Neuropathy Consult ROF

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ Phone ☐ Home ☐ Cell _____ D.O.B _____

Address _____ City _____ State _____ Zip _____

Email _____ SSN _____

Your Occupation _____ Spouse's Name

Retired? ☐ Yes ☐ No Spouse's Occupation

On Disability? ☐ Yes ☐ No Spouse's Phone Number _____

On Workman's Comp ☐ Yes ☐ No Who referred you to our office? _____

Review of Symptoms

Please check ALL that apply.

☐ Hand/Wrist Pain	☐ Numbness	☐ Diabetes	☐ Cancer
☐ Neck Pain	☐ Tingling	☐ High Cholesterol	☐ Chemotherapy
☐ Shoulder/Neck Pain	☐ Burning	☐ High Blood Pressure	☐ Arthritis in Hands
☐ Lower Back Pain	☐ Balance Problems	☐ Pacemaker/Defibrillator	☐ Arthritis in Feet
☐ Knee Pain	☐ Shooting Pain	☐ Herniated Disc	☐ Implanted Cord/Bladder Stimulator
☐ Leg/Hip Pain	☐ Tingling	☐ Bulging Disc	☐ Pinched Nerve
☐ Foot/Ankle Pain	☐ Electric Shocks	☐ Spinal Stenosis	☐ Poor Circulation
☐ Sciatica Pain	☐ Cramping	☐ Degenerative Disc	☐ Joint Replacement
☐ Excessive Thirst or Urination	☐ Pace Maker	☐ Vascular Problems	☐ Foot Surgery
☐ Poor Wound Healing	☐ Electrical Implants	☐ Plantar Fasciitis	☐ Brain Shunt

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

List approximately how long you have noticed these problems:

A & M CHIROPRACTIC HOLISTIC MEDICINE

Neuropathy Consult ROF

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:

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

What do you think is causing your problem?

List all doctors you have seen for these problems and treatments you received:

List the things you have used for these problems:

☐ Gabapentin	☐ Neurontin	☐ Lyrics	☐ Cymbalta
☐ Physical Therapy	☐ Pain Medications	☐ Aleve	☐ Tylenol
☐ Ibuprofen	☐ Mortin	☐ Chiropractic	☐ Massage Therapy
☐ Injections	☐ Topical Cream	☐	☐

Have your Symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse:

List anything that makes your condition better:

A & M CHIROPRACTIC HOLISTIC MEDICINE

Neuropathy Consult ROF

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	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

Is this condition interfering with any of the following?

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

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

A & M CHIROPRACTIC HOLISTIC MEDICINE

Neuropathy Consult ROF

MEDICAL HISTORY

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

Item you react to：	Reaction：

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

AUTHORIZATION

Please initial and sign on the designated lines.

_____ I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.

_____ I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office.

_____ I request and consent to treatment, including various methods of physical therapy and diagnostic x-rays that may be performed by the doctor or trained assistants. I understand that treatment may be performed by the doctors of chiropractic of A&M Chiropractic and/or Care Wellness Centre or other licensed doctors working at this clinic.

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 status.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

**Please wear or bring shorts and a short sleeve shirt for your exam.*

A & M CHIROPRACTIC HOLISTIC MEDICINE

Patient Quality of Life Survey

Name _____ Date _____

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

How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Nutrition/Diet
- ☐ Vitamins
- ☐ _____
- ☐ Routine Medical
- ☐ Exercise
- ☐ Holistic Care
- ☐ Chiropractic
- ☐ _____

How did the previous method(s) work out for you?

- ☐ Bad results
- ☐ Same Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did not get worse
- ☐ Did not work very long
- ☐ Still Trying
- ☐ Confused

How have others been affected by your health condition?

- ☐ No one is affected
- ☐ Haven't noticed any problem
- ☐ They tell me to do something
- ☐ People avoid me

What are you afraid this might be (or beginning) to affect (or will affect)?

- ☐ Job
- ☐ Kids
- ☐ Self-Esteem
- ☐ Time
- ☐ Future Ability
- ☐ Marriage
- ☐ Sleep
- ☐ Freedom

Are there health conditions you are afraid this might turn into?

