Name:_________________________DOB: ______________ Date:__________

NEUROPATHY CLIENT HISTORY AND LIFESTYLE INTAKE

In order for us to completely evaluate your health status, please fill out the following pages. Be as *thorough* as possible. This allows us to assess your neurological and structural imbalances.

Address:____
City:______________________ State:_____ Zip:_________________
Home Phone:______________Work Phone:____________ Cell Phone:__________________
Preferred phone number to call: __ Home __Work __ Cell Phone May we leave a message? Y or N
Date of Birth:____/____/____ Age:________
Spouse's Name ____
Occupation (Current or Previous):_______________________________________Retired: Y or N
Were you exposed to any chemicals in your past employment? Yes or No

HEALTH HISTORY

Allergies
Are you allergic to any medications or drugs? Y □ N □
If yes, list names and type of reaction. (Example: penicillin – rash) ___________________________
____
Have you ever been tested for food allergies? Y □ N □
Do you have any food allergies (i.e., lactose, gluten, nuts)? Y □ N □
If yes, what foods? ____
Do any foods bother you? Y □ N □ (Example: tomatoes – reflux). If yes, what foods? ___________
____
Do you have any environmental allergies? (Example: Dust, ragweed, animals)? Y □ N □
Do you have any seasonal allergies? Y □ N □ Please list all you can think of__________________
____

Diagnoses
List any diagnosis you have had (Example: high blood pressure, hypothyroid, high cholesterol, diabetes, sleep apnea, neuropathy, depression, etc.)
1. ___________________________ 4. ____________________________
2. ___________________________ 5. ____________________________
3. ___________________________ 6. ____________________________

Blood Sugar Readings (if applicable)
What was your lowest reading in the past 3 months? ______________
What was your highest reading in the past 3 months? _____________
What was your blood sugar level today? ______________________
What was your last Hemoglobin A1C level? ____________ Date Checked: _________________

Name:_________________________ DOB: _______________ Date:__________

Current Medications (prescribed and over-the-counter) – please complete separate sheet on last page.

Do you think medications are helping? Y □ N □
Are you having any side effects? Y □ N □ Explain: ______________________________

Current Supplements (Vitamins) – please complete separate sheet on last page

Surgery

Type of Surgery	Date	Reason

Hospitalizations

Date	Hospital	How long?	Reason
Example: 1/1/13	Cleve. Clinic	2 days	Gall Bladder

Family History (If unknown, write "unknown").

Family member	Living?	How old?	List health conditions they had in their life (i.e. cancer, thyroid, heart attack, stroke, etc.)
Mom	Y □ N □		
Dad	Y □ N □		
Mat. Grandmother	Y □ N □		
Pat. Grandmother	Y □ N □		
Mat. Grandfather	Y □ N □		
Pat. Grandfather	Y □ N □		
Sibling	Y □ N □		
Sibling	Y □ N □		
Sibling	Y □ N □		

Kids

Name	Age	Health Status	Living with you?
			Y □ N □
			Y □ N □
			Y □ N □
			Y □ N □
			Y □ N □

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Name:_________________________DOB: _______________ Date:__________

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
□ Pacemaker/Defibrillator
□ Leg Pain
□ Arthritis in Feet
□ Foot Surgery
□ Foot Numbness
□ Herniated Disc
□ Plantar Fasciitis
□ Implanted Cord/Bladder Stimulator
□ Poor wound healing
□ Hand Numbness
□ Bulging Disc
□ Morton’s Neuroma
□ Sciatica
□ Excessive thirst or urination
□ Thyroid

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Name:___________________________DOB: _______________ Date:__________

Present Health Conditions

In order of importance, list the health problems you are most interested in getting corrected, and how long you have noticed these problems:

1) ____ Length of Time: _____________

2) ____ Length of Time: _____________

3) ____ Length of Time: _____________

4) ____ Length of Time: _____________

5) ____ Length of Time: _____________

How would you describe your neuropathy symptoms? **Please check all that apply**. Then grade the level of discomfort on a scale of 1-10. With 1 being the best and 10 being the worse.

