APPLICATION FOR NEUROPATHY TREATMENT

Name:____ Date:_____________

Address:____

City:______________________ State:_____ Zip:________ Home Phone:___________________

Work Phone:____________________________ Cell Phone:____________________________

Social Security #:____-___-_____ Date of Birth:___/___/___ Age:____

Spouse's Name:____

Occupation (Current or Previous):_______________________________________ Retired: Y / N

REVIEW OF SYSTEMS

Please check all that apply:

☐ Foot Pain	☐ Diabetes	☐ Spinal Stenosis	☐ Cancer	☐ Pinched Nerve
☐ Hand Pain	☐ High Cholesterol	☐ Degenerative Discs	☐ Chemotherapy	☐ Poor Circulation
☐ Low Back Pain	☐ High Blood Pressure	☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacements
☐ Neck Pain	☐ Leg Pain	☐ Arthritis in Feet	☐ Foot Surgery	☐ Bulging Disc
☐ Foot Numbness	☐ Herniated Disc	☐ Plantar Fasciitis	☐ Hand Numbness	☐ Sciatica
☐ Pacemaker/ Defibrillator	☐ Implanted Cord /Bladder Stimulator	☐ Poor wound healing	☐ Morton's Neuroma	☐ Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

1)____
2)____
3)____
4)____
5)____

List approximately how long you have noticed these problems:

1)____
2)____
3)____
4)____
5)____

Is there a certain time of day any of these problems are better or worse?

____
____
____

Is your balance/walking ability affected? ☐ Y ☐ N
If yes, please describe:

____
____

List the things you have used for these problems:

☐Gabapentin ☐Neurontin ☐Lyrica ☐Cymbalta
☐Physical Therapy ☐Pain Medications ☐ Aleve
☐Tylenol ☐Ibuprofen ☐Motrin ☐Chiropractic
☐Massage Therapy ☐Injections ☐Creams on Hands/Feet
☐Other Medications or Treatments:_________________
____
____
____
____

What do you think is causing your problem?____
____

Names of all doctors you have seen for these problems and treatment you received:________________________
____
____
____
____

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the Same
List anything that makes your condition worse:____
____
____

List anything that makes your condition better:____
____
____

How would you describe the symptoms? Please check all that apply:

☐ Aching Pain	☐ Numbness	☐ Hot sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins and Needles Pain	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

Is this condition interfering with any of the following?

☐ Sleep ☐ Work ☐ Daily Activities ☐ Housework ☐ Recreational Activities ☐ Walking ☐ Standing ☐ Shopping

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, how many packs/daily:_______
Do you drink? ☐ Yes ☐ No If yes, how many drinks/week:_______
Do you exercise regularly? Yes No If yes, describe what type and how often:______________________________
____

CURRENT PAIN LEVELS

How would you rate your pain in the last week:

No Pain Worst Pain Possible
0 1 2 3 4 5 6 7 8 9 10

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

No Pain Worst Pain Possible
0 1 2 3 4 5 6 7 8 9 10

PREVIOUS HEALTH HISTORY

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request:

Name:____ Signature:____________________________________Date:___________

Please give name, address, and office phone of your primary care physician/family doctor?:

Name: ____

When were you last seen there?_________________________

May we send them updates on your treatment/condition: ☐Yes ☐No

List ALL Allergies (or Sensitivities) to Medicines, Foods, and other items:

Item you react to:	Reaction:

Please list the prescription drugs you are currently taking, or attach list:

Name:	Dose (MG or IU)	Times Daily

List all Nutritional Supplements (vitamins, herbs, homeopathics, etc.) as above:

Date of Above List:____