

Neuropathy Consult ROF

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

Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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 Name: _____ Phone Number: _____

Your Occupation: _____ Retired: Yes No

REVIEW OF SYMPTOMS

Please check all that apply

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

PRESENT HEALTH CONDITION

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

- 1. _____
- 2. _____
- 3. _____
- 4. _____

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

- 1. _____
- 2. _____
- 3. _____
- 4. _____

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

05 Circle 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

03 Is your balance/walking ability affected? If yes, please describe:

06 What do you think is causing your problem?

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

08 Have your symptoms: Improved Worsened Stayed the Same

List anything that makes your condition worse _____

List anything that makes your condition better _____

09 How would you describe the symptoms? Please check ALL that apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Aching Pain | <input type="checkbox"/> Tingling/Electric Shocks | <input type="checkbox"/> Dead Feeling |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Pins & Needles Pain | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Heavy Feeling | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Hot Sensation | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Throbbing Pain | <input type="checkbox"/> Burning |

10 Is this condition interfering with any of the following?

- | | | |
|--|----------------------------------|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Work | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> 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, please 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

PREVIOUS HEALTH CONDITIONS

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:

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

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

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

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

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

Patient Quality of Life Survey


Company Information: _____

Name: _____ Date: _____

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

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

- | | |
|--|---|
| <input type="checkbox"/> Medications | <input type="checkbox"/> Nutrition/Diet |
| <input type="checkbox"/> Emergency Room | <input type="checkbox"/> Holistic Care |
| <input type="checkbox"/> Routine Medical | <input type="checkbox"/> Vitamins |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Other (please specify): _____ | |

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

- | | |
|--|---|
| <input type="checkbox"/> Bad Results | <input type="checkbox"/> Did Not Get Worse |
| <input type="checkbox"/> Some Results | <input type="checkbox"/> Did Not Work Very Long |
| <input type="checkbox"/> Great Results | <input type="checkbox"/> Still Trying |
| <input type="checkbox"/> Nothing Changed | <input type="checkbox"/> Confused |

 **How have others been affected by your health condition?**

- | | |
|--|---|
| <input type="checkbox"/> No One Is Affected | <input type="checkbox"/> They Tell Me To Do Something |
| <input type="checkbox"/> Haven't Noticed Any Problem | <input type="checkbox"/> People Avoid Me |

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

- | | |
|---|-----------------------------------|
| <input type="checkbox"/> Job | <input type="checkbox"/> Sleep |
| <input type="checkbox"/> Kids | <input type="checkbox"/> Time |
| <input type="checkbox"/> Future Ability | <input type="checkbox"/> Finances |
| <input type="checkbox"/> Marriage | <input type="checkbox"/> Freedom |
| <input type="checkbox"/> Self-Esteem | |

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

- | | |
|---|--|
| <input type="checkbox"/> Family Health Problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Need Surgery |
| <input type="checkbox"/> Arthritis | |

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

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

1. _____

2. _____

3. _____

What are you most concerned with regarding your problem?

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

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

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

What would that mean to you?

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check 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 Mellitus
- 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 most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____