Neuropathy Intake Form

Name: _____
Date: _____

Nickname: _____

Date of Birth: _____

Age: _____

Sex: M ☐ **F** ☐

Address: _____

City: _____

State: _____

Zip: _____

Mobile Phone #: _____

Home Phone #: _____

Email Address: _____

Occupation (Current or Previous): _____
Retired: Yes / No

Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse's Name: _____

Marital Status: S M D W

# of Children: _____

In Case of Emergency:

Contact Name: _____

Phone #: _____

How did you hear about our office? _____

What is your main health concern / condition coming in today?

_____

_____

Please check all that apply:

When did this begin?

_____

_____

What makes it worse?

_____

_____

What makes it better?

_____

_____

On a scale of 1 – 10; how committed and serious are you about fixing your condition?

Not Serious 0 1 2 3 4 5 6 7 8 9 10 Totally Committed

Please indicate on this drawing the area(s) where you are currently experiencing symptom(s):

How would you describe your symptoms? *(Circle any that apply)*

| Sharp Pain | Stabbing Pain | Aching Pain | Throbbing Pain | Numbness | Tiredness |

| Heavy Feeling | Dead Feeling | Swelling | Electric Shocks | Pins & Needles | Tingling |

| Cramping | Imbalance / Falls | Burning | Hot Sensation | Cold Hands / Feet |

How would you describe the physical appearance of your feet / legs? *(Circle any that apply)*

| Discoloration of Skin | Dry / Flaky Skin | No Hair Growth | Discoloration of Toe Nail(s) | Loss of Toe Nail(s) |

| Cyanosis (Blue Coloring of Skin) | Petechiae / Red Spots | Blisters / Sores | Fungal | Other |

Are your Symptoms over time *(Please Circle)* : Worsening Staying the Same Improving

Frequency of your Pain:

Constant (75-100%) ____ Frequent (51-75%) ____ Occasional (25-50%) ____ Intermittent (0-25%) ____

On average what level would you rate your overall pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Is this condition interfering with any of the following? *(Circle any that apply)*

| Daily Activities | Hobbies | Walking | Standing | Work | Sleep | Relationships | Sex Life |

Please list any / all prescription medications you are currently taking (or you may attach a list):

Please list any / all allergies and sensitivities:

_____

_____

_____

_____

_____

Please list any / all supplements (vitamins, herbs, homeopathic, etc.) you are currently taking:

Are you currently taking a Blood Thinner (Coumadin, Lovenox, Heparin, etc)? Yes No

Are you currently taking a Statin (Atorvastatin, Lipitor, Crestor, Simvastatin, etc)? Yes No

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you smoke cigarettes? Yes No If yes, how many cigarettes daily? _____

Do you exercise regularly? Yes No If yes, please describe type & how often? _____

Did this start/progress after COVID or receiving the COVID vaccine? Yes No If yes, when? _____

Name of your Primary Care Physician: _____ Clinic: _____

May we contact them with updates regarding your treatment? Yes No

-

- I hereby authorize release of any medical information necessary to evaluate my case to _____.
- _____ will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patients' responsibility to contact their insurance provider.

We invite you to discuss with us any questions regarding our services and/or fees. The best health services are based on a friendly, mutual understanding between the provider and patient. I understand the above information, and guarantee this form was completed correctly, to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature: _____ Date: _____

FUNCTIONAL GOALS SURVEY

Please take several minutes to answer these questions so we can help you get better.

How many doctors have you seen for this condition? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

_____

_____

_____

Has what you've done to date for your condition helped?

☐ **Yes, a lot** ☐ **Yes, some** ☐ **No, not at all** ☐ **Indifferent**

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1._____

2._____

3._____

4._____

5._____

What is your honest vision of your life in the next few years if this problem continues to progress? _____

_____

_____

What would be different &/or better in your life without this problem? Please be specific.

_____

_____

_____

What is your biggest fear if this condition continues to progress? _____

_____

_____

_____

What would success mean to you in our office? _____

_____

_____

_____