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 RehabilitationCenter_____
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?

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2. What are you hoping happens today as a result of your consultation with the Doctor?

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

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3. How long have you been like this?

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

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5. What activities are you limited in?

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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?

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

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

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

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

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

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

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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.

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

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

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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!