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:
