# Neuropathy Consult ROF

TOTTY Neuropathy Center

Please fill out the application entirely and legibly.

***Name*** _____ ***Nickname*** _____ ***Date*** _____

***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*** _____ ***Social Security*** _____

***Spouse's Name*** _____ ***Phone Number*** _____

***Your Occupation*** _____ ***Retired?*** Yes ☐ No ☐

***How did you hear about us?*** _____

## 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
- ☐ Herniated Disc
- ☐ 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

## PRESENT HEALTH CONDITION

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?

_____

_____

_____

_____

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*

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

_____

_____

_____

_____

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 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 & 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

**This is a confidential record of your health history and pertinent personal history. Your signature below allows our doctors and office staff to discuss and share this information with other medical providers approved by you. Your records will not be released without your written and signed consent.**

***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:**

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

# Patient Quality Of Life Survey Example

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**PRACTICE INFORMATION HERE**

Patient Quality Of Life Survey

***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

# Patient Quality Of Life Survey Example

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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?**

**Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific**

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

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

**What would that mean to you?**