Neuropathy Consult ROF

blueprint to Neuropathy

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

Name _____ **Nickname** _____

Address _____

City _____ **State** _____ **Zip** _____

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's Name _____ **Phone Number** _____

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

REVIEW OF SYMPTOMS

Please check all that apply

☐ Foot Pain	☐ Diabetes	☐ Spinal Stenosis	☐ Cancer	☐ Pinched Nerve
☐ Hand Pain	☐ High Cholesterol	☐ Degenerative Disc	☐ Chemotherapy	☐ Poor Circulation
☐ Low Back Pain	☐ High Blood Pressure	☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacement
☐ 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. _____

List approximately how long you have noticed these problems:

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

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

_____
_____
_____
_____

List 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

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

_____
_____
_____
_____

What do you think is causing your problem?

_____
_____
_____
_____

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

_____

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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 & 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
☐ 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 regularly? Yes ☐ No ☐ If yes, please describe type & 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 PAIN POSSIBLE

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 PAIN POSSIBLE

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PREVIOUS HEALTH HISTORYHEALTH

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:

Item you react to:	*Reaction:*

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

Name	*Dose (mg or IU)*	*Times Daily*

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

Patient Quality Of Life Survey Example

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PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ *Date:* _____

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

1. How have you taken care of your health in the past?
   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify): _____

2. How did the previous method(s) work out for you?
   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not get worse
   f. Did not work very long
   g. Still trying
   h. Confused

3. How have others been affected by your health condition?
   a. No one is affected
   b. Haven't noticed any problem
   c. They tell me to do something
   d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

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

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

What are you most concerned with regarding your problem?

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

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

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

What would that mean to you?

Print Patient Name:_____
Date: _____

Informed Consent for Medical / Chiropractic/ Acupuncture/NAET/ Decompression/ Laser Treatment

Dear Patient,

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about your condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. The information is intended to make you better informed in order that you can knowledgably give or withhold your consent.

Every type of health care is associated with some risk of a potential problem. This includes Medical/Chiropractic/ Decompression Laser Therapy /Acupuncture/NAET care. We want you to be informed about potential problems associated with Medical /Chiropractic/ Decompression/ Laser /Acupuncture/NAET care before consenting to treatment. This is called informed consent.

Chiropractic:
Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and this relationship can affect the restoration and preservation of health.

Chiropractic adjustments/ joint mobilizations are performed by Chiropractors. It is the moving of bones to correct or reduce spinal and extremity joint subluxations with the doctor's hands or with the use of a mechanical device, following palpation and/or other examination procedures. A Vertebral Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and /or does not move properly causing interference and /or irritation to the nervous system. The primary goal of Chiropractic Care is the removal and/or reduction of the nerve interference caused by vertebral subluxation. A Chiropractic examination will be performed which may include spinal and physical examination , orthopedic and neurological testing, palpation, specialized instrumentation, x-rays and laboratory testing. Frequently with spinal or joint adjustments techniques create a "pop" or "click" sound/sensation in the area being treated, such as the noise when a knuckle is "cracked", and you may feel movement of the joint. In addition some ancillary procedures, such as hot and cold packs, electric muscle stimulation, therapeutic ultrasound, massage therapy, paraffin wax, cervical traction, mechanical traction, therapeutic exercises, vibrational –propreceptive rehab, spinal and knee decompression, acupuncture/acupressure, laser, laser acupuncture may also be used. In this office, we use trained staff personal to assist the doctor(s) with portions of your consultation, examination, x-ray taking, physical therapy application, traction, decompression, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor under the direction of the primary doctor will treat you on that day.

Possible Risks: As with any heath care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Disc Herniation: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by Chiropractors and Chiropractic adjustments/joint mobilizations, traction, decompression etc. This includes both in the neck and in the back. Yet, occasionally chiropractic treatment (adjustments/joint mobilizations, traction, spinal decompression/knee decompression etc.) may aggravate the problem and rarely surgery may become necessary for correction.

Rarely chiropractic adjustment/joint mobilizations may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments/joint mobilizations, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or the middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment/joint mobilization will crack a rib bone, and this is referred to as a fracture.

Print Patient Name: _____

This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust/manipulate all patients very carefully, and especially those who have osteoporosis noted on their x-rays. These problems occur so rarely that there are no statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, laser therapy (class 3 cold laser). We can recommend ice or heat or moist heat therapy for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no statistics to quantify their probability. Furthermore physiotherapy may include the proceeding as well as a allergic reaction to gels or lotions in some cases.

Soreness: It is common for chiropractic adjustments/joint mobilizations, traction, massage therapy, exercise, etc. to result in a temporary increase in the soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please tell your doctor about it.

Acupuncture: If using dry needling technique the following risks can occur: infection at site of insertion of needle, bruising, itching, redness, swelling, allergic response to needle.

NAET: Sweating when holding the substance, itching, fatigue after treatment, muscle weakness after treatment.

Probability of risks occurring: There may be other problems or complications that might arise from Chiropractic/Medical/Acupuncture/NAET other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and / or explain them all in advance of treatment. The risks of complications due to chiropractic treatment have been described as "rare', about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options, which could be considered, may include the following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects I a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition and make future rehabilitation more difficult. The same consequences can occur with patients suffering from allergies, chronic conditions and specific medical problems not listed here.

Chiropractic/ Medical/ Acupuncture/ NAET is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptoms, disease, or condition as a result of treatment in this center. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

1. I, _____, authorize the performance upon myself of the following procedure(s): Examination/ X-rays(gowned if needed) Ultrasound, sinusoidal current, interferential currents, traction, decompression, hydrocollator, electrical muscle stimulation, laser therapy , ice therapy, acupuncture, N.A.E.T, and chiropractic manipulative/joint mobilization techniques to be performed by or under the direction of the Doctors and staff of Integrated Medical Center, Inc. d.b.a./Quantum Medical & Wellness Center
2. I also consent to the performance of other diagnostic and / or therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the doctors, associates and / or assistants, may consider necessary or advisable in the course of my health care or treatment.

3. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure(s) has been given by the doctors, their associates or assistants.
4. I have read the explanation above of medical / chiropractic/ acupuncture / NAET/decompression treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I, _____ of my own free will choose to become a patient of Drs./Therapists Popkin/Grundstein/Desir/Debrosse. I understand that some of the techniques and products used in this clinic are neither FDA (Food and Drug Association) approved or considered a "main stream" traditional medicine.

Drs. Popkin/Grundstein//Desir/Debrosse can not guarantee the results of these treatments or products.

I am aware that I am free to seek other medical opinions or other care at any time. I am also aware that Drs. Popkin/Grundstein/ Desir/ Debrosse meet the requirements by Florida law.

I hereby exercise my freedom of choice in Medicine/Chiropractic/ NAET/Acupuncture/ Decompression Therapy/ Massage Therapy/ Manual Therapy/ Laser Therapy to follow Drs. Popkin/Grundstein/Desir/Debrosse recommendations or not as I choose.

Signed_____**Date**_____

blueprint nutrition

Trust Your Gut 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 LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:
Headaches and migraines

Hormone imbalance including:
PMS
Emotional imbalance

Gastrointestinal issues including:
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

Respiratory Conditions including:
Chronic sinusitis
Asthma
Allergies

Autoimmune Conditions including:
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

Developmental and social concerns including:
Austism
ADD/ADHD

Skin Conditions: (urticaria)
Eczema
Skin rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire	None	Mild	Moderate	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	Moderate	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
Ulcerative colitis or celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight Trouble	0	1	2	3

YOUR TOTAL: _____