LCD
Lumbar Cervical Decompression

172 Stationway
Arroyo Grande, Ca 93420
805-474-4747

Patient Information Form

As you read through and fill out these questions please understand that this is an application to Dr. Bend's Core Pain Relief Program. This is NOT a guarantee of acceptance. Dr. Bend will be assessing your case and analyzing it for the 5 criteria which he will review with you. This Program is only for patients with severe/chronic back pain, herniated discs, bulging discs, spinal stenosis, and sciatica. Dr. Bend **ONLY** works with patients who are tired of, or who don't want to take medications, those who want an alternative to dangerous injections, invasive surgeries, or have had failed back surgeries. If you are not serious about finding a solution to your problem please be respectful of her time and she will do the same for you.

Today's Date ____________________
Name ____ Age _________ Birthday ____________ Sex M F
Address ____
City__________________________ State _________________ Zip ____________
Home Phone ____________________ Work Phone __________________ Cell Phone ____________________
Best Place To Reach You (circle one) Home / Work / Cell Email Address: ____________________________
Employer ___________________________ Occupation____________________ Length of Employ _____
Marital Status S M W D Spouses Name ______________________ SS# __________________________

I (signature) ___________________________consent to allow Dr. Bend to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for non-surgical spinal decompression and also to determine if he is willing to accept my case. It is also my understanding that the consultation is at no charge.

How Did You Hear About Spinal Relief Centers USA? ____
How Serious Do You Think Your Problem Is? ____
In Reference To The Severity How Would You Rate it On A Scale Of 0-10 __________

What Is Your Reason For Prompting Your Request For A Consultation With The Doctor?

____

How Do You View Your Problem (circle one)....
- 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)

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 today as a result of the doctor spending time with you today?

----

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

----

4. How long have you been like this?

---

5. What changes/modifications have you had to make and how has your lifestyle change since your back problem?

---

6. What actions or activities do you have troubles with or are have limitations in?

---

7. What kinds of treatments have you received?

Surgeries:	How Many ________	Approx Date ____________	
Injections:	How Long ________	Approx Date ____________	How Long ________
Drugs/Pharmaceuticals:	________________	Approx Date ____________	How Long ________
Physical Therapy:		Approx Date ____________	How Long ________

Other____

8. When did you receive these treatments and for how long?

---

9. Did any of these treatments seem to work in helping your pain? If so which one(s)? For how long?

---

10. What actions can you take that temporarily decrease the pain?

---

11. What activities/movements are guaranteed to increase your pain and worsen your condition?

---

12. What does the pain feel like (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...) and where?

---

13. What does it feel like when you wake up compared to the rest of the day? Is it worse in the morning or the evening?

---

14. What do you think will happen to you if you cannot find a solution to your pain/problem?

---

15. What are you hoping Dr. Bend tells you today?

---

16. Please express what you hope or imagine his state of the art program and knowledge might be able to accomplish for you?

---

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

---

18. Please describe in detail the VERY FIRST time you recall having this problem and what it felt like?

List In Order Of Importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above.

1.____ How Long?__________________
2.____ How Long?__________________
3.____ How Long?__________________
4.____ How Long?__________________

What percentage of time are you aware of your main problem? (circle one)
Occasionally (25% of the time)
Intermittently (50% of the time)
Frequently (75% of the time)
Constant (90-100% of the time)

Due To Your Main Problem......
Have You Lost Any Time From Work? Yes No
How Much Time and What Have You been unable to perform? ____
Have You Lost Any Time From Your Obligations 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 Enjoying Your Leisure Activities? (Hobbies, Travel, Sports, etc...)
How Much Time and What Tasks Have Been Limited? ____
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.

