Neuropathy Intake

First Name _____ **Last Name** _____ **Middle Name** _____

Gender
◯ Male ◯ Female

Marital Status
◯ Single ◯ Divorced ◯ Married
◯ Widow ◯ Other

Birthday _____

Street Address
_____

City _____ **State/Province** _____ **Zip Code** _____

Cell Phone _____ **Home Phone** _____ **Work Phone** _____

Email _____

Preferred Contact Method
☐ Cell Phone ☐ Home Phone
☐ Work Phone ☐ Email

Purpose of Visit
☐ Wellness Check-Up ☐ Injury or Accident ☐ Spinal Decompression
☐ Tennis Elbow ☐ Golfers Elbow ☐ Carpal Tunnel/Wrist Pain
☐ Knee Treatment ☐ Adjustment ☐ Neuropathy

Other: _____

Major current health complaints in order of importance to you (Please list the complaint, when it started and the causes):
_____

When did this condition begin?
_____

Is the pain:
◯ Constant ◯ Frequent ◯ Occasional ◯ Intermittent

How have your health problems progressed since they began?
◯ Stable ◯ Fluctuating ◯ Gradually Improving
◯ Gradually Worsening ◯ Rapidly Improving ◯ Rapidly Worsening

Current level of pain:
◯ Mild 1-3 ◯ Moderate 4-6 ◯ Severe 7-9 ◯ Extreme 10 ◯ No Pain

At its worst, pain is:
◯ Mild 1-3 ◯ Moderate 4-5 ◯ Severe 7-9 ◯ Extreme 10 ◯ No Pain

Is condition effecting:
◯ Left ◯ Right ◯ Both

Is pain:

- [ ] Sharp
- [ ] Dull
- [ ] Stabbing
- [ ] Tingling
- [ ] Burning
- [ ] Numbing

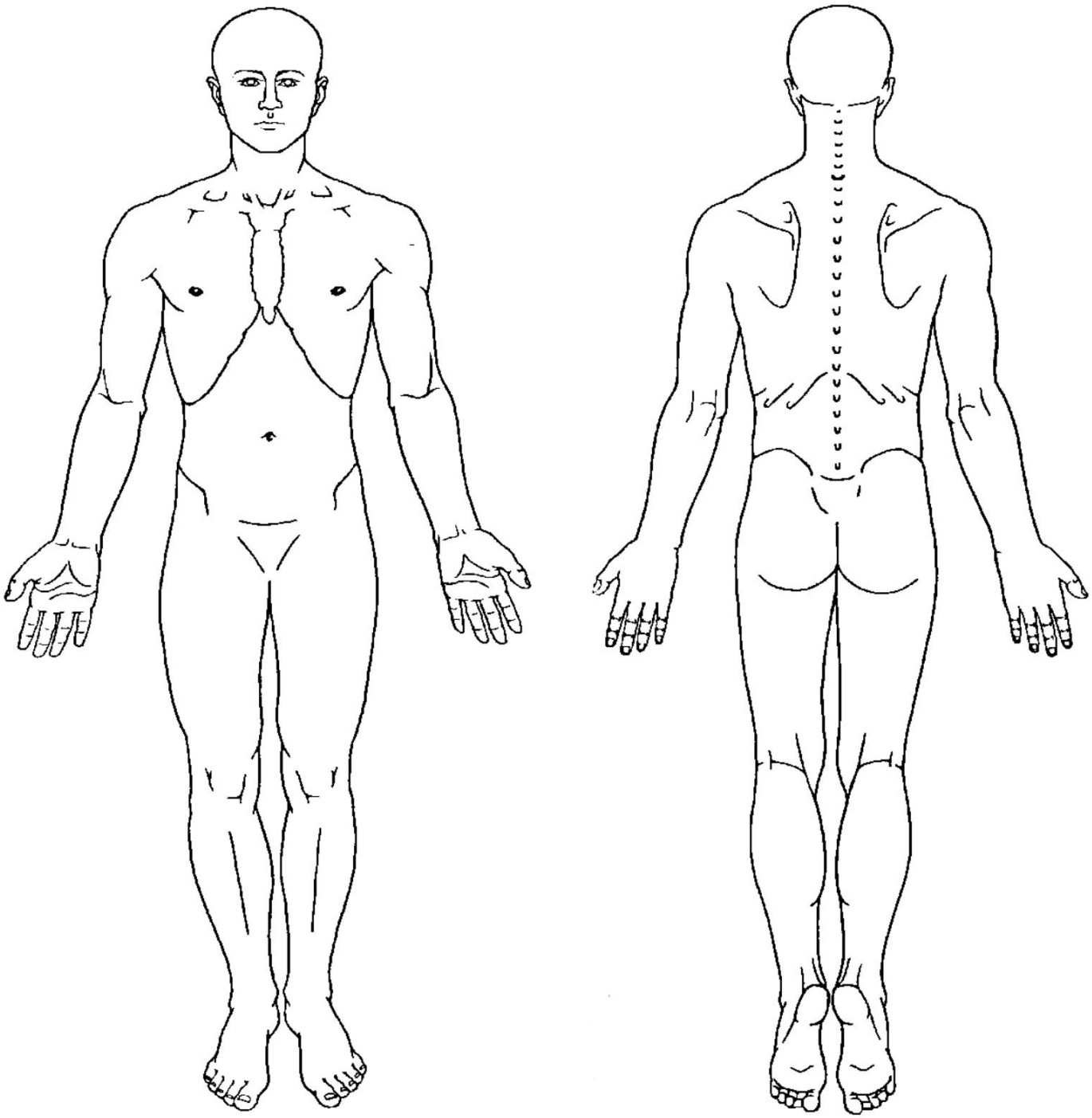
Do you feel Weakness in your:

