William M Bucur, D.C.

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SPINAL DECOMPRESSION REGISTRATION

Date_____

How did you hear about our office? Please circle one.

Walk in, Community Event, Mailing, Internet/Facebook, Patient Referral

Name: _____DOB:_____

Address: _____ City:_____ State:_____

Home #_____ Work #_____ Cell #_____

Email: _____

_____

Chief Complaint: _____

Have you been treated for this condition before? YES NO

If yes, when_____ By Who? _____

Is this a result of an accident/injury? PI WC

Signature: _____

Activities of Daily Living Assessment

Name _____ **Date** _____

Rate your current difficulties by placing the appropriate number in the box.

If an activity does not cause pain or if pain does not affect an activity, leave box blank.

{ 1 } This activity causes some pain, but it is only minor annoyance.

{ 2 } This activity causes a significant amount of pain, but I can do it.

{ 3 } I cannot perform this activity due to pain and disability.

Self Care and Personal Hygiene

{ } bathing/showering { } brushing teeth { } putting on shoes { } eating { } doing laundry

{ } grooming hair { } making the bed { } putting on pants { } dishes { } going to toilet

{ } washing face { } putting on shirt { } cooking { } taking out trash

Physical Activities

{ } standing { } walking { } reaching { } bending right { } twisting right

{ } sitting { } squatting { } bending forward { } bending left { } twisting left

{ } reclining { } kneeling { } bending back { } looking left { } looking righ

Functional Activities

{ } carrying small/large objects { } lifting weights off table { } pushing/pulling while standing

{ } climbing stairs/incline { } lifting object of the floor { } pushing/pulling while seated

{ } carrying briefcase/purse { } exercising upper body { } exercising lower body

Signature: _____

Activities of Daily Living Assessment Continued

Difficulties with Traveling

{ } driving in a car { } driving for long periods of time { } riding as passenger for long periods

Other activities

{ } concentrating { } listening { } reading { } studying { } writing { } using computer { } sleeping

Signature: _____

GREENWAYCOTTON CHIROPRACTIC and Body Harmony Massage

LASER PAIN CENTERS of AMERICA SURPRISE

DISC CENTERS of AMERICA SURPRISE

NEURODoc NEUROPATHY TREATMENT CENTERS SURPRISE

Questionnaire

Name _____ **Date** _____

1. Please check any or all of the primary pain you are experiencing.

{ } Neck { } Buttock { } Leg { } Foot { } Low Back { } Hip { } Calf { } Toes

2. How long have you been experiencing the pain?

{ } Less than 12 weeks

{ } More than 12 weeks

{ } More than 6 months

{ } More than a year

3. Check any or all of the modifiers that most closely describes your pain:

{ } Dull { } Burning { } Sharp { } Tingling { } Shooting { } Numbness { }Throbbing

4. Which best describes the frequency of the pain?

{ } Intermittent – 0-25% of the day

{ } Occasional – 26-50% of the day

{ } Frequent – 51-75% of the day

{ } Constant – 76-100% of the day

5. How has your condition and pain affecting your daily activity?

{ } Pain Sitting { } Decreased Pace { } Trouble Walking { } Interrupted Sleep

{ } Pain Standing { } Decreased Activities { } Trouble Driving { } Trouble Lifting { } Decreases Concentration

Signature: _____

Questionnaire Continued

6. Have you previously contacted another doctor about your pain?

{ } Yes { } No

If yes, whom? _____

7. Have you had back surgery or are you scheduled for surgery?

{ } Yes { } No

If yes, when? _____

8. Have you been diagnosed with any of the following?

{ } Disc Herniation { } Facet Syndrome { } Degeneration { }Spondylolishthesis

{ } Disc Bulge { } Stenosis { } Sciatica { } Other_____

9. If there is an affordable way to treat your condition, are you interested in getting started?

{ } Yes { } No

10. Are there any questions you need answered by the doctor?

{ } Yes { } No

Signature: _____

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Confidential Family Health History

Patient Name_____ Date:_____

Many health problems are hereditary in nature and may be handed down generation after generation. Please review the diseases and conditions listed below, indicate those that are current health problems of a family member. Leave blank those that do not apply. If you require space, use the back of this form.

Condition	Father/Age	Mother/Age	Spouse	Brother (s)	Sister (s)	Children
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problem						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Trouble						
Liver Trouble						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

Signature: _____

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Date_____

Patient Name: _____

SEGMENT DIAGNOSIS

Cervical: _____ MRI --- Yes No

X-Rays taken_____

Lumbar: _____ MRI---Yes No

X-Rays taken_____

Number of treatments requested: _____

Patient accepted treatment: Yes No

If not, why? _____

Dr. Signature_____

Signature: _____