

The Pinnacle Spine Center

PATIENT APPLICATION

Welcome to the Pinnacle Center! We specialize in helping patients to achieve their highest level of health through our Structural, Neurologic and Metabolic corrective care programs.

This application is extensive because we are committed to being thorough with your care. The questions we ask provide important information that will help us determine whether or not we can help you. You deserve the best, so please give us yours when you answer these questions.

Please remember to sign the last page indicating you have thoroughly completed this application. Please feel free to contact us if you need assistance.

Thank you. We look forward to serving you.

PATIENT APPLICATION SURVEY

- If you require more space for any of these answers, please note with “ → ” and use the back side of this form or attach additional information. Please complete this application in Pen.

Today's Date: _____

Name: Mr./Mrs./Ms. _____ Address _____

Apt # _____ City _____ State ____ Zip _____ Home Phone () _____

Work () _____ Cell () _____ Best place to reach you: Home Work Cell

If necessary, may we leave a message for you at any of the above numbers? Yes No

Email: _____ (Additional appointment information may need to be emailed.)

Employer: _____ Occupation (Before retirement): _____ Duties: _____

Duration of Employment: _____ Age: ____ Date of Birth ____/____/____

Sex: M F Martial Status: S M W I Have a 'significant other'

Name (First/Last) of Spouse / Partner / Significant Other: _____

* I (signature) _____ consent to allow Dr. Greenlee to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for care in the Pinnacle Spine Center and also to determine if he is willing to accept my case. If this consult/examination is for a minor over whom I have legal guardianship, I give my permission (signature): _____

Who referred you to our office? / How did you find out about our services? _____

What is your **main concern / symptom (a.k.a., chief complaint)** prompting your request for a consultation with the doctor?

How long have you had this problem? _____ Did your symptoms begin suddenly? Yes No

Considering the amount of discomfort you've had THIS week, how long has your problem been this severe? _____

Is this problem related to an auto **accident / work injury**? Yes No If so, when & describe: _____

Have you had an **auto accident / or work injury** in the last 7 years? Yes No. Do you have any accident claims currently open for any reason? Yes No : Describe: _____

If you can, describe any **activity change, event, or accident** that occurred around the time of the onset of your symptoms which may have contributed to your symptoms? (Include any significant emotionally stressful situations.)

Have you had MRI's / CT scans taken?: Yes No Of **what part(s)** of your body _____

Where (what facility took them) & **When (estimate)** _____

MRI & Report brought to our office Yes No (Please bring these to our office or we can help you request them.)

Previous Spine X-rays taken **within last year** Laying down Standing Seated Neck Low Back

Other: _____ Where were they taken? _____

Women Only: Is there a possibility that you may be pregnant? Yes No

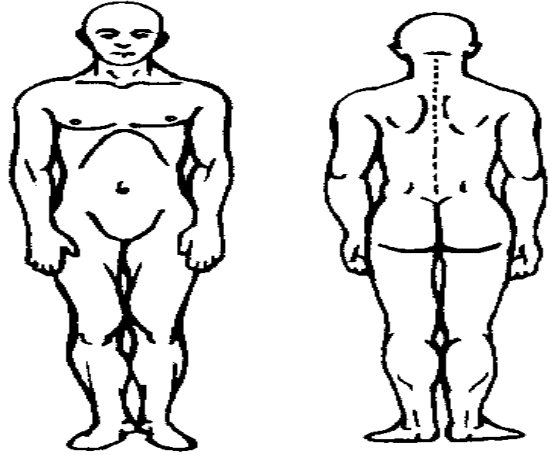
PLEASE LIST AND PRIORITIZE YOUR CURRENT AREAS OF MAIN COMPLAINT:
 (#1 is your chief complaint, #2 is of secondary importance, etc.)

1) _____ 2) _____ 3) _____ 4) _____

What % of the day does your chief complaint bother you? 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

PLEASE MARK YOUR AREAS OF COMPLAINT ON THE BODY DIAGRAM USING THE FOLLOWING KEY:

- Dull = D
- Aching = A
- Stiffness = S
- Burning = B
- Tingling = T
- Numbness = N
- Sharp = ^^^^
- Shooting = →
- Weakness = W
- Other = ***



Please circle the appropriate number(s) for the intensity of your pain when aggravated and the letter(s) for the frequency of the pain.

