EXAM PAID: ____________

ROF: ____________

NEUROPATHY

Patient History Information

Date: ____________

Please fill out the application entirely and legibly. We need all information.

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with other medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization.

Name ____________

Address, City, State, Zip ____________

Cell Phone ____________ Email ____________

Birthdate ____________ SS# ____________

Spouse's Name ____________ Cell Phone ____________

REVIEW OF SYMPTOMS

➔ **Please check all that apply**

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

PRESENT HEALTH CONDITION

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

1 ____________
2 ____________
3 ____________
4 ____________

➔ **List approximately how long you have noticed the problems to the left.**

1 ____________
2 ____________
3 ____________
4 ____________

➔ **Is there a certain time of day any of these probelsm are better or worse?**

____
____
____
____

➔ **Llist the things you have used for these problems.**

Gabapentin	Amitriptyline	Physical Therapy	
Lyrica	Injections	Massage Therapy	
Cymbalta	Ibuprofen	Chiropractic	
Neurontin	Aleve	Tylenol	Creams

➔ **Is your balance/walking ability affected? If yes, please describe.**

____
____
____
____

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

____
____
____
____

PREVIOUS HEALTH HISTORY

Current Doctor ______________________________ Phone ________________

When were you last seen there? ______________________________

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

Item you react to:	Reaction:

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

Name	Dose (mg or IU)	Times Daily

➔ **List ALL nutritional supplements (vitamins, herbs, Homeopathics, etc.) as above:**

Name	Dose (mg or IU)	Times Daily

Signature ______________________________

PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: ______________________________ ***Date:*** ______________

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?

   a. Medications
   b. Emergency Room
   c. Routine Medical
   d. Exercise
   e. Nutrition/Diet
   f. Holistic Care
   g. Vitamins
   h. Chiropractic
   i. Other (please specify): ______________________________

2. How did the previous method(s) work out for you?

   a. Bad results
   b. Some results
   c. Great results
   d. Nothing changed
   e. Did not get worse
   f. Did not work very long
   g. Still trying
   h. Confused

3. How have others been affected by your health condition?

   a. No one is affected
   b. Haven't noticed any problem
   c. They tell me to do something
   d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

   a. Job
   b. Kids
   c. Future ability
   d. Marriage
   e. Self-esteem
   f. Sleep
   g. Time
   h. Finances
   i. Freedom

Informed Consent To Treat

Patient Name:_________________________________ Date: ____________________
Please print clearly

I hereby request and consent to the performance of procedures, including various modes of physio therapy, chiropractic adjustments, examinations, acupuncture, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by this location and/or other licensed providers and support staff who now or in the future treat me while employed by, working or associated with or as back-up, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with this location provider and/or with other office or clinic personnel the nature and purpose of the procedures.

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect this location provider to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest.

I further understand that treatment is designed to improve health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition, these treatment options include, but limited to self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other options if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Signature of Patient:____

If Patient is a minor, what is relationship to Patient:______________________

Guardian/Parental Signature:____