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	□ 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

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 □ Alleve
□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: _____