O = Occasional (0-25% of the time)
F = Frequent (51-75%)

I = Intermittent (26-50%)
C = Constant (76-100%)

Area of Pain	Normal	Minimal	Slight				Moderate				Severe				Frequency					
																	25%	50%	75%	100%
Neck		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Middle Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Lower Back		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Hips L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Shoulders L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Arms L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Legs L R		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Headaches		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Other:		1	2	3	4	5	6	7	8	9	10		O	I	F	C				
Other:		1	2	3	4	5	6	7	8	9	10		O	I	F	C				

Regarding your chief complaint, on a Scale of 0-10 (10 = unbearable, 0 = No Discomfort) Please rate the following:
 The HIGHEST your pain/discomfort gets WITHOUT medication _____ WITH Medication _____
 The LOWEST your pain/discomfort gets WITHOUT medication _____ WITH Medication _____

Questions regarding your Chief Complaint:

When is it worse: in the morning as the day progresses when I sleep no specific time at work

Other: _____

Increase & decrease with no apparent trigger. Details: _____

Does anything relieve your pain? _____

What activities/movements are guaranteed to make it worse? _____

What positions are difficult? Sitting Standing Walking Bending Lying Down

Other _____

If **Low Back Pain**: Which direction hurts more when bending? Backwards Forward Both hurt

STRUCTURAL CONDITIONS

Please **list** and **date all** memorable previous accidents and falls, even if unrelated to complaints: _____

Have you been diagnosed with herniated / bulging disc/ or another spine condition? Yes No

Who Diagnosed you and when? _____

The Diagnosis was made by MRI CT Scan X-ray Other: _____

Have you been advised to have **surgery** or **injections** for the above condition? Yes No. Details about recommendations: _____

How interested are you in following any recommendations for surgery / injections you may have received? _____

Spine & Hip Surgeries

Specific Area	Date	Type (Please be specific.)	Results (to another region)
		<input type="checkbox"/> Fusion → <input type="checkbox"/> metal installed <input type="checkbox"/> no metal <input type="checkbox"/> Laminectomy <input type="checkbox"/> Discectomy <input type="checkbox"/>	<input type="checkbox"/> Improved <input type="checkbox"/> No Change <input type="checkbox"/> Worse
		<input type="checkbox"/> Fusion → <input type="checkbox"/> metal installed <input type="checkbox"/> no metal <input type="checkbox"/> Laminectomy <input type="checkbox"/> Discectomy <input type="checkbox"/>	<input type="checkbox"/> Improved <input type="checkbox"/> No Change <input type="checkbox"/> Worse
		<input type="checkbox"/> Fusion → <input type="checkbox"/> metal installed <input type="checkbox"/> no metal <input type="checkbox"/> Laminectomy <input type="checkbox"/> Discectomy <input type="checkbox"/>	<input type="checkbox"/> Improved <input type="checkbox"/> No Change <input type="checkbox"/> Worse

Additional Surgeries (anything which may have included internal scar tissue, e.g., hysterectomy, gall bladder removal, thyroid, shoulder surgery, etc.)

Area	Date	What was done (Please specific)	Results (to another region)
			<input type="checkbox"/> Improved <input type="checkbox"/> No Change <input type="checkbox"/> Worse
			<input type="checkbox"/> Improved <input type="checkbox"/> No Change <input type="checkbox"/> Worse
			<input type="checkbox"/> Improved <input type="checkbox"/> No Change <input type="checkbox"/> Worse

History of Cancer Yes No

Location of Origin	Status	Spread (to another region)	Additional Remarks
	<input type="checkbox"/> Active <input type="checkbox"/> Remission <input type="checkbox"/> Monitored	<input type="checkbox"/> No <input type="checkbox"/> Yes, to:	
	<input type="checkbox"/> Active <input type="checkbox"/> Remission <input type="checkbox"/> Monitored	<input type="checkbox"/> No <input type="checkbox"/> Yes, to:	

<u>Past Present</u>	<u>Current Treatment</u>	<u>Past Present</u>	<u>Current Treatment</u>
<input type="checkbox"/> <input type="checkbox"/> Anxiety		<input type="checkbox"/> <input type="checkbox"/> Digestive Difficulties	
<input type="checkbox"/> <input type="checkbox"/> Depression		<input type="checkbox"/> <input type="checkbox"/> Heartburn	
<input type="checkbox"/> <input type="checkbox"/> Mood Swings		<input type="checkbox"/> <input type="checkbox"/> Ulcers	
<input type="checkbox"/> <input type="checkbox"/> Sleeping Problems		<input type="checkbox"/> <input type="checkbox"/> Constipation	
<input type="checkbox"/> <input type="checkbox"/> Fatigue		<input type="checkbox"/> <input type="checkbox"/> Urinary Problems	
<input type="checkbox"/> <input type="checkbox"/> Dizziness – Describe.		<input type="checkbox"/> <input type="checkbox"/> Allergies	
<input type="checkbox"/> <input type="checkbox"/> Loss of Balance		<input type="checkbox"/> <input type="checkbox"/> Menstrual Pain	
<input type="checkbox"/> <input type="checkbox"/> Fainting		<input type="checkbox"/> <input type="checkbox"/> Menstrual Irregularity	
<input type="checkbox"/> <input type="checkbox"/> Increased sensitivity to light		<input type="checkbox"/> <input type="checkbox"/> Hot flashes	
<input type="checkbox"/> <input type="checkbox"/> Ringing/ Buzzing in Ears		<input type="checkbox"/> <input type="checkbox"/> Fever	
<input type="checkbox"/> <input type="checkbox"/> Loss of memory		<input type="checkbox"/> <input type="checkbox"/> (other)	
<input type="checkbox"/> <input type="checkbox"/> Loss of smell		<input type="checkbox"/> <input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> Loss of taste		<input type="checkbox"/> <input type="checkbox"/>	

