Please fill out entirely and legibly.

Name ________________________________ **Preferred Name**__________________________

Address____

City ______________________________ **State** ________ **Zip Code** ___________________

Cell Phone _________________________ **Home Phone** _____________________________

Email ____

We will need to contact you by both phone and email. Please be sure to give us the best phone number to reach you

Date of Birth _____/_____/______ **Age** _____ **Gender M**_____ **F**_____

Marital Status: Single _____ **Married** ______ **Widowed** _____ **Divorced** _____

Spouse's Name _____________________________ **Phone Number**_____________________

Emergency Contact ___________________________ **Phone Number**_____________________

Your Current/Previous Occupation(s)____

Retired? (circle) **YES NO**

How did you hear about us?____

REVIEW OF SYMPTOMS

Please check all that apply (C) Currently (P) Past or (CP) for both

_____Foot Pain _____High Blood Pressure _____Neck Pain _____Chemo Drugs (oral)

_____Heart Attack _____Poor Circulation _____Chemotherapy _____Plantar Fasciitis

_____Bulging Disc _____Low Back Pain _____Herniated Disc _____Implanted Cord

_____High Cholesterol _____Cancer _____Arthritis in Feet _____Bladder Stimulator

_____Pinched Nerve _____Spinal Stenosis _____Foot Surgery _____Diabetes (Last A1C#_____)

_____Hand Pain _____Arthritis in Hands _____Foot Numbness _____Leg Pain

_____Blood Thinner _____Joint Replacement (knee/hip/shoulder) _____Degenerative Disc (neck/low back)

_____Hand Numbness _____Pacemaker/Defibrillator _____Blood Clot(s) _____Poor Wound Healing

_____Vascular Problems _____Morton's Neuroma _____Sciatica (R/L leg) _____Excessive Thirst/Urination

PRESENT HEALTH CONDITION

Where is your Neuropathy/Nerve Pain?

____

____

List approximately how long you have been aware of these problems:

____

____

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

____

____

What do you think is causing your problems?

____

____

Please circle ALL that apply

What have you used for your Neuropathy/Nerve Pain?

Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Medications

Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections

Is your balance/walking affected? YES NO

I use a: Cane Walker Wheelchair **I walk:** Unassisted Unsteady Slightly Unsteady

Where is your Neuropathy/Nerve Pain located? Hands Feet Arms Legs

List all Doctors you have seen for Neuropathy/Nerve pain and the treatment you received:

____

____

Have your Neuropathy/Nerve Pain symptoms: ___Improved ___Stayed the same ___Worsened

List anything that makes your **Neuropathy/Nerve Pain** condition **worse**

____

____

List anything that makes your **Neuropathy/Nerve Pain** condition **better**

____

____

How would you describe your Neuropathy/Nerve Pain symptoms? ***Please check ALL that apply***

__Aching Pain __Numbness __Hot Sensation __Cramping

__Stabbing Pain __Tingling __Throbbing Pain __Swelling

__Sharp Pain __Pins and Needles __Dead Feeling __Burning

__Tiredness __Heavy Feeling __Cold Hands/Feet __Electric Shocks

Is your Neuropathy/Nerve Pain interfering with any of the following?

__Sleep __Work __Daily Activities __Housework __Getting Dressed __Walking
__Standing __Shopping __Up/Down Stairs __Exercise __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 and how often:

____

Do you have issues with any of the following? ***Please check ALL that apply***

_____Digestion (GERD, reflux, bloating, constipation, heartburn, diarrhea, IBS, IBD)

_____Sleep (falling asleep, waking up between 1-3 am.)

_____Energy

_____Sense of Well-Being (poor health, feeling run down, getting sick easily)

_____I take Nexium, Prilosec, Tums, etc.

_____I depend of coffee to get started/keep going

_____I crave sweets/carbohydrates during the day

_____I like salty foods

Have any of the above issues gotten worse since your Neuropathy/Nerve pain started? YES NO

PREVIOUS HEALTH HISTORY

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

Item you react to:	Reaction:

PLEASE PRINT NEATLY all prescription drugs you are currently taking (or you may attach a list):

Name:	Dose (mg or IU):	For what condition:

List all nutritional supplements you are currently taking (vitamins, herbs, homeopathics, etc.):

Name:	Dose (mg or IU):	For what condition:

CURRENT DISCOMFORT LEVELS

How would you rate your discomfort in the last week?

NO DISCOMFORT **WORST DISCOMFORT POSSIBLE**

0 1 2 3 4 5 6 7 8 9 10

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

NO PAIN **WORST PAIN POSSIBLE**

0 1 2 3 4 5 6 7 8 9 10

Please give the 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 treatments/condition? (Your initials here) _______**YES** _______**NO**

Please give the name, address, and phone number of your Neurologist, if seen:

Name_________________________**Phone**_________________**Address**___________________________

May we send them updates on your treatments/condition? (Your initials here) _______**YES** _______**NO**

Other Doctors that you would like updates sent to. Please fill out the information below:
(ex. Endocrinologist, Oncologist, Podiatrist, Cardiologist, Vein/Vascular Specialist, etc.)

Name______________________**Specialty**_______________ **Phone**________________**Fax**_____________

Address____

Name______________________**Specialty**_______________ **Phone**________________ **Fax**____________

Address____

May we send them updates on your treatments/condition? (Your initials here) _______**YES** _______**NO**

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.

