Please fill out entirely and legibly.

Name _____ Preferred Name_____

Address_____

City _____ State _____ Zip Code _____

Cell Phone _____ Home phone _____
Email _____

We will need to contact you by both phone and email. Please be sure to give us the best phone number to reach you

Date of Birth _____/_____/_____ Age _____ Gender M_____ F_____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

Spouse's Name _____ Phone Number_____

Emergency Contact _____ Phone Number_____

Your Current/Previous Occupation(s)_____

Retired? YES/NO

REVIEW OF SYMPTOMS

Please check all that apply (C) Currently (P) Past or (CP) for both

_____Foot pain	_____High Blood Pressure	_____Neck Pain	_____ Chemo Drugs(Oral)
_____Heart Attack	_____Poor Circulation	_____ Chemotherapy	_____ Plantar Fasciitis
_____Bulging Disc	_____Low Back Pain	_____ Herniated Disc	_____ Implanted Cord
_____High Cholesterol	_____ Cancer	_____ Arthritis in Feet	_____ Bladder Stimulator
_____Pinched Nerve	_____ Spinal Stenosis (Neck/low back)	_____ Foot Surgery	_____ Diabetes

_____Hand Pain _____Arthritis in Hands _____ Foot Numbness _____ Leg Pain

_____ Blood Thinner _____Joint Replacement (Knee/Hip/Shoulder) _____Degenerative Disc (Neck/low back)

_____Hand Numbness _____ Pacemaker/ Defibrillator _____ Blood Clot(s) _____ Diabetes (Last A1C#_____)

_____Vascular Problems _____ Morton's Neuroma _____Sciatica R L leg _____Excessive Thirst/Urination

_____ Poor Wound Healing

PRESENT HEALTH CONDITION

Where is your Neuropathy/Nerve Pain?

_____
_____

List approximately how long you have been aware of these problems:

_____
_____

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

_____
_____

What do you think is causing your problems?

_____
_____

Circle the things you have used for Neuropathy or Nerve Pain:
Gabapentin Neurontin Lyrica Cymbalta
Physical Therapy Pain Medications Aleve Tylenol
Ibuprofen Motrin Chiropractic Massage Therapy
Injections

Is your balance/walking affected? Yes or No

I use a: (Circle) Cane Walker Wheelchair

I walk: (Circle) Unassisted I am unsteady
I am slightly unsteady

Where is your **Neuropathy/Nerve pain** located: (Circle all that apply) **Hands Feet Arms Legs**

Name of all doctors you have seen for Neuropathy/Nerve pain and the treatment you received:

_____

_____

Have your Neuropathy/Nerve Pain symptoms: __Improved __Stayed the same __Worsened

List anything that makes your **Neuropathy/Nerve Pain** condition **worse**

_____

_____

List anything that makes your **Neuropathy/Nerve Pain** condition **better**

_____

_____

How would you describe your Neuropathy/Nerve Pain symptoms? Please check ALL that apply

__Aching Pain	__Numbness	__Hot Sensation	__Cramping
__Stabbing Pain	__Tingling	__Throbbing Pain	__Swelling
__Sharp Pain	__Pins and Needles	__Dead Feeling	__Burning
__Tiredness	__Heavy Feeling	__Cold Hands/Feet	__Electric Shocks

Is your Neuropathy/Nerve Pain interfering with any of the following?

__Sleep __Work __Daily Activities __Housework __Getting Dressed __Walking
__Standing __Shopping __Up/Down Stairs __Exercise __Recreational Activities

SOCIAL HISTORY

Do you smoke? __Yes __No If yes, how many cigarettes daily?_____
Do you drink? __Yes __No If yes, how many drinks per week? _____
Do you exercise regularly? __Yes __No If yes, please describe type and how often:

_____
_____

Do you have issues with any of the following? (Check those that apply)