Additional Details:

Medications Currently Taking

Name	For What Condition	Name	For What Condition

HEALTH & LIFESTYLE

Check box if you: Drink coffee / another source of caffeine? Amount & Frequency: _____

Drink diet soda? Amount & Frequency: _____ Do you **smoke**? Amount & Frequency: _____

Consume alcohol? How often? _____ Use recreational drugs? Type & How often: _____

Exercise? Yes No How often? _____ X per week/month. What activities? _____

Take any supplements (i.e. vitamins, minerals, herbs)? What type? **(If not easily listed, please provide a list.)** _____

Do you have to **sleep** in a particular position to be comfortable? _____

When you wake, are you refreshed in more pain then when you went to bed. Describe: _____

Mattress/Bed comfort → poor fair excellent Age of mattress: _____

Pillow comfort → poor fair excellent Age of pillow: _____

Please write down *in detail* everything you eat and drink for 3 consecutive days. We want this to be your 'normal' diet!

Day 1 (Include approximate times)	Day 2	Day 3
Breakfast:		
Snacks		
Lunch		
Mid-Day		
Dinner		
Other		

Have you had recent changes to your diet or eating habits? Yes No Describe: _____

Do you suspect you have any food allergy or intolerance? Yes No Describe: _____

What tests have you received to determine food sensitivities? _____

FAMILY HISTORY

Has anyone in your family had the following?

Any **immune disease** such as Arthritis, Rheumatoid Arthritis, Juvenile RA, Lupus, Diabetes I or II, Hashimotos Dz or other Thyroid condition, Psoriasis or other? Who and What? (List even if unsure if it is an immune system disorder). _____

Gastrointestinal condition or food intolerance (allergies to wheat, dairy, soy, egg, etc.)? _____

List any additional significant health history issues in your family:

LIFE IMPACT ASSESSMENT

As you answer the following questions, please do not minimize any impact on your life no matter how small it appears. We consider any loss of ability or function which affects your daily life as significant. **Please check as many that apply; add additional comments in the margin or on the back as needed.**

How have others been affected by your health condition? No one is affected Haven't noticed any problem
 They tell me to do something People avoid me Other: _____

What are you afraid this might be (or is beginning) to affect (or will affect) in any way? Energy
 Your mood / attitude Stress Job Kids Future ability Marriage
 Any relationships (frequency visiting, quality, etc.) Self-esteem Sleep Time
 Finances Freedom Other: _____

Are there health conditions you are afraid this might turn into? Family health problems
 Heart disease Diabetes Arthritis Fibromyalgia Depression Chronic Fatigue
 Need surgery Other: _____

How has your health condition affected your job, relationships, finances, family, or other activities?

Please give examples: _____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)

Try to give 3 examples: _____

What are you most concerned with regarding your problem? _____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of?

What would be different/better without this problem? Please be specific _____

What do you desire most to get from working with us? _____

SELF ASSESSMENT & TREATMENT GOALS

In spite of the fact that you are not a specialist, what, in your opinion, do you think the real problem is?

Would you consider this problem (check one): MINIMAL (Annoying but causing NO limitations)

SLIGHT (Tolerable but causing a little limitation)

MODERATE (Sometimes tolerable but causing limitations)

SEVERE (Causing significant limitations and/or concern)

EXTREME (Causing near constant (Limits you > 80% of the time))

Which best describes your health goals:

Pain Relief Only (not interested in correction of the problem).

Would like to find the cause of this problem and have it improved or corrected.

How strong is your desire to correct this problem Mild Moderate High Extremely High

Wellness / Preventative care – I just want to stay well and be at optimal health

How supportive is your Spouse/Family/Significant Other to you seeking care? (Be very specific)

What is YOUR idea of an ideal doctor? _____

There may be services that your insurance company does not cover. If this is the case, we have many reasonable and affordable payment options. If you have a problem that we can help, would you be willing to pay out of pocket to get better? Yes No

Based on your complementary consultation, history and exam findings, you may require additional tests that require payment at time of service. If this is required, you will be informed in advance.

Method of payment for any additional uncovered services today: Cash Check Credit Card

I, _____ (Please Print Full Name), have thoroughly completed this application and all supportive documents, answering every question to the best of my ability. Additionally, I have read and reviewed all supportive information that has been included with my application – this may include written or recorded material. If I do not have the means to review the material, I have contacted the Pinnacle Spine Center to arrange for additional support. I understand that failure to complete this application fully and review the enclosed material may mean the doctor will not be able to conduct the consultation and evaluation. I will also bring any labs, images or reports which have been requested in this application.

Signature: _____ Date: _____
