Application For Admission To The
Non-Surgical Spinal Decompression Program
At The Spinal Decompression Center of Long Beach

If you are reading this form, you have qualified for a ***consultation*** with Dr. Stokes at no charge. This however does NOT mean that your case has been accepted. Your consultation will determine if:

A) You are a legitimate candidate and are qualified for this program and
B) Your condition is serious enough to warrant your case being accepted for Treatment.

If Dr. Stokes determines that your condition IS NOT serious enough to or you are not qualified for this program, Dr. Stokes let you know and do his best to give you some recommendations about where you need to go for help.

I (Your Signature) _____consent to allow Dr. Stokes 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 therapy and also to determine if the doctor is willing to accept my case.

PLEASE PRINT CLEARLY Today's Date _____

Name _____ Sex: M Fe

Address _____

City_____ State _____ Zip _____

Age ____ Birth date ____/____/____ SS# ____-____-____

Phone #'s (home) _____ (Work) _____(Cell) _____

e-mail _____@_____ Best Place To Reach You: ☐ Home ☐

Work ☐ Cell ☐ e-mail ☐ May we leave a message for you? Yes ☐ No ☐

Marital Status S M W D Spouses Name _____ _____

# of children _____ Ages _____

PLEASE PRINT CLEARLY

Employer _____

Occupation_____ Length of Employment_____

Past Occupation if retired _____

1. How Did You Hear About The Spinal Decompression Center of Long Beach?
_____

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

3. How Serious Do You Think Your Problem Is? (check 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 or more, limitations)

4. 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? _____
_____

5. What are you hoping happens today as a result of your consultation with the Doctor? _____

6. Since your back pain became this severe what three things has it caused you to miss the most? 1._____ 2._____3._____

7 How long have you had this problem? _____

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

PLEASE PRINT CLEARLY

9. What kinds of treatments have you received for this condition?
☐ Medication: Which Drugs? _____
☐ Physical Therapy: How Long _____ When (approx) _____
☐ Chiropractic: How Long _____ When (approx) _____
☐ Acupuncture How long _____ When (approx) _____
☐ Epidural injections: How Many _____ When (approx) _____
☐ Surgery: Type_____ When(approx) _____
☐ Other _____

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

11. What can you do that makes it feel better? _____

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

13. Please describe the quality of the pain. ☐ Sharp, ☐ Dull, ☐ Toothache, ☐ Shooting, ☐ Stabbing, ☐ Numb, ☐ Tingling, ☐ Other: _____

14. Is the pain worse in the morning ☐ or is it worse as the day progresses ☐ ?

15. If you can not find a solution to this problem what will it be like in two years?
_____

16. What do you hope or think the doctor might be able to do for you?
☐ Be able to work again without pain. ☐ Play golf /sports etc.
☐ Be able to sleep again. ☐ Be able to travel and see my kids / grandkids.
☐ Get out of constant pain and enjoy my life. ☐ Get off the drugs meds.
☐ Be able to sit though a ballgame or a show. ☐ Avoid surgery.
☐ Other, I am hoping to: _____

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

PLEASE PRINT CLEARLY

18. List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem.

A ._____For How Long?_____
B ._____For How Long? _____
C ._____For How Long? _____
D ._____For How Long? _____
E. _____For How Long ?_____

19. In Reference To Your MAIN PROBLEM How Often Are You Aware of it?

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

20. Due To Your Main Problem..... Have You Lost Any Time From Work?

Yes ☐ No ☐ How Much Time? _____

22. What Tasks at work Have Been Limited? _____

23. Have You Lost Any Time From Your Chores/Tasks At Home?

Yes ☐ No ☐ How Much Time? _____

24. What Tasks Have Been Limited? _____

25. Have You Lost Any Time From Your Family or leisure Activities, hobbies, sports, etc. ? Yes ☐ No ☐ How Much Time? _____

26. What Activities Have Been Limited? _____

27. Considering the amount of pain / discomfort you've had THIS week, how long has your problem been this severe? _____

28. On a scale of 1-10 (10 being unbearable, (can't get out of bed) and 1 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 _____

29. List ANY surgeries that you have had and the approximate dates.

Surgery:	Date:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

30. Please List All Medication You Are Taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

31. If you are a good candidate, qualify for spinal decompression therapy and the Doctor accepts you as a patient, is there someone else who will be involved in making the decision to begin care? Yes ☐ No ☐

If yes, Who would that be? _____

Have you had ANY of the following in the last 12 months or do you have them currently.
"C" = Current. "P" = in the last 12 mos.)

GENERAL

C	P	
☐	☐	Chills
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Headache
☐	☐	Loss of Sleep
☐	☐	Allergy (Tto 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
☐	☐	Eating Disorder
☐	☐	Glaucoma

C	P	
☐	☐	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

C	P	
☐	☐	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
☐	☐	Can't achieve or maintain an erection

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

_____ _____

Signature Date