

Application For Admission
Wisconsin Spinal Rehabilitation Center, S.C.

If you are reading this you have been fortunate enough to qualify for a **consultation** with Dr. Friedrichs
This however does NOT mean that your case has been accepted.
Your consultation today will determine if: A) You are a legitimate candidate for care in this office
B) Your condition is serious enough to warrant your case being accepted for treatment and
C) Which form of treatment would best suit your current condition.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____ Email _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
Best Place To Reach You (circle one) Home / Work / Cell May we leave a voice mail message for you? Yes No
Employer _____ Occupation _____ Length of Employ _____
Marital Status S M W D Spouses Name _____ SS# _____
Insured Date of Birth Needed for Insurance Claim Submission _____
How Did You Hear About Wisconsin Spinal Rehabilitation Center _____
How Serious Do You Think Your Problem Is? _____
What Is Your Main Problem/Symptom Prompting Your Request For A Consultation With Dr. Friedrichs?

Would You Consider This 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 body 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 your consultation with the Doctor?

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

3. How long have you been like this?

4. How has your life changed since your health became a problem?

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5. What activities are you limited in?

6. What kinds of treatments have you received?

Epidural:	How Many _____	When (approx) _____
Physical Therapy:	How Long _____	When (approx) _____
Medication:	_____	When (approx) _____
Surgery:	Type _____	When (approx) _____
Chiropractic:	Previous Dr. _____	When (approx) _____
Other _____		

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

8. Did any of these treatments work? If so which one(s)? For how long?

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

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

11. Please describe the quality of the pain. (Sharp, Dull, achy, toothache, shooting, stabbing, numb, tingling, etc...)

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

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

14. What are you hoping the Dr. tells you today?

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15. Describe what you hope or think the Dr. might be able to do for you.

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

17. When is the VERY FIRST time you recall having this problem?

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? _____

In Reference To Your MAIN PROBLEM How Often Are You Aware of This 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 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? _____
- 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 an MRI of the area of the body in which you are concerned with? _____

If so, when and where was it perfomed? _____

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Have you had or do you currently have ANY of the following in the last 12 months? (Mark C for Current and X for in last 12 mos.)

GENERAL

Chills ___ Convulsions ___ Dizziness ___ Fainting ___ Fatigue ___ Fever ___ Headache ___ Loss of Sleep ___
Allergy ___ (to what _____) Loss of Weight ___ Nervousness ___ Wheezing ___ Bronchitis ___
Numbness in BOTH hands AND feet ___

CARDIOVASCULAR

High Blood Pressure ___ Low Blood Pressure ___ Pain over heart ___ Poor Circulation ___ Rapid Heartbeat ___
Previous Heart Problem ___ (Describe _____) Slow Heartbeat ___ Stroke ___ TIA ___
Swollen Ankles ___ Varicose Veins ___ Aortic Aneurysm ___ Bruise Easily ___

DISEASES/CONDITIONS

Appendicitis ___ Anemia ___ Arthritis ___ Alcoholism ___ Abdominal Surgery ___ Bleeding Disorder ___
Blood Clot(s) ___ Breathing Difficulty ___ Cancer ___ Cholesterol High ___ Colon Problems ___ Diabetes ___
Depression ___ Epilepsy ___ Eczema ___ Eating Disorder ___ Glaucoma ___ HIV + ___ Heart Disease ___
Hernia ___ Headaches ___ Influenza ___ Kidney Disease ___ Liver Disease ___ Low back Pain ___
Mental Illness ___ Measles ___ Mumps ___ Pleurisy ___ Pneumonia ___ Polio ___ Prostate Problems ___
Hyperthyroid ___ Hypothyroid ___ Rectal Surgery ___

EARS/EYES/NOSE/THROAT

Asthma ___ Crossed Eyes ___ Double Vision ___ Blurred Vision ___ Difficulty Swallowing ___ Deafness ___
Hearing Loss ___ Ear Pain ___ Thyroid Problem ___ Nose Bleeds ___ Sinus Problems ___ Sore Throats ___

GASTRO-INTESTINAL

Gas ___ Colon Trouble ___ Constipation ___ Diarrhea ___ Gallbladder Trouble ___ Hemorrhoids ___
Liver Trouble ___ Nausea ___ Stomach Ache ___ Poor Appetite ___ Poor Digestion ___ Vomiting ___
Vomiting Blood ___ Rectal Bleeding ___ Bloating ___

GENITO-URINARY

Blood in Urine ___ Frequent Urination ___ Inability to control urine ___ Kidney Infection ___ Painful Urination ___
Prostate Trouble ___ Painful Urination ___

FOR MEN ONLY

Lump in testicles ___ Penis discharge ___

FOR WOMEN ONLY

Menstrual Cramps ___ Excessive menstrual flow ___ Hot Flashes ___ Irregular Cycle ___ Painful periods ___
Birth Control Pills ___ Abnormal Pap Smear ___

MUSCLE/JOINT/BONE

Backache ___ Foot Trouble ___ Pain Between Shoulders ___ Painful Tailbone ___ Stiff Neck ___
Spinal Curvature ___ Swollen Joints ___

NEUROLOGIC

Seizures ___ Dizziness ___ Hand Trembling ___ Weakness ___ Difficulty with speech ___ Loss of memory ___
Loss of coordination ___

RESPIRATORY

Chest Pain ___ Chronic Cough ___ Difficulty Breathing ___ Coughing/Spitting Blood ___

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Terms of Agreement:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office may prepare the necessary reports and forms to assist me in making collection from my insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-insured remittances for the conveyance of credit to my account. However, I clearly understand and agree that I am personally responsible for payment. I also understand if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be due immediately. I understand that a 1.5% monthly interest charge will be applied to all accounts over 30 days past due. I understand that Wisconsin Spinal Rehabilitation Center, S.C. is responsible for subluxation identification and reduction only. Wisconsin Spinal Rehabilitation Center, S.C. is not responsible for any past, present or future medical illnesses or diagnosis treatment or identification. Dr. Friedrichs is not my primary physician. I also understand that insurance does not pay for spinal decompression and if decompression is deemed necessary in my particular case I will pre-pay for decompression services provided to me by Dr. Friedrichs. I understand that decompression or any other services provided to me does not guarantee cure or healing and that Dr. Friedrichs may need to refer me to another doctor or facility to assist me in my health care.

