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Peripheral Neuropathy Consultation

Please fill out the application entirely and legibly.

Name: ______________________________________ **Nickname**: ___________________

Address: ____

City: ________________________________ **State**: ______________ **Zip**: ____________

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 ______________________________________

Spouse's Name ______________________ **Phone number** ________________________

Your Occupation _________________________________ **Retired?** Yes No

REVIEW OF SYMPTOMS

Please check all that apply

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Pacemaker/Defibrillator
- ☐ Herniate Discs
- ☐ Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Vascular Problems
- ☐ Leg Pain
- ☐ Plantar Fasciitis
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Arthritis in Hands
- ☐ Arthritis in Feet
- ☐ Implanted Cord/Bladder Stimulator
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Poor Circulation
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Poor wound healing
- ☐ Excessive thirst or urination

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

1. ____________________
2. ____________________
3. ____________________
4. ____________________

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:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

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 all the doctors you have seen for these problems and treatment you received:

____
____
____
____

Have your symptoms: Improved Worsened Stayed the same

List anything that makes your condition worse:

____
____

Is this condition interfering with any of the following?

- ☐ Sleep
- ☐ Work
- ☐ Daily Activities
- ☐ Recreational Activities
- ☐ Walking
- ☐ Standing

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

- ☐ Aching pain
- ☐ Stabbing pain
- ☐ Sharp pain
- ☐ Tiredness
- ☐ Numbness
- ☐ Tingling
- ☐ Pins & Needles Pain
- ☐ Heavy Feeling
- ☐ Hot sensation
- ☐ Throbbing Pain
- ☐ Dead Feeling
- ☐ Cold Hands/Feet
- ☐ Cramping
- ☐ Swelling
- ☐ Burning
- ☐ Electric Shocks

SOCIAL HISTORY

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

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

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

____

____

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

PREVIOUS HEALTH HISTORY

This is confidential record or your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professional per the informed consent. Copies of this record can only be release 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/conditions? Yes No

List ALL allergies/sensitivities to medication, food, and other times 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: