CITY SPINE CENTER

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: _____

CITY SPINE CENTER
Advanced Non Surgical Pain Relief

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 _____ **Age** _____ **Birthday** _____

Address_____ City_____ State _____ Zip Code _____

Cell Phone _____ Work Phone _____ Email _____

Employer _____ Occupation_____ Length of Employ_____

Marital Status [ ]Single [ ]Married [ ]Widowed [ ]Divorced Spouse's Name _____

How Did You Find Out About Us? [ ] Friends/Family [ ] Facebook [ ] Google [ ] Ads [ ] Other

How Serious Do You Think Your Problem Is?_____

What Is Your Main Problem/Pain/Discomfort & How Long It Has Been (Onset)?

_____

Would You Consider This Problem (check one below)

[ ] **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)

How Often Are You Aware of this Problem? (check one below)

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

On a **Scale of 0 to 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 _____

Please Describe the **Quality of the Pain or Discomfort** (check all that applies).

[ ]Dull [ ]Ache [ ]Sharp [ ]Shooting [ ]Stabbing [ ]Numbness [ ]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)?

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

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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?

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5. What main activities are you limited in doing (e.g. sleeping, walking, sitting, standing, etc..)?

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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?

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

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

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

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

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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 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?

_____

List ANY past major surgeries that you have had and the corresponding dates.

Surgery: Type_____ When (approx) _____
Surgery: Type_____ When (approx) _____
Surgery: Type_____ When (approx) _____
Surgery: Type_____ When (approx) _____

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?_____

Other Comments:

_____

_____

Signature: _____ Date:_____