intouchchiropractic

Neuropathy Treatment

Today's Date: _____

Name: _____ Age: _____ Date of Birth: _____ Sex: M F

Address: _____ City: _____ State: _____ Zip: _____

Cell: _____ Home: _____ E-mail Address: _____

Employer: _____ Occupation: _____

Marital Status: S M W D Spouse's Name: _____ Children's Name(s): _____

Emergency Contact:_____Phone:_____

How did you hear about our clinic? _____Height_____Weight_____

Would you like us to check your insurance benefits? Yes No (please note that we are out-of-network providers)

What is your main health concern / condition today? _____

Please circle all that apply:

Foot Pain	Low Back Pain	Bulging Disc	High Blood Pressure	Neck Pain
Foot Numbness	Sciatica	Joint Replacement	High Cholesterol	Morton's Neuroma
Foot Surgery	Pinched Nerve	Falls	Diabetes	Last A1C_____
Leg Pain	Herniated Disc	Balance Issues	Plantar Fasciitis	Vascular Problems
Hand Pain	Spinal Stenosis	Poor Circulation	Cancer	
Hand Numbness	Spinal Arthritis	Poor Wound Healing	Chemotherapy	
Arthritis in Hands/Feet	Degenerative Disc Disease	Pacemaker/ Defibrillator	Implanted Cord/ Bladder Stimulator	

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

Daily Activities Work Hobbies Exercise Standing Walking Relationships Sleep Sex Life

When did this begin? _____

What makes it worse? _____

What makes it better? _____

Frequency of your pain:

Constant (76 – 100%) _____ Frequent (51 – 75%) _____ Occasional (25 – 50%) _____ Intermittent (24% or less) _____

On average what level would you rate your overall peripheral neuropathy symptoms?

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

On a scale of 0 – 10, How serious and committed are you about fixing your condition?

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

How would you describe your symptoms? (*circle all 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 all that apply)*

Discoloration of Skin	Dry / Flaky Skin	No Hair Growth	Other	Loss of Toe Nail(s)
Cyanosis (Blue Coloring of Skin)	Blisters/Sores	Fungal	Petechiae/Red Spots	Discoloration of Toe Nails

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

Name	Dosage per Day

Please list any allergies and sensitivities: _____

_____

Are you currently taking a blood thinner (Coumandin, 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 per day?_____

Do you exercise regularly? Yes No What type of exercise and how often?_____

Please circle the things you have used / tried to relieve your symptoms:

Gabapentin	Amitriptyline	Neurontin	Cymbalta	Lyrica	Opioids	Injections
Aleve (naproxen)	Tylenol (acetaminophen)		Advil (ibuprofen)		Motrin	Rx Pain Medication
Creams	CBD (hemp products)		Chiropractic	Physical therapy		Massage therapy

Other: _____

Have the medications, treatments, etc. that you have tried helped your condition? (circle one)

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

Name of your Primary Care Physician: _____ Clinic: _____

May we contact him/her with updates regarding your treatment? Yes No

- I hereby authorize release of any medical information necessary to evaluate my case.
- I understand that Intouch Chiropractic doctors are out-network providers, and do not bill insurance companies.

_____ _____

Patient/Guardian Signature Date

Neuropathy Functional Goals Survey

Please be as detailed as possible, so we can best help you.

How many doctors have you seen for this condition? _____

What are 3 to 5 different 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?

_____
_____
_____

Are your symptoms getting (circle one): Better Worse Staying the same

Is your balance/ability to walk affected? Yes No If yes, please describe:_____
_____

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

If you had to accept some level of symptoms after completion of treatment, what would be an acceptable level?:

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

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

_____
_____
_____

What would success mean to you in our clinic? _____
_____

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As part of our commitment to quality care, we are pleased to offer several adjunct therapies. These therapies are safe and effective options to manage your symptoms, improve mobility, and help you return to normal activities faster.

These therapies stimulate the tissues to kick start the healing process. These can reduce recovery time, even post-operatively, leading to a quicker return to work or other important activities.

Please circle Yes or No for each of the following:

Use of Immuno-Suppressant Drugs (e.g. prednisone)	Y	N	Seizure Disorder Triggered by Light (e.g. epilepsy)	Y	N
Use of Blood Thinners (potential bruising)	Y	N	Steroid Injections (in the last month)	Y	N
Pregnancy	Y	N	Pacemaker	Y	N
Active Cancer	Y	N	Neurostimulation Device	Y	N
Laminectomy (at level of complaint)	Y	N	Joint Replacement	Y	N

I understand that treatment recommendations will be based on my health history and current health needs. This consent covers the entire course of care from all providers and staff in this clinic for my present condition and for any future condition(s) for which I seek chiropractic care from this clinic. I will notify the doctor(s) of any changes.

Patient/Guardian Signature_____ Date_____

Witness Signature_____

Consent to Physical Examination and X-Rays

Prior to receiving care in our clinic, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, and your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed before treatment. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you.

During the consultation, the doctor may determine that an examination and x-rays are required for my care. I consent to an examination an x-rays in order to diagnose my condition. I accept and acknowledge ultimate responsibility for all charges incurred. Payment is due at time of service.

Patient/Guardian Signature: _____Date: _____

Patient Consent for Use & Disclosure of Protected Health Information

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with healthcare providers who may be involved directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

We use an 'open adjusting' area. If at any time you prefer or need a 'closed' adjusting area or would like to discuss your health in the privacy of a closed room, please communicate this to a member of our staff. I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

Patient/Guardian Signature: _____Date: _____

Females Only: Regarding the Possibility of Pregnancy

This is to certify that to the best of my knowledge, I am not pregnant. It is neither suspected nor confirmed at this time that I am pregnant. If determined at a later date that I am pregnant, I do not hold the doctor, doctor's associates, association, corporation, partnership, employees, agents and estate of this establishment accountable in any way. I give the doctor and his/her associates my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual period: _____

Patient/Guardian Signature: _____Date: _____