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

List anything that makes your condition worse:

____
____
____
____

List anything that makes your condition better:

____
____
____
____

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Name:___________________________DOB: _______________ Date:__________

Have your symptoms: □ Improved □ Worsened □ Stayed the Same

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:

____
____
____

Put a check mark by 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:____

What do you think is causing your problem?:

____
____
____
____

How would you rate your overall symptoms in the last week? (On a scale of 0-10.With 0 being no pain or discomfort and 10 being the worse pain or discomfort). 01 2 3 4 5 6 7 8 9 10

If you had to accept some level of pain or discomfort after completion of treatment, what would be an acceptable level? (On a scale of 0-10.With 0 being no pain or discomfort and 10 being the worse pain or discomfort). 0 1 2 3 4 5 6 7 8 9 10

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Name:_________________________DOB: ______________ Date:__________

Is this condition interfering with any of the following?
□ Sleep
□ Work
□ Daily Activities
□ Housework
□ Recreational Activities
□ Walking
□ Standing
□ Shopping

Musculoskeletal

Do you have a spinal curvature or scoliosis? Y □ N □
Do you have arthritis? Y □ N □ If yes, where? ____________________________________
What is your pain level? Best 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Worst
Do you have joint pain? Y □ N □ What joints? ____________________________________
What is your pain level? Best 1□ 2□ 3□ 4□ 5□ 6□ 7□ 8□ 9□ 10□ Worst
Does your joint pain move around (i.e., from knees to shoulder)? Y □ N □
Do you have muscle pain? Y □ N □ Where? ____________________________________
Do you get muscle cramps? Y □ N □ Where? ____________________________________
Do you cramp when active? Y □ N □ What activity? ________________________________
Do you cramp when resting (i.e., in bed)? Y □ N □
Do you have any muscle/joint weakness? Y □ N □
Do you have difficulty walking? Y □ N □ If yes, why? ______________________________

Social History:

Tobacco

Do you currently use tobacco? Y □ N □ Type: cigars □ # per day ____How many years?___
Cigarettes □ # packs per day _______# per week_______How many years? __________
chewing tobacco □ how many times in a day? ________________ How many years? ______
Have you ever tried to quit the use of tobacco? Y □ N □ How many times? __________
Did you ever use tobacco? Y □ N □ When? _______ How long? ________ How much? ________
Were you (or are you) exposed to second-hand smoke? Y □ N □
Do you use recreational drugs (i.e, marijuana, cocaine, etc.)? Y □ N □

Beverages – Liquids:

Water: How many ounces of water (by itself) do you drink per day? ______________________
What type of water? Filtered □ City / Well □ Spring □ Distilled □
Milk: Do you drink milk? Y □ N □ Type: Skim □ 1% □ 2% □ Whole □ Soy □ Almond □
How many glasses per day? ________ Per week? ________
Decaffeinated Beverages: Do you drink any caffeine-free beverages? Y □ N □
Type: Decaf Coffee Y □ N □ How many cups? ________ Day ________ Week
Decaf – Herbal Tea Y □ N □ How many cups? __________Day _________ Week
No-Caffeine Sodas Y □ N □ How many cups? __________ Day __________ Week
Caffeinated Beverages: Do you drink any caffeinated beverages? Y □ N □
Type: Coffee: How many cups? __________ Day __________ Week
Tea: How many cups? __________Day __________Week
Soda/Diet Soda: How many cups? __________Day __________Week
Name of soda: ____

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Name:___________________________DOB: _______________ Date:__________

Alcohol: Do you consume any alcoholic beverages? Y □ N □

Type	# per Day	# Per Week	# Per Month	# Per Year
Beer □	____________	____________	____________	________
Wine □	____________	____________	____________	________
Mixed Drinks □	____________	____________	____________	________