HEALTH HISTORY

Name: ______________________________ Date: ______________

Age: ________ Birthday: ______________ Date of last physical examination: ______________

What is your reason for this visit? ______________________________

SYMPTOMS **Check symptoms you currently have or have had in the past year.**

GENERAL
__Sweats
__Nervousness
__Loss of Weight
__Loss of Sleep
__Headache
__Forgetfulness
__Fever
__Fainting
__Dizziness
__Depression
__Chills

EAR/NOSE/THROAT
__Persistent Cough
__Difficulty Swallowing
__Hoarseness
__Bleeding Gums
__Nose Bleeds
__Sinus Problem
__Hay Fever
__Loss of Hearing
__Ringing in Ears
__Ear Discharge
__Earache

WOMEN ONLY
__Abnormal Pap Smear
__Bleeding between periods
__Breast Lumps
__Extreme Menstrual Pain
__Hot Flashes
__Nipples Discharge
__Painful Intercourse
__Vaginal Discharge
__Other__________
__Date of Last Period
____
__Date of Last Pap Smear__________
__Have you had a mammogram?________
__Are you Pregnant?
____
__Number of Children
____

MEN ONLY
__Breast Lumps
__Erection Difficulties
__Lump in Testicles
__Penis Discharge
__Sore on Penis
__Other__________

EYES
__Blurred Vision
__Vision- Halos
__Vision- Flashes
__Double Vision
__Crossed Eyes

RESPIRATORY
__Distress __Sputum
__Cough __Congestion
__Shortness of Breath

INTEGUMENTARY
__Scars
__Rash
__Sores
__Ulcers
__Unusual Swelling
__Itching
__Sores that won't heal
__Changes in Moles
__Hives
__Bruise Easy

MUSCLE/JOINT/BONE
__Arms
__Hips
__Back
__Legs
__Feet
__Neck
__Hands
__Shoulders

PSYCHIATRIC
__Hyperventilation
__Insecurity
__Depression
__Trouble Sleeping
__Irritable
__Anxiousness
__Indecisiveness
__Timid
__Hallucinations
__Loss of Memory
__Alcoholism
__Drug Addiction
__Drug Dependency
__Extreme Worry
__Sexual Problems
__Suicidal Thoughts

NEUROLOGICAL
__Seizures
__Vertigo
__Dizziness
__Hand Trembling
__Loss of Sensations
__Loss of Facial Expression
__Weak Grip
__Paralysis
__Difficulty of Speech
__Tingling
__Loss of Memory
__Numbness
__Un-coordination

CARDIOVASCULAR
__Varicose Veins
__Swelling of ankles
__Rapid Heart Beat
__Poor circulation
__Low Blood Pressure
__Irregular Heart Beat
__High Blood Pressure
__Chest Pain

GASTROINTESTINAL
__Appetite Poor
__Bloating
__Bowel Changes
__Diarrhea
__Excessive Hunger
__Excessive Thirst
__Gas
__Hemorrhoids
__Indigestion
__Nausea
__Rectal Bleeding
__Stomach Pain
__Vomiting no blood
__Vomiting bleeding

ENDOCRINE
__Weight Gain
__Weight Loss
__Hoarseness
__Heat Intolerance
__Cold Intolerance
__Breast Changes
__Hair C Changes
__Extreme Thirst

CONDITIONS
__AIDS
__Alcoholism
__Anemia
__Anorexia
__Appendicitis
__Asthma
__Bleeding Disorders
__Breast Lumps
__Bronchitis
__Breath Shortness
__Bulimia
__Cancer
__Cataracts
__Chemical Dependency
__Chicken Pox
__Diabetes
__Emphysema
__Epilepsy
__Glaucoma
__Goiter
__Gonorrhea
__Gout
__Heart Disease
__Hepatitis
__Hernia
__Herpes
__High Cholesterol
__HIV Positive
__Kidney Disease
__Liver Disease
__Measles
__Migraine Headaches
__Miscarriage
__Mononucleosis
__Multiple Sclerosis
__Mumps
__Pneumonia
__Polio
__Prostate Problem
__Psychiatric Care
__Rheumatic Fever
__Scarlet Fever
__Stroke
__Suicide Attempt
__Thyroid Fever
__Ulcers
__Vaginal Infections
__Venereal Disease
__Other______________

GENITO-URINARY
__Painful Urination
__Lack of Bladder Control
__Frequent Urination
__Blood in Urine

MEDICATIONS (list any medications you are taking, and dosages)

____
____
____

ALLERGIES to medications or substances

____
____
____
____

PATIENT SIGNATURE(or guardian)______________________________**Date**______________