blueprint to Neuropathy

Neuropathy Consult ROF

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name: _____ **Nickname:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Email:** _____

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

Date of Birth: _____ **Social Security:** _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse Name: _____ **Phone Number:** _____

Your Occupation: _____ **Retired:** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

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

PRESENT HEALTH CONDITION

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

1. _____
2. _____
3. _____
4. _____

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

_____

_____

_____

_____

03 **Is your balance/walking ability affected? If yes, please describe:**

_____

_____

_____

_____

04 **List approximately how long you have noticed these problems in your life:**

1. _____
2. _____
3. _____
4. _____

05 **Circle 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

06 **What do you think is causing your problem?**

_____

_____

_____

_____

07 **Name of all doctors you have seen for these problems and treatment you received**

_____

_____

_____

_____

08 **Have your symptoms:** Improved ☐ Worsened ☐ Stayed the Same ☐

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

09 **How would you describe the symptoms? Please check ALL that apply:**

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

10 **Is this condition interfering with any of the following?**

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

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? Yes ☐ No ☐ If yes, please describe type and how often?

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

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

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

PREVIOUS HEALTH CONDITIONS

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:** _____

Please give 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 treatment/condition? Yes ☐ No ☐

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

Items you react to:	Reaction:

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Time Daily

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

Patient Quality of Life Survey

Company Information: _____

Name: _____ **Date:** _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): _____

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

_____

_____

_____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. _____
2. _____
3. _____

08 **What are you most concerned with regarding your problem?**

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

10 **What would be different/better without this problem? Please be specific.**

11 **What do you desire most to get from working with us?**

12 **What would that mean to you?**

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____