Spinal Relief
CENTER

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Kirkland, WA 98034
425-823-1296

Patient Information Form

This 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. Meadows 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 ____________
Home Phone ____________________ Work Phone __________________ Cell Phone _________________________
Best Place To Reach You (circle one) Home / Work / Cell Email Address: ______________________________
Employer _____________________________________ Occupation____________________ Length of Employ _____
Marital Status S M W D Spouses Name ______________________ SS# _________________________________

I (signature) ___________________________consent to allow Dr. Meadows 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 the doctor is willing to accept my case.

How Did You Hear About Spinal Relief Centers USA? ____
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?

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

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

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4. How long have you been like this?

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

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6. What activities are you limited in?

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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?

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

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

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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...)

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

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

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

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

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

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

HEALTH HISTORY

Name: ____ Date: _______________

Age: ________ Birthday: _________________ Date of last physical examination: _________________

What is your reason for this visit? ____

SYMPTOMS **Check symptoms you currently have or have had in the past year.**

GENERAL
__Sweats
__Nervousness
__Loss of Weight
__Loss of Sleep
__Headache
__Forgetfulness
__Fever
__Fainting
__Dizziness
__Depression
__Chills

EAR/NOSE/THROAT
__Persistent Cough
__Difficulty Swallowing
__Hoarseness
__Bleeding Gums
__Nose Bleeds
__Sinus Problem
__Hay Fever
__Loss of Hearing
__Ringing in Ears
__Ear Discharge
__Earache

WOMEN ONLY
__Abnormal Pap Smear
__Bleeding between periods
__Breast Lumps
__Extreme Menstrual Pain
__Hot Flashes
__Nipples Discharge
__Painful Intercourse
__Vaginal Discharge
__Other______________
__Date of Last Period
____
__Date of Last Pap Smear________________
__Have you had a mammogram?________
__Are you Pregnant?
____
__Number of Children
____

MEN ONLY
__Breast Lumps
__Erection Difficulties
__Lump in Testicles
__Penis Discharge
__Sore on Penis
__Other______________

EYES
__Blurred Vision
__Vision- Halos
__Vision- Flashes
__Double Vision
__Crossed Eyes

RESPIRATORY
__Distress __Sputum
__Cough __Congestion
__Shortness of Breath

INTEGUMENTARY
__Scars
__Rash
__Sores
__Ulcers
__Unusual Swelling
__Itching
__Sores that won't heal
__Changes in Moles
__Hives
__Bruise Easy

MUSCLE/JOINT/BONE
__Arms
__Hips
__Back
__Legs
__Feet
__Neck
__Hands
__Shoulders

PSYCHIATRIC
__Hyperventilation
__Insecurity
__Depression
__Trouble Sleeping
__Irritable
__Anxiousness
__Indecisiveness
__Timid
__Hallucinations
__Loss of Memory
__Alcoholism
__Drug Addiction
__Drug Dependency
__Extreme Worry
__Sexual Problems
__Suicidal Thoughts

NEUROLOGICAL
__Seizures
__Vertigo
__Dizziness
__Hand Trembling
__Loss of Sensations
__Loss of Facial Expression
__Weak Grip
__Paralysis
__Difficulty of Speech
__Tingling
__Loss of Memory
__Numbness
__Un-coordination

CARDIOVASCULAR
__Varicose Veins
__Swelling of ankles
__Rapid Heart Beat
__Poor circulation
__Low Blood Pressure
__Irregular Heart Beat
__High Blood Pressure
__Chest Pain

GASTROINTESTINAL
__Appetite Poor
__Bloating
__Bowel Changes
__Diarrhea
__Excessive Hunger
__Excessive Thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal Bleeding
__Stomach Pain
__Vomiting no blood
__Vomiting bleeding

ENDOCRINE
__Weight Gain
__Weight Loss
__Hoarseness
__Heat Intolerance
__Cold Intolerance
__Breast Changes
__Hair C Changes
__Extreme Thirst

CONDITIONS
__AIDS
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Asthma
__Bleeding Disorders
__Breast Lumps
__Bronchitis
__Breath Shortness
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herpes
__High Cholesterol
__HIV Positive
__Kidney Disease
__Liver Disease
__Measles
__Migraine Headaches
__Miscarriage
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Pneumonia
__Polio
__Prostate Problem
__Psychiatric Care
__Rheumatic Fever
__Scarlet Fever
__Stroke
__Suicide Attempt
__Thyroid Fever
__Ulcers
__Vaginal Infections
__Venereal Disease
__Other_______________

GENITO-URINARY
__Painful Urination
__Lack of Bladder Control
__Frequent Urination
__Blood in Urine

MEDICATIONS (list any medications you are taking, and dosages)
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____
____
____

ALLERGIES to medications or substances
____
____
____
____