- [ ] Neck
- [ ] Shoulder
- [ ] Arm
- [ ] Forearm
- [ ] Wrist
- [ ] Fingers
- [ ] Ribs
- [ ] Upper Back
- [ ] Abdomen
- [ ] Low Back
- [ ] Pelvis
- [ ] Hips
- [ ] Thighs
- [ ] Knees
- [ ] Legs
- [ ] Ankles
- [ ] Feet

Do you feel loss of sensation in your:

- [ ] Neck
- [ ] Shoulder
- [ ] Arm
- [ ] Forearm
- [ ] Wrist
- [ ] Fingers
- [ ] Ribs
- [ ] Upper Back
- [ ] Abdomen
- [ ] Low Back
- [ ] Pelvis
- [ ] Hips
- [ ] Thighs
- [ ] Knees
- [ ] Legs
- [ ] Ankles
- [ ] Feet

Please mark area(s) of concern:



Who have you seen for this condition (Please list the Name of the Practitioner/Doctor/Specialist, the date of last visit and results achieved)?

Are you currently under the care of a family physician or any other health professional? If yes, please indicate the health professional's name, health professional's contact, condition and treatment:

Please list any prescribed medications you take including the name, dosage and how long you've been taking it:

Please list all non-prescription medications you take include the name, dosage and how long you've been taking it:

Please list all allergies:

Have you had previous diagnostic tests?

☐ X-Ray ☐ MRI ☐ Nerve Condition ☐ E.M.G.

Other: _____

Do you have a copy of:

☐ X-Ray ☐ MRI ☐ Nerve Condition ☐ Any Reports

Have you had:

☐ Spinal Epidural ☐ Spine Surgery

Please Explain: _____

If no, has any doctor ever suggested?

☐ Spinal Epidural ☐ Spinal Surgery

What else have you tried?

How does this effect your activities of daily living? Please select all that apply:

☐ Sports
☐ Working Out
☐ Hobbies
☐ Social Life
☐ Getting Ready
☐ House Projects
☐ Yard Work
☐ Errands
☐ Driving
☐ Sleeping
☐ Wake in Pain
☐ Going to the Bathroom
☐ Intimacy
☐ Playing with Children
☐ Spending Time with Partner
☐ Self Care
☐ Sitting
☐ Standing
☐ Bending
☐ Lifting
☐ Computer Work
☐ Walking
☐ Missed Time of Work
☐ Placed on Disability

What activities of daily living would you like to do again or do better than you can now? Please be specific. This is IMPORTANT!

What is your level of commitment to improving this condition if we determine we can help you?

◯ Not Committed 1-4
◯ Not Sure 5-8
◯ Committed 9-10

Please write down any concerns you may have about treatment in our office?

_____

I DO NOT HAVE ANY OF THE FOLLOWING CONDITIONS:

☐ Pregnancy
☐ Metastatic Cancer
☐ Severe Osteoporosis
☐ Prior Spinal Fusions
☐ Spondylolisthesis Grade 3 or 4
☐ Pelvic or Abdominal Cancer
☐ L1-L5 Compression fx<Pars decfect
☐ Pathologic Aortic Aneurysm (.3.5)
☐ Disc Space Infection
☐ Severe Peripheral Neuropathy
☐ Cognitive Dysfunctions
☐ Metal implants or hardwire surgically installed in my spine
☐ History of Significant Trauma
☐ Trouble starting or stopping urination
☐ Legs give out or feel weak
☐ Bowel Accidents
☐ Prolonged use of corticosteroids
☐ Intravenous Drug use
☐ Current urinary tract, respiratory track or other infections
☐ Unexplained Weight loss
☐ Any past history of cancer
☐ Pace Maker
☐ Defibrillator

Have you been diagnosed with any of the following conditions?

- [ ] Diabetes
- [ ] Epilepsy
- [ ] Heart Condition
- [ ] Cancer
- [ ] Bleeding Disorder
- [ ] Thyroid Condition
- [ ] Irritable Bowel
- [ ] Ulcerative Colitis
- [ ] Liver Disease
- [ ] Asthma
- [ ] HIV/AIDS
- [ ] Osteoporosis
- [ ] Rheumatoid Arthritis
- [ ] Kidney Disease
- [ ] Cardiovascular Disease

Other:

_____

Give details and symptoms of the above conditions. (When were you diagnosed, frequency, what makes symptoms better or worse, treatments and were they successful?)

