

Application for Admission
Korsh Spinal Health and Wellness
Evolution DT Severe Back/Neck Pain Solution Program

If you are reading this you have been fortunate enough to qualify for a **consultation** with Dr. Korsh. This however does NOT mean that your case has been accepted. Your consultation will determine if:

- a) You are a legitimate candidate for this program, and
- b) Your condition is serious enough to warrant your case being accepted for treatment.

Today's Date: _____

Name: _____ Age: ____ Birthday: _____ Sex: M F

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Best place to reach you: Home Work Cell May we leave a voice mail message? Yes No

Employer: _____ Occupation: _____ Length of Employ: _____

AHC#: _____ Marital Status: S M W D Spouse's Name: _____

I (signature) _____ consent to allow Dr. Korsh to speak with me and perform an examination (if necessary) in order to determine if I'm a good candidate for non-surgical spinal decompression and also to determine if he is willing to accept my case.

How did you hear about Korsh Spinal Health and Wellness ? _____

How serious do you think your problem is? _____

What is your main problem/symptom prompting your request for a consultation with Dr. Korsh? _____

Would you consider this problem:

- MINIMAL (annoying but causing NO limitations)
- SLIGHT (tolerable but causing a little limitations)
- MODERATE (Sometimes tolerable but definitely causing limitations)
- SEVERE (causing significant limitations)
- EXTREME (causing near constant (80% or more) limitations)

1. In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own Words and in your own opinion what do you think the real problem is?

2. What are you hoping happens as a result of your consultation with Dr. Korsh

3. Since your back/neck pain became this severe what three things has it caused you to miss the most?

1 _____
2 _____
3 _____

4. How long have you been like this? (circle)

- 1 week 1 month 3 months 6 months 1 year 2 years 5 years 6 years or more

5. What kinds of treatments have you received?

Results? Good, fair, poor?

<input type="checkbox"/>	Epidural:	How Many: _____	When (approx) : _____	_____
<input type="checkbox"/>	Physical Therapy	How Long: _____	When (approx) : _____	_____
<input type="checkbox"/>	Chiropractic	How Long: _____	When (approx) : _____	_____
<input type="checkbox"/>	Medication	_____	When (approx) : _____	_____
<input type="checkbox"/>	Surgery	Type: _____	When (approx) : _____	_____
<input type="checkbox"/>	Acupuncture	How Long: _____	When (approx) : _____	_____
<input type="checkbox"/>	Massage Therapy	How Long: _____	When (approx) : _____	_____
<input type="checkbox"/>	Other:	_____		

6. Did any of these treatments work? If so, which treatment and for how long?

7. List All other physicians you have had evaluate for this condition:

1	Name: _____	Type of Doctor: _____
	Phone # : _____	Address: _____
2	Name: _____	Type of Doctor: _____
	Phone # : _____	Address: _____
3	Name: _____	Type of Doctor: _____
	Phone # : _____	Address: _____

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

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

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

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

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

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

List in order of important 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?	_____

In reference to you MAIN PROBLEM, how often are you aware of this problem?

Occasionally (25% of the time)

Intermittently (50% of the time)

Frequently (75% of the time)

Constantly (90-100% of the time)

Due to your MAIN PROBLEM...

1. Have you lost any time from work? NO YES - How much time and what tasks have been limited? WCB Yes No

2. Have you lost any time from your chores/tasks at home? NO YES- How much time and what tasks have been limited? _____

3. Have you lost any time from your family? NO YES - How much time and what tasks have been limited?

4. Have you lost any time from your leisure activities (hobbies, travel, sports, etc...)? NO YES - How much time and what tasks have been limited? _____

5. Considering the amount of pain/discomfort you've had this week, how long has your problem been this severe?

On a scale of 0 - 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: _____

List ANY surgeries that you have had and the corresponding dates;

Have you had ANY of the following in the last 12 months or currently (mark C for current; X for in the last 12 months)?

General	Disease/Conditions	Ears/Eyes/Nose/Throat	For Men Only
Anxiety _____	Appendicitis _____	Asthma _____	Lump in Testicles _____
Binge eat/drink _____	Anemia _____	Crossed Eyes _____	Penis Discharge _____
Chills _____	Arthritis _____	Double Vision _____	
Convulsions _____	Alcoholism _____	Blurred Vision _____	For Women Only
Dizziness _____	Abdominal Surgery _____	Diffuculty swallowing _____	Menstrual Cramps _____
Fainting _____	Autoimmune disease _____	Deafness _____	Excessive Menstrual Flow _____
Fatigue _____	Bleeding Disorder _____	Hearing Loss _____	Hot Flashes _____
Fever _____	Blood Clot(s) _____	Ear Pain _____	Irregular Cycle _____
Headache _____	Breathing Difficulties _____	Thyroid Problems _____	Painful Periods _____
Loss of sleep _____	Cancer _____	Nose Bleeds _____	Birth Control Pills _____
Allergy-to what: _____	Cholesterol - High _____	Sinus Problems _____	Abnormal Pap Smear _____
	Colon Problems _____	Sore Throats _____	
Loss of weight _____	Diabetes _____		Muscle/Joint/Bone
Nervousness _____	Depression _____	Gastro-Intestinal	Backache _____
Wheezing _____	Epilepsy _____	Gas _____	Foot Trouble _____
Bronchitis _____	Eczema _____	Colon Trouble _____	Pain between Shoulders _____
Numbness in _____	Eating disorder _____	Constipation _____	Painful Tailbone _____
both hands and feet _____	Glaucoma _____	Diarrhea _____	Stiff Neck _____
	HIV positive _____	Gallbladder Trouble _____	Spinal Curvature _____
Cardiovascular	Heart Disease _____	Heartburn _____	Swollen Joints _____
High Blood _____	Hernia _____	Hemorrhoids _____	Morning Stiffness _____
Pressure _____	Headaches _____	Liver Trouble _____	
Low Blood _____	Influenza _____	Nausea _____	Neurologic
Pressure _____	Infertility _____	Stomach Ache _____	Seizures _____
Pain Over Heart _____	Kidney Disease _____	Poor Appetite _____	Dizziness _____
Poor Circulation _____	Liver Disease _____	Poor Digestion _____	Hand Trembling _____
Rapid Heartbeat _____	Low Back Pain _____	Vomiting _____	Weakness _____
Previous Heart _____	Mental Illness _____	Vomiting Blood _____	Difficulty with Speech _____
Problem - describe _____	Measles _____	Rectal Bleeding _____	Loss of Memory _____
	Mumps _____	Bloating _____	Loss of Coordination _____
	Pleurisy _____		Stuttering/Stammering _____
Slow Heartrate _____	Pneumonia _____	Genito-Urinary	
Stroke _____	Polio _____	Blood in Urine _____	Respiratory
TIA(multi, mini strokes) _____	Prostate Problems _____	Frequent Urination _____	Chest Pain _____
Swollen Ankles _____	Hyperthyroid _____	Inability to control Urine _____	Chronic Cough _____
Varicose Veins _____	Hypothyroid _____	Kidney Infection _____	Difficulty Breathing _____
Aortic Aneurysm _____	Rectal Surgery _____	Painful Urination _____	Coughing / Spitting Blood _____
Bruise Easy _____	STD _____	Prostate Trouble _____	Short of breath _____
Other : _____			