Associates in Spinal Relief

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Patient Information Form

As you read through and fill out these questions please understand that this is an application to Dr. Kerwin's Core Pain Relief Program. This is NOT a guarantee of acceptance. Dr. Kerwin 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 back pain, herniated discs, bulging discs, spinal stenosis, and sciatica. Dr. Kerwin 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 ____________________
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# __________________________________
Insurance Company ________________________________ Is this injury related to an auto or work accident? Y/N

I (signature) ______________________________consent to allow Dr. Kerwin 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 Associates in Spinal Relief? ____
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?
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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?

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2. What are you hoping happens today as a result of the doctor spending time with you today?

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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?

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

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

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

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

12. 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?

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

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

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15. 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?___________________
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
Have You Lost Any Time From Your Family? Yes No
Have You Lost Any Time From Enjoying Your Leisure Activities? (Hobbies, Travel, Sports, etc...) Yes No

If you have any other questions or concerns for Dr. Kerwin, please use the space provided below.

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