

EliteCare Center

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Decatur, IL 62526
217-877-8992

Patient Information Form

As you read through and fill out these questions please understand that this is an application to Dr. Niehaus' Spinal Decompression Program. This is NOT a guarantee of acceptance. Dr. Niehaus will be assessing your case and analyzing it for **5 criteria** which he will review with you. This Program is only for patients with severe/chronic neck/back pain, herniated discs, bulging discs, spinal stenosis, and sciatica. Dr. Niehaus 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 his time and he will do the same for you.

Today's Date _____ **E-Mail Address** _____
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 May we leave a voice mail for you? Yes No
Employer _____ Occupation _____ Length of Employ _____
SS# _____ Martial Status S M W D Spouses Name _____

I (signature) _____ consent to allow Dr. Niehaus 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 EliteCare Center? _____
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 Main Problem/Symptom Prompting Your Request For A Consultation With The Doctor?

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.)

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

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

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

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) _____

Did any of these treatments help and for how long?

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

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

Please describe the quality of the pain. (Sharp, Dull, Achy, Shooting Stabbing, Numb, Tingling, etc.) _____

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

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

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)

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

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 ____

DISEASE/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 ____
Hyper Thyroid ____ Hypo Thyroid ____ 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 ____

FOR MEN ONLY

Lump in Testicles ____ Penis Discharge ____

FOR WOMEN ONLY

Menstrual Cramps ____ Excessive Menstrual Flow ____ Hot Flashes ____ Irregular Cycle ____ Painful Period ____
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 ____