Date: _____ Signed: _____

I authorize release of information necessary to process this claim and request payment be made directly to Wisconsin Spinal Rehabilitation Center, S.C. and the attending Doctor.

Date: _____ Signed: _____

Females Only

Upon completion of the patient history and examination, Dr. Friedrichs will decide if X-rays will be taken for your specific condition or illness. If you are pregnant, X-rays cannot and will not be taken. Therefore, I am NOT pregnant and Dr. Friedrichs is hereby authorized and directed to complete a radiographic examination to treat my present specific condition or illness.

Date: _____ Signed: _____

Medicare Only - Explanation of Medicare Benefits for Chiropractic Care

Medicare may reimburse for Chiropractic adjustments coded 98940-98943 on your insurance claim. Medicare may only cover these adjustments if current X-rays are taken, unfortunately Medicare will not cover the cost of these X-rays. Medicare sets a limit of 24 adjustments per year, depending on the patient's condition. Additional items not covered by Medicare are examinations, therapies and support charges.

Therefore you will be responsible for all charges. We will gladly submit all claims for your Medicare reimbursement. Medicare will then send you a check for the services that they cover.

I further agree that by signing below, I have been notified by Wisconsin Spinal Rehabilitation Center, S.C. that they believe, in my case, Medicare is likely to deny payment for services identified above, for the reasons stated. If Medicare denies payment, I agree to be personally and fully responsible for payment.

Date: _____ Signed: _____

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Consent for Treatment

Every type of health care is associated with some risk of a potential problem. This includes Chiropractic health care. We want you to be informed about potential problems associated with Chiropractic health care before consenting to treatment. This is called informed consent. Chiropractic adjustments are the moving of bones with the doctor's hands or with the use of a machine. Usually those movements result in a "pop" or "click" sound and/or sensation in the area being adjusted.

In this office we may use trained staff personnel to assist the doctor with portions of you consultation, examination, X-ray taking, traction, massage therapy, exercise instruction, or other services. Occasionally, when your doctor is unavailable, another doctor will adjust you on that day.

STROKE: Stroke is the most serious potential problem associated with Chiropractic adjustments. Stroke means that a portion of the brain does not receive enough oxygen for the bloodstream. The result can be temporary or permanent dysfunction of the brain, or even death. Chiropractic adjustments have been associated with strokes that arise from the vertebral artery only. This is because the vertebral artery is actually found inside the neck vertebrae. The adjustment that is related to the vertebral artery stroke is called the "Extension-rotation thrust atlas adjustment". Fortunately, we do not perform this type of adjustment on patients. Other types of neck adjustment may also potentially be related to vertebral artery strokes, but no one is certain. The most recent studies (Journal of the CCA. Vol. 37. No. 2 June, 1993) estimate that the incident of this type of stroke is 1 per every 3, 000,000 upper neck adjustments. This means that an average Chiropractor would have to be in practice for hundreds of years before he or she would statistically be associated with a single patient stroke.

SOFT TISSUE INJURY: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely a chiropractic adjustment, traction, massage therapy, and/ or therapeutic exercise may damage some muscle or ligament fibers. The result is a temporary increase in pain which may necessitate extra visits for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no available statistics to quantify their probability.

RIB FRACTURES: The ribs are found only in the thoracic spine or middle back. They extend from your back to your front chest area. Rarely does a chiropractic adjustment crack a rib bone, and this is referred to as a fracture. This occurs only in patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients very carefully, and especially those who have osteoporosis on their x-rays. These problems occur so rarely that there are no available statistics to quantify their probability.

SORENESS: It is common for Chiropractic adjustments, spinal decompression, massage therapy, and or/ therapeutic exercise to result in an increase in soreness in the region being treated. This is nearly always a temporary symptom that occurs while you body is undergoing therapeutic change. It is not dangerous, and may vary according to your general health.

SPINAL DECOMPRESSION: The AxiomWorldwide DRX9000 is a vertebral decompression device which has been cleared for marketing by the FDA for temporary relief of pain. The DRX9000 has not been approved by the FDA. The FDA has never tested the efficacy of safety of the DRX9000.

OTHER PROBLEMS: There may be other problems or complications that can arise from Chiropractic care other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and/or explain them all in advance of treatment. Chiropractic is a system of health care delivery, and therefore, as with any health care delivery system, we can not and do not promise a cure for any symptom, disease, or condition as a result of treatment in this office.

We will always give you our best care, and if results are not acceptable, we will refer you to another provider who may be better able to fulfill your needs. If you have any questions of the above, please ask you doctor. When you have full understanding, please sign and date below.

Patient's Printed Name

Patient's Signature (or Guardian)

Date

**Thank you for choosing Wisconsin Spinal Rehabilitation Center, S.C.
We are looking forward to helping you develop a healthier spine and nervous system!**