyroid ___ Hypothyroid ___ Rectal Surgery ___

EARS/EYES/NOSE/THROAT

Asthma ___ Crossed Eyes ___ Double Vision ___ Blurred Vision ___ Difficulty Swallowing ___ Deafness ___
Hearing Loss ___ Ear Pain ___ Thyroid Problem ___ Nose Bleeds ___ Sinus Problems ___ Sore Throats ___

GASTRO-INTESTINAL

Gas ___ Colon Trouble ___ Constipation ___ Diarrhea ___ Gallbladder Trouble ___ Hemorrhoids ___
Liver Trouble ___ Nausea ___ Stomach Ache ___ Poor Appetite ___ Poor Digestion ___ Vomiting ___
Vomiting Blood ___ Rectal Bleeding ___ Bloating ___

GENITO-URINARY

Blood in Urine ___ Frequent Urination ___ Inability to control urine ___ Kidney Infection ___ Painful Urination ___
Prostate Trouble ___ Painful Urination ___

FOR MEN ONLY

Lump in testicles ___ Penis discharge ___

FOR WOMEN ONLY

Menstrual Cramps ___ Excessive menstrual flow ___ Hot Flashes ___ Irregular Cycle ___ Painful periods ___
Birth Control Pills ___ Abnormal Pap Smear ___

MUSCLE/JOINT/BONE

Backache ___ Foot Trouble ___ Pain Between Shoulders ___ Painful Tailbone ___ Stiff Neck ___
Spinal Curvature ___ Swollen Joints ___

NEUROLOGIC

Seizures ___ Dizziness ___ Hand Trembling ___ Weakness ___ Difficulty with speech ___ Loss of memory ___
Loss of coordination ___

RESPIRATORY

Chest Pain ___ Chronic Cough ___ Difficulty Breathing ___ Coughing/Spitting Blood ___

OFFICE USE ONLY:

Pn. Loc.:
