

# Application for Neuropathy Treatment

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Spouse's Name: \_\_\_\_\_  
Occupation (Current or Previous): \_\_\_\_\_ Retired: Y N

## Review of Systems

Please check all that apply

- |  |  |   |  |   |
|--|--|---|--|---|
| <input type="checkbox"/> Foot Pain     | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Spinal Stenosis    | <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Pinched Nerve                    |
| <input type="checkbox"/> Hand Pain     | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Degenerative Discs | <input type="checkbox"/> Chemotherapy                          | <input type="checkbox"/> Poor Circulation                 |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Vascular Problems  | <input type="checkbox"/> Arthritis in Hands                    | <input type="checkbox"/> Joint Replacements               |
| <input type="checkbox"/> Neck Pain     | <input type="checkbox"/> Pacemaker/<br>Defibrillator | <input type="checkbox"/> Leg Pain           | <input type="checkbox"/> Arthritis in Feet                     | <input type="checkbox"/> Foot Surgery                     |
| <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Herniated Disc              | <input type="checkbox"/> Plantar Fasciitis  | <input type="checkbox"/> Implanted Cord/<br>Bladder Stimulator | <input type="checkbox"/> Poor wound heal-<br>ing          |
| <input type="checkbox"/> Hand Numbness | <input type="checkbox"/> Bulging Disc                | <input type="checkbox"/> Morton's Neuroma   | <input type="checkbox"/> Sciatica                              | <input type="checkbox"/> Excessive thirst or<br>urination |

## Present Health Condition

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

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

List approximately how long you have noticed these problems:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

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  Alleve  
 Tylenol  Ibuprofen  Motrin  Chiropractic  
 Massage Therapy  Injections  Creams on Hands/Feet  
 Other Medications or Treatments: \_\_\_\_\_

Is your balance/walking ability affected?  Y  N

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What do you think is causing your problem?: \_\_\_\_\_

Names of all doctors you have seen for these problems and treatment you received: \_\_\_\_\_

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
- Stabbing Pain
- Sharp Pain
- Tiredness
- Numbness
- Tingling
- Pins and Needles Pain
- Heavy Feeling
- Hot sensation
- Throbbing Pain
- Dead Feeling
- Cold Hands/Feet
- Cramping
- Swelling
- Burning
- Electric Shocks

Is this condition interfering with any of the following?

- Sleep
- Work
- Daily Activities
- Housework
- Recreational Activities
- Walking
- Standing
- Shopping

## Social History

Do you smoke?  Yes  No If yes, how many packs/daily: \_\_\_\_\_

Do you drink?  Yes  No If yes, how many drinks/week: \_\_\_\_\_

Do you exercise regularly? Yes No If yes, describe what type and how often: \_\_\_\_\_

## Current Pain Levels

How would you rate your pain in the last week:

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

# Previous Health History

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: \_\_\_\_\_ Date: \_\_\_\_\_

Please give name, address, and office phone of your primary care physician/family doctor?:

Name: \_\_\_\_\_

When were you last seen there: \_\_\_\_\_

May we send them updates on your treatment/condition: Yes No

List ALL Allergies (or Sensitivities) to Medicines, Foods, and other items:

Item you react to:

Reaction:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list the prescription drugs you are currently taking, or attach list:

Name:

Dose (MG or IU)

Times Daily

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Nutritional Supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of Above List: \_\_\_\_\_