Neuropathy Consultation

Please fill out the application entirely and legibly.

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: ____________

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/Feet
- ☐ Plantar Fasciitis
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor Wound Healing
- ☐ Excessive Thirst or Urination

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

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

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

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

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

____

____

____

____

4 **Circle the things you have used for these problems:**

Gabapentin Neurontin Lyrica
Cymbalta Physical Therapy Aleve
Tylenol Ibuprofen Motrin
Pain Medications Injections Creams
Chiropractic Massage Therapy

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

____

____

____

____

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

____

____

____

____

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

____

____

____

____

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

List anything that makes your condition worse ______________________________

____

List anything that makes your condition better ______________________________

____

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

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

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

☐ Sleep
☐ Recreational Activities
☐ Work
☐ Walking
☐ Daily Activities
☐ 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. Our Medical Providers reserve 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:

____

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____

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