_____

Please check the boxes which indicate areas you currently have or ever had problems with:

- [ ] Endocrine System
- [ ] Digestive System
- [ ] Urinary System
- [ ] Respiratory System
- [ ] Cardiovascular System
- [ ] Nervous System
- [ ] Muscular/Skeletal System
- [ ] Reproductive System
- [ ] Immune & Lymphatic System
- [ ] Other

Other:

_____

Please check the boxes which indicate conditions you have had or presently have. If any other conditions, please list them on the box down below:

- [ ] Abscesses
- [ ] Acne
- [ ] AIDS/HIV
- [ ] Alcoholism
- [ ] Allergies
- [ ] Amnesia
- [ ] Anemia
- [ ] Angina
- [ ] Anxiety Disorder
- [ ] Arthritis
- [ ] Asthma
- [ ] Bladder infections
- [ ] Bronchitis
- [ ] Cancer
- [ ] Chicken Pox
- [ ] Cold Sores
- [ ] Colitis
- [ ] Depression
- [ ] Diabetes
- [ ] Eating disorder
- [ ] Eczema
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Gall Stones
- [ ] Goitre
- [ ] Gonorrhea
- [ ] Gout
- [ ] Hay Fever
- [ ] Hemorrhoids
- [ ] Heart Disease
- [ ] Hepatitis A, B or C
- [ ] Herpes
- [ ] Herpes Genitalia
- [ ] High/Low Blood Pressure
- [ ] Hypoglycemia
- [ ] Influenza
- [ ] Kidney Disease
- [ ] Kidney Stones
- [ ] Leukemia
- [ ] Malaria
- [ ] Measles
- [ ] Migraines
- [ ] Miscarriage
- [ ] Mononucleosis
- [ ] Mood disorder
- [ ] Mumps
- [ ] Parasites
- [ ] Pelvic Inflammatory Disease
- [ ] Peritonitis
- [ ] Pleurisy
- [ ] Pneumonia
- [ ] Post-partum depression
- [ ] Prostatitis
- [ ] Rheumatic Fever
- [ ] Rubella
- [ ] Scarlet Fever
- [ ] Schizophrenia
- [ ] Sexual Abuse
- [ ] Skin Disease
- [ ] Stomach problems
- [ ] Strep Throat
- [ ] Sinusitis
- [ ] Stroke
- [ ] Sun Stroke
- [ ] Syphilis
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Typhoid Fever
- [ ] Ulcers
- [ ] Venereal Warts
- [ ] Warts
- [ ] Whooping Cough
- [ ] Worms
- [ ] Yellow Fever
- [ ] Other(s)

If "other(s)", please specifiy

_____

Ear health. Do you suffer from any of the following?

- [ ] Recurrent ear infections
- [ ] Tinnitus (ringing ears)
- [ ] Hearing problems
- [ ] Perforated ear drum
- [ ] Other(s)

If "other(s), please specify

_____

Eye health. Do you suffer from any of the following?

- [ ] Short sightedness
- [ ] Long sightedness
- [ ] Glaucoma
- [ ] Cataracts
- [ ] Conjunctivitis
- [ ] Styes
- [ ] Red eyes
- [ ] Itchy eyes
- [ ] Dry eyes
- [ ] Watery eyes
- [ ] Yellow sclera
- [ ] Dark circles around eyes
- [ ] Other(s)

If "other(s), please specify,

_____

Nose and respiratory system. Do you suffer from any of the following?

- [ ] Hay fever (allergic rhinitis) (seasonal or all year round?)
- [ ] Recurring tonsilitis
- [ ] Asthma
- [ ] Sinusitis
- [ ] Pneumonia
- [ ] Bronchitis
- [ ] Wheezing
- [ ] Breathlessness on exertion
- [ ] Frequent nose bleeds
- [ ] Nasal polyps
- [ ] Other(s)

If "other(s)", please specify

_____

Cardiovascular health. Do you suffer from any of the following conditions?

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] High colesterol
- [ ] Chest pain
- [ ] Heart palpitations
- [ ] Bruise easily
- [ ] Varicose veins
- [ ] Cold hands and feet
- [ ] Swollen feet or ankles
- [ ] Palpitations on exertion

Please check the boxes which indicate ailments that have affected your relatives and specify to which relative (s) the ailments apply :

- [ ] Alcoholism
- [ ] Allergies
- [ ] Arthritis
- [ ] Asthma
- [ ] Cancer
- [ ] Depression
- [ ] Diabetes
- [ ] Epilepsy
- [ ] Gonorrhea
- [ ] Gout
- [ ] Heart Disease
- [ ] Insanity
- [ ] Paralysis
- [ ] Pneumonia
- [ ] Skin Disease
- [ ] Syphilis
- [ ] Tuberculosis

Signature

Date Signed

_____

Printed Name

_____

Email

_____