

Patient Qualification Consultation & Evaluation Terms

1. I understand that today's consultation is used to determine whether or not I am a candidate for our treatment.

2. I understand that the consultation process does not establish me as a patient under Dr. Chau's care and there is no doctor-patient relationship or obligation.

3. I am aware that after the consultation, I may not be accepted as a patient.

4. I understand that Dr. Chau is not able to and does not accept every case. Dr. Chau's schedule is extremely busy and he strictly limits the number of new patients he accepts so as to ensure a highest probability of treatment success.

5. Please fill out all paperwork completely to the best of your knowledge. Do not leave anything blank. If paperwork is not filled out completely Dr. Chau may refuse to do the consultation.

6. It is imperative that you are under the care of a medical doctor or a doctor licensed to prescribe medication. Please list below the name and contact information of that physician.

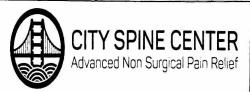
Name of Physician

Phone number

I have read, understand and accept the terms of the initial patient qualification consultation and evaluation.

Name (please print): _____

Signature: _____ Date: _____



Patient Qualification Intake Form

Welcome to City Spine Center, an advanced non-surgical treatment & healing center. In order to accurately assess you and to determine if you are a true candidate for our care, it is important that you fill out this form as thoroughly as possible. Thank You.

Today's Date	Time	[]am []pm	Sex []M []F
Full Name			
Address			
Cell Phone			
Employer			
Marital Status []Single []M			
How Did You Find Out Abou	t Us? [] Friends/Family []Facebook []Google [] Ads [] Other
How Serious Do You Think	Your Problem Is?		
What Is Your Main Problem	n/Pain/Discomfort & How	Long It Has Been (Onse	t)?
[] SLIGHT (Tolerabl [] MODERATE (Sor [] SEVERE (Causing	ng but causing NO limitation e but causing a little limitation netimes tolerable but defin g Significant limitations)	ion) itely causing limitations)	
[] EXTREME (Cause How Often Are You Aware o [] Occasionally (25) [] Intermittently (50) [] Frequently (75%) [] Constant (90-100)	% of the time) % of the time) of the time)		
The LOWEST your pa The HIGHEST your p	aing Unbearable, 0 Being N ain gets WITHOUT medica ain gets WITHOUT medica ain gets WITH medication ain gets WITH medication	ation	
Please Describe the Quality	of the Pain or Discomfo	rt (check all that applies).	
[]Dull []Ache []Sharp []S	Shooting []Stabbing []Nu	mbness []Tingling [] _	· ·····

1. In spite of the fact that you are not a specialist, you are in fact the person who knows more about you're your problem than anyone else. In your own words and in your own opinion what do you think the real problem is (the root cause of your problem)? 2. What are you hoping happens today as a result of your consultation with the doctor today? 3. What three things you miss the most since the onset of this problem? 4. How has your life changed since your condition became a serious problem? 5. What main activities are you limited in doing (e.g. sleeping, walking, sitting, standing, etc..)? 6. What type of treatment(s) have you received prior to coming in here? Medication/OTC: How Many Doctor's/Clinic's Name: -----When (approx) Physical Therapy: How Long When (approx) Epidural/Cortisone Injection: How Many _____ When (approx) _____ Surgery: Type___ When (approx) _____ Chiropractic Care: How Long _____ When (approx) _____ Doctor's/Clinic's Name: When (approx) _____ Acupuncture: How Long _____ When(approx) _____ Massage Therapy: How Long _____ When(approx) CBD/Cannabis: How Long When(approx) 7. Did any of these treatments work? If so which one(s)? For how long it lasted? 8. Is there anything you can do that makes it feel better? 9. What activities/movements are guaranteed to make it worse? 10. Is it worse in the morning or is it worse as the day progresses? -------11. If you cannot find a solution to this problem what do you think will happen to you? _____ 12. Describe what will be different in your life if you can get better.

Have You Lost	Any Time From Work? []Yes []No
How Much Time	e and What Tasks Have Been Limited?
Have You Lost How Much Time	Any Time From Your Chores/Tasks At Home? []Yes []No e and What Tasks Have Been Limited?
Have You Lost	Any Time From Your Family? []Yes []No
How Much Time	e and What Tasks Have Been Limited?
Have You Lost	Any Time From Your Leisure Activities? (Hobbies, Travel, Sports, etc)
	e and What Tasks Have Been Limited?
ist ANY past n	najor surgeries that you have had and the corresponding dates.
surgery:	Type When (approx)
	Importance all OTHER Health Problems/Concerns NOT including Your Main ProblemHow Long Have You Had This?
2	
	How Long Have You Had This?
	How Long Have You Had This? How Long Have You Had This?
Other Commen	
Signature:	Date:
Signature:	

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