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Please fill out the application entirely and legibly.

Name:_____ **Birth Date:**_____

Address:_____**City**_____**Zip**_____

Email address: _____

Phone Number:_____

Spouse's Name:_____**Phone#**_____

Number of Children:_____ **Your Occupation:**_____

Emergency Contact:_____**Phone#**_____

How did you hear about us?:_____

Your Preferred Name (Nickname):_____

General Symptoms

Please check all that apply

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

Present Health Condition

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

1_____

2_____

3_____

4_____

2. List approximately how long you have noticed these problems in your life:

1_____

2_____

3_____

4_____

3. Is there a certain time of day any of these problems are better or worse?

_____

_____

_____

_____

4. Circle the things you have used for these problems.

Gapapentin Neurontin Lyrica

Cymbalta Physical/Message Therapy

Pain Medications Aleve/Tylenol/Motrin

Chiropractic Care Injections Creams

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

_____

_____

6. What do you think is causing your neuropathy? _____

_____

7. Name of all doctors you have seen for these problems and treatment you recieved.

_____

_____

_____

_____

8. In the past 3 months has your neuropathy: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse: _____

_____

List anything that makes your condition better:_____

_____

9. How would you describe your symptoms? Please mark ALL that apply:

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

10. Is your condition interfering with any of the following? Please circle ALL that apply:

☐ 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? Yes ☐ No ☐ If yes, describe type and 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 possible pain

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 possible pain

Health History

This is a confidential record of your medical history and pertinent 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:_____

Primary Care Provider: _____

Address:_____

Phone:_____ Fax:_____

When were you last seen there? _____

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

List <u>ALL</u> allergies/sensitivities to medication, food, or other items here:

Items you react to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

List <u>ALL</u> the prescription drugs you are currently taking (or attach a list):

Name	Dose (mg or IU)	Time Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List ALL nutritional supplements (vitamins, herbs, homeopathic, etc.) as above.

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

Quality of Life Survey

Please take a moment to answer these questions so we can help you get better.

Please mark all that apply.

1. How have you addressed your concerns regarding your neuropathy?

☐ Medications ☐ Nutrition/Diet ☐ Emergency Room

☐ Holistic Care ☐ Routine Medical Visits

☐ Vitamins ☐ Exercise ☐ Chiropractic Care

☐ Other (please specify):_____

_____

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

☐ Bad results ☐ Did not get any worse ☐ Some results

☐ Did not work very long ☐ Great results ☐ Still trying

☐ Nothing changed ☐ Confused

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

☐ No one is affected ☐ They tell me to do something

☐ People avoid me ☐ Haven't noticed a problem

4. Which areas of your life are affected by these symptoms?

☐ Job ☐ Sleep ☐ Kids ☐ Time

☐ Future ability ☐ Finances ☐ Marriage

☐ Freedom ☐ Self-Esteem

5. Are there health conditions you are afraid this might turn into?

☐ Diabetes ☐ Arthritis ☐ Need surgery

☐ Chronic Fatigue ☐ Depression ☐ Cancer

☐ Heart Disease ☐ Fibromyalgia

☐ Family health problems

6. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

_____

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

_____

_____

_____

8. What most concerns you regarding your neuropathy?

_____

_____

_____

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

_____

_____

10. How would life change if neuropathy was not a problem for you?

_____

_____

_____

11. If you are a candidate for treatment, what do you want to get from working with the doctor?

_____

_____

_____

12. What would that mean to you?

_____

_____

_____

Rate your discomfort level based on how you have felt this past week.

0 = None 1 = Little Bit 2 = Little more than usual 3 = Even more than usual 4 = A lot more 5 = Extremely more

1. How numb have your legs and/or feet been feeling? _____	0	1	2	3	4	5
2. Burning pain in your legs/feet _____	0	1	2	3	4	5
3. Feet too sensitive to touch _____	0	1	2	3	4	5
4. Have you gotten any muscles cramps in your legs/feet? _____	0	1	2	3	4	5
5. Have any prickling or tingling feelings in your legs or feet? _____	0	1	2	3	4	5
6. At night, or when the covers touch your skin, is there pain? _____	0	1	2	3	4	5
7. Have you have any sharp, stabbing, shooting pain in your feet or legs? _____	0	1	2	3	4	5
8. Do your legs and/or feet hurt when you walk? _____	0	1	2	3	4	5
9. Are you able to sense your feet when you walk? _____	0	1	2	3	4	5
10. Is the skin on your feet so dry that it cracks open? _____	0	1	2	3	4	5
11. Do you have electric shock-like pain in your feet or legs? _____	0	1	2	3	4	5
12. When you get into the tub or shower, are you able to tell the hot from the cold water? _____	0	1	2	3	4	5
13. Have you experienced an asleep feeling or loss of sensation in your legs or feet? _____	0	1	2	3	4	5
14. Do you feel weak when you walk? _____	0	1	2	3	4	5
15. Are your symptoms worse at night? _____	0	1	2	3	4	5

Wellness Evaluation

Please complete this evaluation to help our doctor determine how we can help your condition.

Mark any that apply to you.

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic Sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that closely fits, then add them up.

0=None 1=Mild 2=Moderate 3=Severe

Constipation and/or diarrhea	0 1 2 3	Asthma, Hayfever, or airborne allergies	0 1 2 3
Abdominal Pain or bloating	0 1 2 3	Confusion, poor memory or mood swings	0 1 2 3
Mucous or blood in stool	0 1 2 3	Use of NSAIDS (Aspirin, Tylenol, Motrin)	0 1 2 3
Joint pain or swelling	0 1 2 3	History of antibiotic use	0 1 2 3
Chronic or frequent fatigue	0 1 2 3	Alcohol consumption makes me feel sick	0 1 2 3
Food allergies, sensitivities	0 1 2 3	Gluten sensitivity or Celiac's disease	0 1 2 3
Sinus or nasal congestion	0 1 2 3	Nausea	0 1 2 3
Chronic or frequent inflammations	0 1 2 3	Weight issues	0 1 2 3
Eczema, skin rashes or hives	0 1 2 3		

Your Total: _____