____Digestion (GERD, Reflux, Bloating, Constipation, Heartburn, Diarrhea, IBS, IBD)
____Sleep (Falling asleep, Waking up between 1-3 am.)
____Energy
____Sense of Well Being (Poor health, Feel run down, Get sick easily)
____I take (Nexium, Prilosec, Tums, etc.)
____Depend on coffee to get started/keep going
____Crave sweets/carbohydrates during the day
___ Like salty foods

Have any of these above issues gotten worse since your Neuropathy/Nerve pain started? YES / NO

PREVIOUS HEALTH HISTORY

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to: Reaction:

_____ _____
_____ _____
_____ _____

PLEASE PRINT NEATLY all prescription drugs you are currently taking (or you may attach a list):

Name:	Dose (mg or IU):	For what condition:

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

Name:	Dose (mg or IU):	For what condition:

CURRENT DISCOMFORT LEVELS

How would you rate your discomfort in the last week?

NO DISCOMFORT **WORST DISCOMFORT 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

Please give the name, address, and office phone number of your Primary Care Physician:

Name_____ **Phone**_____ **Address**_____

When were you last seen there? _____

May we send them updates on your treatments/condition? (Your initials here) _____**YES** _____**NO** Please give the name, address, and phone number of your Neurologist, if seen:

Name_____**Phone**_____**Address**_____

May we send them updates on your treatments/condition? (Your initials here) _____**YES** _____**NO**

Other Doctors that you would like updates sent to. Please fill out the information below:
(ex. Endocrinologist, Oncologist, Podiatrist, Cardiologist, Vein/Vascular Specialist, etc.)

Name_____**Specialty**_____ **Phone**_____**Fax**_____

Address_____

Name_____**Specialty**_____ **Phone**_____ **Fax**_____

Address_____

May we send them updates on your treatments/condition? (Your initials here) _____**YES** _____**NO**

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.

Print Name _____**Signature** _____**Date**_____

IMPACT OF NEUROPATHY/NERVE PAIN ON YOUR LIFE

What have you tried doing to resolve your Neuropathy/Nerve Pain that **DID NOT** work?

_____
_____
_____

Have you become discouraged or stressed about handling your Neuropathy/Nerve Pain?

_____
_____
_____

When your Neuropathy/Nerve Pain is at its **worst**, how does it make you feel?

_____

_____
_____

What effects does your Neuropathy/Nerve Pain have on your body functions?

_____
_____
_____

Are you visiting us to: (Circle all that apply)

1) Resolve my immediate problem
2) Lifestyle program for optimized living
3) Both
4) Other _____

What have you tried to do to relieve your Neuropathy/Nerve Pain in the past? (Please circle)

Medications
Routine Medical
Exercise
Diet and Nutrition
Holistic
Vitamins
Chiropractic
Other: _____

What are you concerned your Neuropathy/Nerve Pain might affect if it doesn't improve? (Please circle all that apply)

Ability to walk Freedom Balance Worsens Get around Mobility Sleep Marriage
Driving a car Take care of yourself, spouse, or others

Are there any health conditions that you are concerned your Neuropathy/Nerve Pain might turn into? (Please circle all that apply)

Disability Surgery Diabetes Depression
Stress Arthritis Heart Disease Cancer Weight Gain
Other _____

_____

Where do you picture yourself being in the next 3-5 years if your Neuropathy/Nerve Pain is NOT taken care of? Please be specific.

_____
_____
_____
_____

What would be different or better without your Neuropathy/Nerve Pain? (Please circle all that apply)

Diminished Stress
More Energy
Self Esteem
Confidence
Sleep
Getting Around/Mobility
Outlook
Family

If you were to sit down three years from now, what would have had to happen for you to be happy with your Neuropathy/Nerve Pain progress? How would you like your life to be? (Please take your time and don't sell yourself short! Include anything that is a part of your happiness. This includes health, family, work, finance, travel, marriage or even your bucket list).

_____
_____
_____
_____
_____

What potential barriers do you foresee that would prevent these things from happening?

_____
_____
_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____
_____
_____

What are your strengths that enable you to accomplish your goals?

_____
_____
_____

Rate on a scale of 1-10 (10 being the highest)

_____ How important is it for you to resolve your health concerns?