# Application For Admission

## *Dr. Malay's Severe Neuropathy And Chronic Pain Program*

If you are reading this you have been fortunate enough to qualify for a ***consultation*** with the Doctor 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 the Doctor is UNAVAILABLE to treat you, options will be made available to you.

Today's Date ____________________ Email: ________________________________

Name _______________________________________ Age _________ Birthday ____________ SS# ___________________

Address _________________________________________________City____________________________ State _________________

Zip __________Sex M F 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 __________________

I (signature) _______________________________consent to allow Dr. Malay and staff to speak with me and perform an examination (if necessary) in order to determine if I am a good candidate for high power laser and also to determine if they are willing to accept my case. It is also my understanding that BOTH the consultation AND examination (if necessary) are at no charge.

How Did You Hear About Dr. Malay's Neuropathy Program? ______________________________________

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)

1. In spite of the fact that you are not a pain specialist, you are in fact the person who knows more about your pain 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 pain became this severe what three things has it caused you to miss the most?

1)----------------------------------------------------------------------------------------------------------------------------------------------

2)----------------------------------------------------------------------------------------------------------------------------------------------

3)----------------------------------------------------------------------------------------------------------------------------------------------

4. How long have you been like this?

5. How has your life changed since your pain became a problem?

6. What activities are you limited in?

7. 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____________________________________________________________

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

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

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

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

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

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

15. What are you hoping the Doctor tells you today?

16. Describe what you hope or think the Doctor might be able to do for you.

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

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18 When is the VERY FIRST time you recall having this problem?

______________________________________________________________________________

______________________________________________________________________________

If your insurance company does not cover your treatment plan would you be willing to pay out of pocket to alleviate this condition?

Yes or No

**List In Order Of Importance all OTHER Health Problems/Concerns NOT includng 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 Liesure 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 getst 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.

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