WISCONSIN SPINAL REHABILITATION CENTER

Second Opinion Spine Care Questionnaire

YES I want a SECOND OPINION!

Please complete this questionnaire and submit, along with your most recent X-rays and or MRI's and their respective radiology reports

via fax at 262.695.1872

or email directly to drjohn@spinalrevival.com

Today's Date _____ Name_____

Age _____ Birthday _____Sex_____

Address_____

Email_____City_____

State _____ Zip _____Home Phone _____

Work Phone _____ Cell Phone _____

Occupation_____ Marital Status S M W D

Height _____ Weight _____

1. Please explain in detail your main problem/symptom prompting your request for a second opinion from Dr. Friedrichs

_____

_____

2. When did this symptom begin _____/_____/_____ Did it begin:

Gradual Sudden Progressive over time

3. Is this related to an auto accident/ work injury? _____ If yes, please explain:

_____

4. Circle type of pain: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting

5. Circle the intensity of your pain with 10 being the worst pain: 1 2 3 4 5 6 7 8 9 10

6. How often do you experience this symptom throughout the day: 100% 75% 50% 25%

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

_____

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

9. Have you ever experienced this condition before? _____ If yes, please explain:

_____

10. Do you believe that your weight may be a contributing factor to your concern?

Yes_____ No_____

11. List any other problems/ symptoms you currently have

_____

Please list all past surgeries:

Type:_____

Date:_____

Type:_____

Date:_____

Please list all previous auto accidents, accidents and falls (even if you sought no treatment for it):

What:_____

Date:_____

What:_____

Date:_____

Please list any medications or vitamins you are currently taking:

Have you seen a Doctor for this current complaint? _____ If so, when and what has been done to attempt to help you?

Disclaimer:

This service should be used for additional reviews and opinion only. This service does not intend to replace any diagnosis, treatment plan or prescription provided to you by your physician, doctor or other caretaker you are currently or have in the past consulted with regarding your health diagnosis and treatment. Our doctors provide opinions, not diagnosis or treatment plans. All opinions provided are to be shared with and consulted with your primary doctor in person to determine your best avenue of treatment to improve your health. This service does not replace or attempt to establish any patient-doctor relationship. This service provides unbiased opinions on options for spinal care based on X-ray or MRI reports submitted to Second Opinion Spine Care. This service does not replace in person consultation and or physical examination, which must be sought out individually with your personal physician or doctor of choice.

Please Read The Following:

I attest the information provided above is true and represents the most recent facts regarding my current health status. I give authorization to Second Opinion Spine Care (as subsidiary of Wisconsin Spinal Rehab Center, LLC) to review this confidential health history and questionnaire. I authorize Second Opinion Spine Care to provide me with a second opinion on a recommended treatment for my current health status based solely on this questionnaire and X Rays or MRI's that I have submitted to Second Opinion Spine Care. I also understand that this second opinion does not in any way replace or attempt to replace a person to person in person physical examination with my current physician or any other physician or doctor. This second opinion I am requesting is simply an opinion for suggested treatment options based on information provided via the internet. I am aware that any information I receive from Second Opinion Spine Care is to be reviewed and discussed with my personal physician, caretaker and or other doctor whom I have direct in person contact with. I am also over the age of 18 and I am of sound mind.

I agree to prepay $99 via phone prior to your being completed. I agree to a ***no refund*** policy upon payment. Please call 262.695.1870 to arrange payment. Once payment is received along with your questionnaire and supporting radiology and reports, Dr. Friedrichs will begin his analysis and provide his **SECOND OPINION**.

NAME_____

Signature_____ Date_____