

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

- | | | | | |
|--|--|---|--|---|
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Degenerative Discs | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vascular Problems | <input type="checkbox"/> Arthritis in Hands | <input type="checkbox"/> Joint Replacements |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pacemaker/
Defibrillator | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Arthritis in Feet | <input type="checkbox"/> Foot Surgery |
| <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Implanted Cord/
Bladder Stimulator | <input type="checkbox"/> Poor wound heal-
ing |
| <input type="checkbox"/> Hand Numbness | <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Morton's Neuroma | <input type="checkbox"/> Sciatica | <input type="checkbox"/> 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?

List the things you have used for these problems:

- Gabapentin Neurontin Lyrica Cymbalta
 Physical Therapy Pain Medications Alleve
 Tylenol Ibuprofen Motrin Chiropractic
 Massage Therapy Injections Creams on Hands/Feet
 Other Medications or Treatments: _____

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

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
- Stabbing Pain
- Sharp Pain
- Tiredness
- Numbness
- Tingling
- Pins and Needles Pain
- Heavy Feeling
- Hot sensation
- Throbbing Pain
- Dead Feeling
- Cold Hands/Feet
- Cramping
- Swelling
- Burning
- 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 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

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

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

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: _____