Dietary Patterns:
Infant Diet: Breast Fed? Y □ N □ Bottle Fed? Y □ N □
Childhood Diet: American? Y □ N □ Vegetarian? Y □ N □ Other? explain)_______________
Adult Diet: American? Y □ N □ Vegetarian Y □ N □ Other? (explain) ____________________
Present Diet: American? Y □ N □ Vegetarian Y □ N □ Other? (explain) __________________
Do you follow a low-fat diet? Y □ N □ Not sure □
How many meals do you eat per day? ____
What % of your meals are eaten at home? __________% What % are eaten out? _________%
What % of the food you eat is cooked? ___________% What % is raw? ______________%
Do you eat/consume any: Soy/tofu products? Y □ N □ If yes, how often?________________
Do you use any soy nutritional supplements? Y □ N □
What foods or mixtures do you avoid and why do you avoid them? ____________________
Do you have food cravings? Y □ N □. If so, which foods or type of foods do you usually crave?
____
____
What food do you sometimes crave (if any)? _____________________________________

Exercise Habits
Are you doing any type of exercise? Y □ N □ Consistently? Y □ N □
What type (ex. swimming, walking, aerobic, weights)? _____________________________

Type	# times per week	Length of time
______________________	______________	_______________________
______________________	______________	_______________________
______________________	______________	_______________________
______________________	______________	_______________________

Please list all doctors you currently see:

Primary doctor: _____________________________
For what condition(s) are you seeing him/her?_____________________________________

Doctor #2: ________________________________
For what condition(s) are you seeing him/her?_____________________________________

Doctor #3: ________________________________
For what condition(s) are you seeing him/her?_____________________________________

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Name:___________________________DOB: _______________ Date:__________

Have you ever had any of the following tests?

□ CAT Scan Date(s) ___________ Area(s) _________________ Reason ___________________
□ MRI Date(s) ___________ Area(s) _________________ Reason ___________________
□ Bone scan Date(s) ___________ Area(s) _________________ Reason ___________________
□ X-Rays Date(s) ___________ Area(s) _________________ Reason ___________________
□ Ultrasound Date(s) ___________ Area(s) _________________ Reason ___________________
□ Bone density Date(s) ___________ Area(s) _________________ Reason ___________________
□ EKG Date(s) ___________ Area(s) _________________ Reason ___________________
□ Stress EKG Date(s) ___________ Area(s) _________________ Reason ___________________
□ Other Test Type: ________Date(s) ______ Area(s) _______ Reason ___________________
□ Other Test Type: ________Date(s) ______ Area(s) _______ Reason ___________________
□ Other Test Type: ________Date(s) ______ Area(s) _______ Reason ___________________

How willing are you to get your health back? On a scale of 1 to 10 with 10 being the MOST willing mark the number that best describes your motivation to:

Significantly modify your diet? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Take several nutritional vitamins each day? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Keep a record of everything that you eat? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Modify your lifestyle (diet,sleep,habits)? Least1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

At the present time, how supportive do you think people in your household will be to your implementing the above changes? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Where do you think you will be health-wise in 1 year if you **DO NOT** get help now?
____
____

Where do you think you will be health-wise in 5 years if you **DO NOT** get help now?
____
____

On a scale of 1-10 (10 being the **most** motivated), how motivated are you to getting your health back? Least 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ Most

Is health your top priority? Y □ N □ If no, why not? ____________________________________
____
____
____

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Name:___________________________DOB: _______________ Date:__________

Additional Information: Is there anything you would like to add that I did not ask you?

____

____

____

____

____

____

____

Health Goals

What are your health goals if we accept you into care? Be specific and realistic!
Examples: Decrease pain Decrease numbness, tingling, better balance etc.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

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Name:_________________________DOB: ______________ Date:__________

Prescribed and Over the Counter Medications (not vitamins)

Name	Dosage	# Times You Take Per Day	Reason for Use	How Many Years
Example: Metformin____	__500 mg_	___2X_______	_Diabetes______	__10__

Current Supplements (Vitamins)

Name	Dosage	# Times You Take Per Day	Reason for Use	How Many Years
Example: Vitamin D ____	__1000 IU_	___2X_______	_Low Vit. D Levels	__10__

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