CENK
Integrated Health & Spine Centers

Application for Admission

Spinal Decompression

Cenk Integrated Health and Spine Centers

Your consultation and Exam today will determine if:

1. You're a legitimate candidate for our program.
2. 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 we are UNABLE to treat you, your case will be referred to another clinic.

NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ SEX: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

CELL: _____ HOME: _____

May we leave a voicemail? _____

OCCUPATION: _____ EMPLOYER: _____

Emergency Contact: _____ PHONE: _____

Primary Care Physician: _____ Phone: _____

I consent to allow Cenk Integrated Health & Spine Centers to speak with me and perform an examination (if necessary) in order to determine if I am a candidate for non-surgical decompression and also to determine if they are willing to accept my case.

PATIENT SIGNATURE: _____ DATE: _____

HOW DID YOU HEAR ABOUT US? _____

_____

_____

WOULD YOU CONSIDER YOUR PROBLEM: (please check)

- **MINIMAL:** annoying buy causing no limitation?
- **SLIGHT:** tolerable but causing only little limitation?
- **MODERATE**: sometimes tolerable but definitely causing limitations?
- **SEVERE:** causing significant limitations)?
- **EXTREME:** causing nearly consistent limitations more than 80% of the time?

Although you are not a back specialist, you are the person who knows more about your back pain than anyone else. In your own words what do you think your real problem is?

_____

_____

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

_____

_____

Since your back pain has become so severe, what three things has it caused you to miss the most?

_____

_____

How long have you been like this?

_____

_____

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

Please explain any previous treatment(s) you have received.

When did you receive these treatments and for how long?

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

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

What activities/movements are guaranteed to make it worse?

Please describe the quality of pain. (sharp, achy, toothache, shooting, stabbing, numb, tingling, etc…)

Is it worse in the morning or does it get worse as the day progresses?

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

What are you hoping the Doctor tells you today?

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

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

List any other serious health concerns you have in order of importance to you.

Due to your back problem and pain, have you lost any time from work? ☐ YES ☐ NO

Have you lost any time from your chores/tasks at home? ☐ YES ☐ NO

Have you lost time with your family? ☐ YES ☐ NO

Have you lost any time with your leisure activities? ☐ YES ☐ NO

On a scale of 0-10 (10 being unbearable, 0 being no pain or discomfort at all)
**Please rate the following by circling your pain.

1)The highest your pain gets WITHOUT medication? 0 1 2 3 4 5 6 7 8 9 10

2)The lowest your pain gets WITHOUT medication? 0 1 2 3 4 5 6 7 8 9 10

3)The highest your pain gets WITH medication? 0 1 2 3 4 5 6 7 8 9 10

4)The lowest your pain gets WITH medication? 0 1 2 3 4 5 6 7 8 9 10

What is your past surgical history?

_____

_____

Please check all things that have occurred to you in the last 12 months or currently.

GENERAL

☐ Chills ☐ Convulsions ☐ Dizziness

☐ Fainting ☐ Fatigue ☐ Fever

☐ Headache ☐ Sleep Loss ☐ Allergies

☐ Weight Loss ☐ Nervousness ☐ Wheezing

CARDIOVASCULAR

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain ☐ Poor Circulation

☐ Rapid Heartbeat ☐ Heart Problems ☐ Slow Heartbeat ☐ Stroke ☐ TIA

☐ Swollen Ankles ☐ Varicose Veins ☐ Aortic Aneurysm ☐ Bruise Easily

DISEASE/CONDITIONS

☐ Appendicitis ☐ Anemia ☐ Arthritis ☐ Alcoholism ☐ Bleeding Disorder ☐ Blood Clot

☐ Breathing Difficulty ☐ Cancer ☐ Colon Problems ☐ Diabetes ☐ Depression ☐ Epilepsy

☐ Eczema ☐ Eating Disorders ☐ Glaucoma ☐ HIV+ ☐ Heart Disease ☐ Hernia ☐ Headaches

☐ Influenza ☐ Kidney Disease ☐ Liver Disease ☐ Low Back Pain ☐ Mental Illness ☐ Measles

☐ Mumps ☐ Pleurisy ☐ Polio ☐ Prostate Problems ☐ Hyperthyroid ☐ Hypothyroid

EARS/EYES/NOSE/THROAT

☐ Asthma ☐ Double Vision ☐ Blurred Vision ☐ Difficulty Swallowing ☐ Deafness

☐ Hearing Loss ☐ Ear Pain ☐ Nose Bleeds ☐ Sinus Problems ☐ Sore Throats

GASTRO-INTESTINAL

☐ Gas ☐ Constipation ☐ Diarrhea ☐ Hemorrhoids ☐ Liver Trouble ☐ Nausea

☐ Stomach Ache ☐ Poor Appetite ☐ Poor Digestion ☐ Vomiting ☐ Rectal Bleeding ☐ Bloating

GENITO-URINARY

☐ Frequent Urination ☐ Inability to Control Urine ☐ Kidney Infection ☐ 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

NEUROLOGIC

☐ Seizures ☐ Dizziness ☐ Tremors ☐ Weakness ☐ Difficulty With Speech

☐ Memory Loss ☐ Coordination Loss

RESPIRTORY

☐ Chest Pain Chronic Cough ☐ Difficulty Breathing ☐ Coughing/Spitting Blood ☐ Pneumonia