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Arthritis
- ☐ Depression
- ☐ Need surgery
- ☐ Cancer
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Amputation/losing toes or limb

1. List the 3 most important reasons why you want help, without using the word "pain":

_____

_____

_____

2. How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

_____

A & M CHIROPRACTIC HOLISTIC MEDICINE

Patient Quality of Life Survey

3. What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)
   Give 3 examples:

4. What frustrates or concerns you most due to your current limitations or condition?

5. Where do you picture yourself in the next 1-3 years if this problem is not taken care of?

6. What would be different/better without this problem? Please be specific.

7. What do you desire most to get from working with us?

8. What would that mean to you?

A & M
CHIROPRACTIC
HOLISTIC MEDICINE

Name:_____ **Date:**_____

Past Medical History, Family Medical History, and Medications

Previous surgeries:

What surgery?_____ **When?**_____
What surgery?_____ **When?**_____
What surgery?_____ **When?**_____
What surgery?_____ **When?**_____
What surgery?_____ **When?**_____

Any other disease/conditions:

_____

_____

Medications:

_____

_____

_____

_____

_____

Have you ever had a stroke? ☐ **Yes** ☐ **No** **If yes, when?** _____

Has anyone in your family had a stroke? ☐ **Yes** ☐ **No** **If yes, who?**_____

Family Medical History: Please list any further disease/conditions in your family below

Father:_____

Mother:_____

Siblings:_____

Children:_____

Name: _____ **Date:** _____

Review of Systems

Please circle and list any symptoms that apply to you. If no symptoms apply, circle "negative."

Eyes	Negative	Vision Change / Glasses / Contacts / Glaucoma	Comments:
Ear, Nose, and Throat	Negative	Ulcers/ Sinusitis / Headache / Hearing Loss	Comments:
Cardiovascular	Negative	Chest Pain / Edema / Palpitations / Blood Thinners / Difficulty Breathing on Exertion / High Blood pressure / CHF / Stroke / A-Fib Heart Condition / PACE Maker / Electrical Implant / High cholesterol	Comments:
Respiratory	Negative	Wheezing / Coughing Blood / COPD / TB Pneumonia / Shortness of Breath / Cough Bronchitis	Comments:
Gastrointestinal	Negative	Diarrhea / Bloody Stool / Nausea Vomiting / Indigestion / Constipation / Gall bladder / Liver / Pancreas / Stomach reflux / GERD	Comments:
Genitourinary	Negative	Bladder Urgency/Frequency / Blood in Urine Painful Urination / Incontinence / Incomplete Emptying / Painful Intercourse / Abnormal/Painful Periods / Abnormal Vaginal Bleeding / Abnormal Vaginal Discharge Kidney Disease / Bladder Inflection / Gout / Hernia Hemorrhoids	Comments:
Hormonal Imbalance	Negative	Low Libido / Hot flashes / PMS / Vaginal Dryness / Bleeding Problems / Fatigue	Comments:
Musculoskeletal	Negative	Joint pain / Muscle pain / Muscle Weakness Neck Pain / Back Pain / Plantar Fasc. / Tailbone Pain / Arthritis / Hand Tingling / Feet Numbness / Feet Burning	Comments:
Skin	Negative	Rash / Ulcers / Fibrome / Dry Skin / Pigmented Lesions / Hives / Eczema / Easily bruises Swelling	Comments:
Breast	Negative	Mastalgia / Discharge / Masses / Lymphedema Mastectomy / Cancer	Comments:
Neurologic	Negative	Fainting / Seizures / Numbness / Severe Memory Loss Difficulty Walking / Tremors / Twitches / Epilepsy / Migraines / Insomnia	Comments:
Psychiatric	Negative	Crying / Bipolar / Mood Disorder / Depression / Anxiety / Stress	Comments:
Endocrine	Negative	Diabetes / Hypothyroid / Hair Loss / Heat-Cold Intolerance / Thyroid issues / Hyperthyroidism	Comments:
Hematologic/Lymphatic	Negative	Bleeding / Swollen Lymph Nodes Anemia / Hepatitis / Thrombophlebitis Deep Vein Thrombosis / Blood Clots Varicose Veins	Comments:
Other	Negative	Aids/HIV / Shingles / Herpes / Simplex Lupus / Cancer / Fibromyalgia / Stroke Implantable Device / PACE Maker / Insulin pump / Insulin monitor implant / A-fib implant	Comments: