Neuropathy Consult ROF

blueprint to Neuropathy

Please fill out the application entirely and legibly.

Name ______________________ **Nickname** ______________________

Address ____

City ______________ **State** ______________ **Zip** ______________

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 ______________________ **Social Security** ______________________

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name ______________________ **Phone Number** ______________________

Your Occupation ______________________ **Retired?** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

☐ Foot Pain	☐ Diabetes	☐ Spinal Stenosis	☐ Cancer	☐ Pinched Nerve
☐ Hand Pain	☐ High Cholesterol	☐ Degenerative Disc	☐ Chemotherapy	☐ Poor Circulation
☐ Low Back Pain	☐ High Blood Pressure	☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacement
☐ Neck Pain	☐ Pacemaker/ Defibrillator	☐ Leg Pain	☐ Arthritis in Feet	☐ Foot Surgery
☐ Foot Numbness	☐ Herniated Disc	☐ Plantar Fasciitis	☐ Implanted Cord/ Bladder Stimulator	☐ Poor wound healing
☐ Hand Numbness	☐ Bulging Disc	☐ Morton's Neuroma	☐ Sciatica	☐ Excessive thirst or 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 these problems:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

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 Aleve
Tylenol Ibuprofen Motrin Chiropractic
Massage Therapy Injections Creams

Is your balance/walking ability a ected?
If yes, please describe:

____

What do you think is causing your problem?

____

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

____

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

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ 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 regularly? Yes ☐ No ☐ If yes, please describe type & 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 PAIN POSSIBLE

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 PAIN POSSIBLE

PREVIOUS HEALTH HISTORYHEALTH

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*** ______________________

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:

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:

hood county
NATURAL HEALTH
CLINIC

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

5. Are there health conditions you are afraid this might turn into?
    a. Family health problems
    b. Heart disease
    c. Cancer
    d. Diabetes
    e. Arthritis
    f. Fibromyalgia
    g. Depression
    h. Chronic Fatigue
    i. Need surgery
6. How has your health condition affected your job, relationships, finances, family, or other activates? Please give examples: -

    ____
    ____
    ____

7. What has that cost you? (Time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

    ____
    ____
    ____

8. What are you most concerned with regarding your problem?

    ____
    ____
    ____

9. Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

    ____
    ____
    ____

10. What would be different/better without his problem? Please be specific

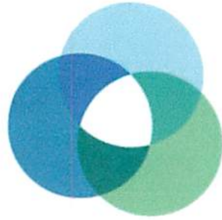
    ____
    ____
    ____

11. What do you desire most to get from working with us?

    ____
    ____
    ____

12. What would that mean to you?

    ____
    ____



hood county NATURAL HEALTH CLINIC

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Health Insurance Portability & Accountability Act (HIPAA) Consent Form
THIS NOTICE DESCRIBES HOW RELATED INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO
THIS INFORMATION

In the course of your care as a patient at our office, we may use or disclosure personal and health related information about you in the following ways: 1)Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment of treatment. 2) Your health records as well as your billing records may be disclosed to another party, such as insurance carriers (HMO,PPO,etc.),or your employer(if they are responsible for payment). 3)Your name, address, phone number, email and your health records may be used to contact you regarding appointment reminders, missed appointments notifications, birthday cards, holiday related cards, information about treatment alternatives or other health related information. A message may be left on your answering machine. 4) Your name may be listed on our referral board, in testimonial letters you provide, or on our kid's board if applicable. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization, it will not affect the care provided to you. Under federal law, we are also permitted to use or disclose your health information without your consent or authorization in the following circumstances:

- If we are providing health care services to you based on the orders of another health care provider
- If we provide health care services to you in an emergency
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so
- If there are substantial barriers to communication with you, but in our professional judgment we believe that you intend for us to provide care

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. By signing below, I acknowledge that I have read the above information and give full disclosure of my information.

____

Patient's/Guardian Signature **Date**

CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION

I hereby authorize and release the doctor and whomever he/she may designate as his/her assistant to administer treatment, physical examination, x-ray studies, laboratory procedure, chiropractic care or any clinic services that he/she deems necessary in my case: and further authorize him/her to disclose all or any part of my (patients) records to any person or corporation which is or may be liable under a contract to the clinic or the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to, hospital or medical services companies, insurance companies, workers compensation carriers, welfare funds, or the patients employer.

____

Patient's Signature **Date**