NEUROPATHY SOLUTIONS

Patient Information:

Date: _____ SSN: _____ Birthday: _____

First Name: _____ Middle Name: _____ Last Name: _____

Sex: O Male O Female Height: _____ Weight: _____

Married/Single: _____ Spouse Name: _____ Email: _____

Home # _____ Cell # _____ Retired: O Yes O No

Text Appointment Reminders: O Yes O No (If you choose yes, one text message will be sent to you the day of your appointment)

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Emergency Relation _____ Emergency Phone _____

Employer Information:

Employed: O Yes O No Retired: O Yes O No Employer Name: _____

Occupation: _____ Work Duties: _____

Referral Information:

Did someone refer you to our office?

Referring Physician: _____ Referring Patient: _____ Other: _____

How did you hear about us?

O Google O Facebook O Yahoo O Health Grades O Newspaper

O Sign O Drive By O Yellow Pages O Mailing O Other _____

Review Of Symptoms: (*Please Check ALL that apply)*

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

Reason for this Visit:

Current Health Problems You Are Wanting Corrected? ***(Please list in order of importance getting corrected)***

1. _____ **Started**_____
2. _____ **Started**_____
3. _____ **Started**_____
4. _____ **Started**_____

Has this concern occurred before? ○ **Yes** ○ **No**

Have you seen other doctors for this concern? ○ **Yes** ○ **No** **Doctor's Name:** _____

Type of Treatment: _____

What do you think is causing the problem? _____

_____

Please Mark The Any Areas of Pain/ Discomfort

○ **Neck**	○ **Upper Back**	○ **Mid Back**	○ **Lower Back**
○ **Right Shoulder**	○ **Right Arm**	○ **Right Elbow**	○ **Right Hand**
○ **Left Shoulder**	○ **Left Arm**	○ **Left Elbow**	○ **Left Hand**
○ **Right Thigh**	○ **Right Knee**	○ **Right Leg**	○ **Right Foot**
○ **Left Thigh**	○ **Left Knee**	○ **Left Leg**	○ **Left Foot**

Please Mark Any The Areas of Numbness/or Tingling

○ **Neck**	○ **Upper Back**	○ **Mid Back**	○ **Lower Back**
○ **Right Shoulder**	○ **Right Arm**	○ **Right Elbow**	○ **Right Hand**
○ **Left Shoulder**	○ **Left Arm**	○ **Left Elbow**	○ **Left Hand**
○ **Right Thigh**	○ **Right Knee**	○ **Right Leg**	○ **Right Foot**
○ **Left Thigh**	○ **Left Knee**	○ **Left Leg**	○ **Left Foot**

On a scale from 1 to 10, rate your pain or numbness/tingling right now? ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

How much of the day is the pain or numbness/tingling there? ○ **25%** ○ **50%** ○ **75%** ○ **100%**

On a scale from 1 to 10, rate your worst pain or numbness/tingling: ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

On a scale from 1 to 10, rate your least pain or numbness/tingling: ○ **1** ○ **2** ○ **3** ○ **4** ○ **5** ○ **6** ○ **7** ○ **8** ○ **9** ○ **10**

How did this pain or numbness/tingling begin: ○ **Suddenly** ○ **Gradually** **If suddenly please explain:**_____

Have your symptoms been getting: ○ **Improving** ○ **Worse** ○ **Same**

Personal Incident History:

Broken Bones:	○ Yes ○ No	**Explain:** _____
Sprains/Strains:	○ Yes ○ No	**Explain:** _____
Hospitalized:	○ Yes ○ No	**Explain:** _____
Surgery:	○ Yes ○ No	**Explain:** _____
Auto Accident:	○ Yes ○ No	**Explain:** _____
Stroke:	○ Yes ○ No	**Explain:** _____

Present Health Condition:

Please describe your condition at It's Worse:

○ Aching Pain ○ Numbness ○ Tiredness ○ Muscle Cramping ○ Swelling ○ Throbbing Pain

○ Stabbing Pain ○ Pins and Needles ○ Electrical Shocks ○ Dead Feeling ○ Cold Hands ○ Cold Feet

○ Sharp Pain ○ Heavy Feeling ○ Burning Sensation ○ Tightening Sensation ○ Stiffness ○ Swelling

○ Other _____

Please indicate what you have tried to help your condition:

○ Ice ○ Stretching ○ Primary Care ○ Ibuprofen ○ Gabapentin ○ Rest

○ Heat ○ Exercise ○ Neurologist ○ Acetaminophen ○ Lyrica ○ Cortisone Injection

○ Acupuncture ○ Icy Hot ○ Chiropractor ○ Aleve ○ Neurontin ○ Spinal Surgery

○ Massage Therapy ○ Bio Freeze ○ Pain Management ○ Tylenol ○ Cymbalta ○ Muscle Relaxers

○ Physical Therapy ○ Bengay ○ Podiatrist ○ Advil ○ Insulin ○ VA Hospital

○ Urgent Care ○ Blue Emu ○ Orthopedist ○ Naproxen ○ Vitamins_____

○ Other_____

Please indicate <u>All</u> the things that are difficult because of your condition: ***(what would you like to see improve)***

_____

_____

_____

_____

Personal Health History:

Primary Physician: _____ Physician' s Phone #: _____ Last Seen: _____

Physician's Address:_____

May we send your Primary Care physician updates on your treatment/condition? ○ **Yes** ○ **No**

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

	Prescription Name	Dose (Mg or UI)	How Many Times a Day
1.)	_____	_____	_____
2.)	_____	_____	_____
3.)	_____	_____	_____
4.)	_____	_____	_____
5.)	_____	_____	_____
6.)	_____	_____	_____
7.)	_____	_____	_____
8.)	_____	_____	_____
9.)	_____	_____	_____
10.)	_____	_____	_____

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

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

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

	Items Reacted To	Reaction
1.)	_____	_____
2.)	_____	_____
3.)	_____	_____
4.)	_____	_____

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.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____