Application For Admission

Allied Health Group DRX Severe Back/Neck Pain Solution Program

If you are reading this you have been fortunate enough to qualify for a ***consultation*** with Dr. Dickhut at no charge. This however does NOT mean that your case has been accepted.

Your consultation today 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. In the event your condition IS serious enough to warrant being considered for acceptance and Dr. Dickhut is UNAVAILABLE to treat you, your case will be referred to another clinic.

Today's Date _____
Name _____ Age _____ Birthday _____ Sex M F
Address _____
City_____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____
E-Mail Address _____
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_____
SS# _____-_____-_____ Marital Status S M W D Spouses Name _____

I (signature) _____consent to allow Dr. Dickhut 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.

How Did You Hear About Allied Health Group? _____
How Serious Do You Think Your Problem Is? _____

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)

Are you willing to pay for a part of the cost of care out of pocket? (Circle) YES or No
On a scale of 1-10 (with 10 being the highest) how motivated are you to get rid of this problem? _____

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?

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

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4. How long have you been like this?

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5. Is there a particular activity or event that you believe caused and/or worsened your pain?

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6. How has your life changed since your back became a problem?

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7. What activities are you limited in?

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8. 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) _____
Other_____When (approx) _____

9. Are you currently receiving any treatments for your pain?

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

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

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

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

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

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

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16. What are you hoping Dr. Dickhut tells you today?

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17. Describe what you hope or think he might be able to do for you.

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

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 ANY of the following currently or in the last 12 months?
(Mark C for Current. Mark X for last 12 mos. Leave blank if no symptoms in last 12 months.)

GENERAL
Chills ____ Convulsions ____ Diziness ____ 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 ____

OFFICE USE ONLY:
Pn. Loc.: _____

Patient Consent

CONSENT FOR TREATMENT:
I voluntarily consent to the rendering of care, including treatment and performance of diagnostic procedures. I understand that I am under the care and supervision of the attending physician and it is the responsibility of the staff to carry out the instructions of such physician(s).

RELEASE OF INFORMATION:
By signing this form, you are granting consent to Allied Health Group to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephoning our office at 309.268.9000. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

MEDICARE AND MEDICAID CONSENT TO RELEASE INFORMATION:
I certify that the information given by me in applying for payment under Title XVIII and /or Title XI of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration or its intermediary carriers, any information needed for this or related Medicare or Medicaid claim.

VERIFICATION OF NON-PREGNANCY (Female Patients Only):
By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

X _____
Print Patient's Name
X _____
Patient's Signature
X _____
Other Than Patient, Print Name & Relationship
X _____
Witness

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NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment. You may inspect and receive copies of your records within 30 days of submitting a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

You may request changes to your records. Our practice has the right to accept or deny your request. We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Name _____ Phone_____

The effective date of this Notice of Information Practice is _____.

Thank you.