



Patient Information Form (NSSD) (Please Print)

As you read through and fill out these questions please understand that this is an application to Dr. Nahali's Core Pain Relief Program. This is NOT a guarantee of acceptance. Dr. Nahali 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, stenosis, and sciatica. Dr. Nahali **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.

Name _____ Today's date _____
Last First Middle Initial

Street or Mailing Address: _____ Apt# _____

City: _____ State: _____ Zip: _____ SS# _____

Phones: H: (____) _____ W:(____) _____ Ext: _____ Cell:(____) _____ Email: _____

Age: _____ Birth Date: _____ M F Marital: Married Single Widowed Divorced Number of children: _____

Your Employer: _____ Occupation: _____

Business Address: _____ Type of work activities: _____

Spouse's Name: _____ Spouse's work phone :(____) _____ Ext. _____

Spouse's Employer: _____ Spouse's Occupation: _____

Patient's Nearest Relative (other than spouse): _____ Relation: _____

Address: _____ Phone: (____) _____

How did you hear about Orlando SpinalAid Centers of America? _____

FEMALE: Are you pregnant? YES / NO

I (signature) _____ consent to allow Dr. Nahali 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 serious to you think your problem is? _____

In a reference to the severity how would you rate your pain on a scale of 1 – 10 (With 10 most severe) _____.

On a scale of 1 – 10, how committed are you to getting rid of your pain? (With 10 most committed) _____.

What is your reason for prompting your request for a consultation with the Doctor? _____

- How do you view your Problem (circle one)....
- MINIMAL** (Annoying but causing NO limitation)
 - SLIGHT** (Tolerable but causing a little limitation)
 - MODERATE** (Sometimes tolerable but definitely causing limitation)
 - 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? _____

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

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

4. How long have you been like this? _____
5. What changes/modifications have you had to make and how has your lifestyle changed since your back problems? _____

6. What actions or activities do you have troubles with or have limitations in? _____

7. Mechanism of Trauma (how did initial injury occur) _____
8. Location/Radiation: _____
9. Duration: Sudden / Gradual / Insidious Onset (date) _____ Length of time you have had it? _____
 Context: Had similar before New Problem Recurrence of Dormant Aggravation Not as bad worst
10. Quality: Aching/ Burning/ Cramping/ Tingling/ Dull/ Numbness/ Sharp/ Stabbing/ Shooting/ Squeezing/ Tearing/ Throbbing/ Spasm/
 Can't Describe / Other _____
11. Modifying Factors: Exacerbated or relieved by: Nothing Movement Resting Straining Lifting Meds Other _____
12. What kinds of treatments have you received?
- | | | | |
|------------------------|----------------|--------------------|----------------|
| Surgeries: | How Many _____ | Approx. Date _____ | |
| Injections: | How Many _____ | Approx. Date _____ | How Long _____ |
| Drugs/Pharmaceuticals: | How Many _____ | Approx. Date _____ | How Long _____ |
| Physical Therapy: | # Times _____ | Approx Date _____ | How Long _____ |
13. Did any of these treatments seem to work in helping your pain? If so which one(s) and for how long? _____

14. Have you had (please circle)? **MRI's, C/T Scan's, or NCV's**, approximate date _____ and the results: _____

15. What actions can you take that temporarily decrease the pain? _____
16. What activities/movements are guaranteed to increase your pain and or worsen your condition? _____

17. 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? _____

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

19. What are you hoping Dr. Nahali will tell you today? _____

20. Please express what you hope or imagine his state of the art program and knowledge might be able to accomplish for you? _____

21. Describe what will be different in your life if you can get better? _____

22. Please describe in detail the VERY FIRST time you recall having this problem and what it felt like? _____

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
How much time and what have you been unable to perform? _____
- Have you lost any time from your obligations at home? YES / NO
How much time and what tasks have been limited? _____
- Have you lost any time from the family? YES / NO
How much time and if so what? _____
- Have you lost any time from enjoying your Leisure activities (Hobbies, Travel, Sports, etc.)? YES / NO
How much time and which activities? _____
- 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) 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 _____

DOCTOR COMMENTS ONLY _____
