Neuropathy Consult

ELEVATED HEALTH

PLEASE FILL OUT ALL THE AREAS OF THE APPLICATION ENTIRELY AND LEGIBLY

*Name*_____ *Nickname* _____

*Address*_____

*City*_____ *State*_____ *Zip*_____

*Phone*_____ *Email*_____

We will need to contact you both by phone and email. Please be sure to give us the best phone number to reach you

*Date of Birth*_____ *Social Security*_____

*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	☐ Sciatica	☐ Leg Pain	☐ Arthritis in Feet	☐ Foot Surgery
☐ Foot Numbness	☐ Herniated Disk	☐ Plantar Fasciitis	☐ Morton's Neuroma	☐ Poor wound healing
☐ Hand Numbness	☐ Bulging Disk	☐ Implanted Cord/ Bladder Stimulator	☐ Pacemaker/ Defibrillator	☐ Excessive thirst or urination

PRESENT HEALTH CONDITIONS

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?

_____

_____

_____

Circle the things you have used for these problems:

Gabapentin	*Neurontin*	*Lyrica*	*Cymbalta*
Tylenol	*Aleve*	*Ibuprofen*	*Motrin*
Injections	*Creams*	*Physical Therapy*	*Pain Medication*
Chiropractic	*Massage Therapy*		

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

_____

_____

_____

What do you think is causing your problem?

_____

_____

_____

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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 of exercise and how often: ____

_____

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week? (please circle)

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

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PREVIOUS HEALTH HISTORY

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*	*Times Daily*

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