

Neuropathy Intake Form

Name: _____ Date: _____

Nickname: _____ Date of Birth: _____ Age: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone #: _____ Home Phone #: _____

Email Address: _____

Occupation (Current or Previous): _____ Retired: Yes / No

Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse's Name: _____ Marital Status: S M D W # of Children: _____

In Case of Emergency: Contact Name: _____ Phone #: _____

How did you hear about our office? _____

What is your main health concern / condition coming in today?

Please check all that apply:

- | | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Morton's Neuroma |
| <input type="checkbox"/> Foot Surgery | <input type="checkbox"/> Pinched Nerve | <input type="checkbox"/> Falls | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Last A1C: _____ |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Balance Issues | <input type="checkbox"/> Plantar Fasciitis | |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Hand Numbness | <input type="checkbox"/> Spinal Arthritis | <input type="checkbox"/> Poor Wound Healing | <input type="checkbox"/> Chemotherapy | |
| <input type="checkbox"/> Arthritis in Hands/Feet | <input type="checkbox"/> Degenerative Disc Disease | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Implanted Cord / Bladder Stimulator | |

When did this begin? _____

What makes it worse? _____

What makes it better? _____

On a scale of 1 – 10; how committed and serious are you about fixing your condition?

Not Serious 0 1 2 3 4 5 6 7 8 9 10 Totally Committed

Neuropathy Intake Form

How would you describe your symptoms? *(Circle any that apply)*

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

How would you describe the physical appearance of your feet / legs? *(Circle any that apply)*

Discoloration of Skin Dry / Flaky Skin No Hair Growth Discoloration of Toe Nail(s) Loss of Toe Nail(s)

Cyanosis (Blue Coloring of Skin) Petechiae / Red Spots Blisters / Sores Fungal Other

Are your Symptoms over time *(Please Circle)*: Worsening Staying the Same Improving

Frequency of your Pain:

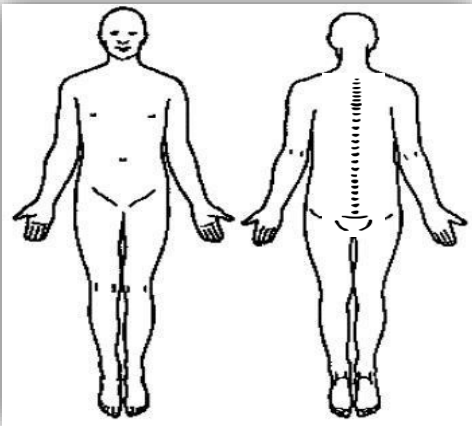
Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (0-25%) ___

On average what level would you rate your overall pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Is this condition interfering with any of the following? *(Circle any that apply)*

Daily Activities Hobbies Walking Standing Work Sleep Relationships Other (Explain)



Please indicate on this drawing the area(s) where you are currently experiencing symptom(s):

Please circle the things you have used / tried to relieve your symptoms:

Gabapentin Amitriptyline Neurontin Cymbalta Lyrica Opioids Injections
 Aleve / Naproxen Tylenol / Acetaminophen Advil / Ibuprofen Motrin
 Creams CBD / Hemp Products Chiropractic Physical Therapy Massage Therapy Other:

Neuropathy Intake Form

Please list any / all prescription medications you are currently taking (or you may attach a list):

<u>Name</u>	<u>Dosage per Day</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any / all allergies and sensitivities: _____

Please list any / all supplements (vitamins, herbs, homeopathic, etc.) you are currently taking:

<u>Name</u>	<u>Dosage per Day</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently taking a Blood Thinner (Coumadin, Lovenox, Heparin, etc)? Yes No

Are you currently taking a Statin (Atorvastatin, Lipitor, Crestor, Simvastatin, etc)? Yes No

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you smoke cigarettes? Yes No If yes, how many cigarettes daily? _____

Do you exercise regularly? Yes No If yes, please describe type & how often? _____

Did this start/progress after COVID or receiving the COVID vaccine? Yes No If yes, when? _____

Name of your Primary Care Physician: _____ Clinic: _____

May we contact them with updates regarding your treatment? Yes No

- I hereby authorize release of any medical information necessary to evaluate my case to _____.
- _____ will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patients' responsibility to contact their insurance provider.

We invite you to discuss with us any questions regarding our services and/or fees. The best health services are based on a friendly, mutual understanding between the provider and patient. I understand the above information, and guarantee this form was completed correctly, to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature: _____ Date: _____

Neuropathy Intake Form

FUNCTIONAL GOALS SURVEY

Please take several minutes to answer these questions so we can help you get better.

How many doctors have you seen for this condition? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

Has what you've done to date for your condition helped?

Yes, a lot Yes, some No, not at all Indifferent I've Done Nothing

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1. _____

2. _____

3. _____

4. _____

5. _____

What is your honest vision of your life in the next few years if this problem continues to progress? _____

What would be different &/or better in your life without this problem? Please be specific.

What is your biggest fear if this condition continues to progress? _____

What would success mean to you in our office? _____
