NEUROPATHY PROGRAM APPLICATION

TODAY'S DATE: ____________

NAME ____________ NICKNAME ____________

ADDRESS ____________

CITY ____________ STATE ____________ ZIP ____________

PHONE ____________ EMAIL ____________

We will need to contact you both by phone & email.

DATE OF BIRTH ____________ YOUR OCCUPATION ____________

EMERGENCY CONTACT ____________ PHONE NUMBER ____________

RELATIONSHIP: ☐ SPOUSE ☐ RELATIVE ☐ FRIEND INSURANCE CARRIER ____________

REVIEW OF SYMPTOMS

PLEASE CHECK ALL THAT APPLY

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Herniated Disc
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Plantar Fasciitis
- ☐ Morton's Neuroma
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor wound healing
- ☐ Excessive thirst or urination

PRESENT HEALTH CONDITION

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

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

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

List approximately how long you have noticed these problems:

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

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	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Pain 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

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PREVIOUS HEALTH HISTORY HEALTH

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:

NERVE COACH NEUROPATHY PROGRAM APPLICATION

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

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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

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:

WHAT ARE YOU MOST CONCERNED WITH REGARDING YOUR PROBLEM?

WHAT IS THIS CONDITION CURRENTLY AFFECTING? AND/OR WHAT ARE YOU CONCERNED IT MAY AFFECT IN THE FUTURE?

WHAT WOULD BE DIFFERENT/BETTER WITHOUT THIS PROBLEM? PLEASE BE SPECFIC

WHAT DO YOU DESIRE MOST TO GET FROM WORKING WITH US?

WHAT WOULD THAT MEAN TO YOU?