Print Name _________________________**Signature** ___________________________**Date**____________

IMPACT OF NEUROPATHY/NERVE PAIN ON YOUR LIFE

What have you tried doing to resolve your **Neuropathy/Nerve Pain** that **DID NOT** work?

____

____

Have you become discouraged or stressed about handling your **Neuropathy/Nerve Pain**?

____

____

When your **Neuropathy/Nerve Pain** is at its **worst**, how does it make you feel?

____

____

What effects does your **Neuropathy/Nerve Pain** have on your body functions?

____

____

Please circle ALL that apply

Why are you visiting us?

1) Resolve my immediate problem(s)
2) Lifestyle program for optimized living
3) Other__________________________

What have you tried in order to relieve your Neuropathy/Nerve Pain in the past?

Medications	Holistic	Routine Medical	Vitamins
Exercise	Chiropractic	Diet and Nutrition	Other_________________________

What are you concerned your Neuropathy/Nerve Pain might affect if it doesn't improve?

Ability to walk	Freedom	Balance worsens	Mobility	Sleep
Marriage	Driving	Ability to take care of yourself, spouse, or others		

What health conditions are you concerned your Neuropathy/Nerve Pain might turn into?

Disability	Surgery	Diabetes	Depression	Heart Disease
Arthritis	Stress	Cancer	Weight Gain	Other_____________________

Where do picture yourself being in the next 3-5 years if your **Neuropathy/Nerve Pain** is NOT taken care of?
Please be specific.

____
____
____
____

What would be better or different without your **Neuropathy/Nerve Pain**? ***Please circle ALL that apply***

Diminished Stress	Sleep	More Energy	Mobility
Self Esteem	Outlook	Confidence	Family

If you were to sit down three years from now, what would have had to happen for you to be happy with your **Neuropathy/Nerve Pain** progress? How would you like your life to be?
Please take your time and don't sell yourself short! Include anything that is a part of your happiness.
This includes health, family, work, finance, travel, marriage or even your bucket list.

____
____
____
____

What potential barriers do you foresee that would prevent these things from happening?

____
____
____

Do you feel it is possible to eliminate or prevent these potential barriers?

____
____
____

What are your strengths that enable you to accomplish your goals?

____
____
____

Rate on a scale of 1-10 (10 being the highest)

________ How important is it for you to resolve your health concerns?

APPOINTMENT PREPARATION AGREEMENT

Please initial your understanding and agreement for the following information.

Consent to Bringing a Spouse/Family Member

Neuropathy is a serious condition. Bye Bye Neuropathy Advanced Treatment Center requests you bring a spouse or family member with you to your Initial (1st) and Follow-Up (2nd) appointments, as there is a lot of information covered and two sets of eyes and ears are better than one.

I further agree that my spouse or family member will attend my first two appointments with me.

_____ (*Initial*)

Consent to Appropriate Dress Code

To effectively perform your exam(s) and treatment(s), Bye Bye Neuropathy Advanced Treatment Center requests you wear loose-fitted, comfortable clothing during your Initial (1st) and Follow-Up (2nd) appointments.

I further agree to wear appropriate attire during my appointments.

_____ (*Initial*)

Please Highlight or Circle
ANY medications on this
list that you HAVE or ARE taking.

MEDICATIONS THAT CAN CAUSE PERIPHERAL NEUROPATHY

NAME OF MEDICATION	COMMON BRAND NAMES	USED TO TREAT
Amiodarone	Cordarone, Nexterone, Pacerone	Abnormal heart rhythm
Bortezombid	Velcade	Bone marrow cancer
Carbolplatin		Cancer
Chloramphenicol	Econochlor, Chloromycetin	Serious bacterial infections
Chloroquine		Malaria, autoimmune disorders
Cisplatin	Platinol-AQ, Platinol	Cancer
Colchicine	Colcrys	Gout
Cytarabine	Depocyt	Cancer
Dapsone	Aczone	Leprosy, skin diseases
Didanosine	Videx	HIV infection
Disulfiram	Antabuse	Alcohol addition
Docetaxel	Taxotere, Docefrez	Cancer
Etanercept	Infliximab, Golimumab	Rheumatoid arthritis
Ethambutol	Myambutol	Tuberculosis
Fluoroquinolones (class of antibiotics)	Quinolone	Bacterial infections
Gold		Rheumatoid arthritis
Hydralazine	Vasodilator	High blood pressure
Hydroxychloroquine	Plaquenil	Malaria, autoimmune disorders
Infliximab	Remicade	Bone marrow cancer
Isoniazid (antibiotic)		Tuberculosis
Leflunomide	Arava	Rheumatoid arthritis and psoriasis
Lenalidomide	Revlimid	Bone marrow cancer
Metronidazole	Flagyl, Metrogel, Noritate, MetroCream, Rosadan, and MetroLotion	Bacterial infections, symptoms of rosacea
Misonidazole		Cancer (used in radiation treatment)
Nitrofurantoin	Macrobid, Furadantin, Macrodantin	Urinary tract infection
Oxaliplatin	Eloxatin	Cancer
Paclitaxel	Abraxane	Cancer
Phenytoin	Dilantin, Dilantin-125, Phenytek	Seizures
Procainamide	Matulane	Abnormal heart rhythm
Procarbazine	Matulane	Cancer
Pyridoxine (vitamin B6)		Vitamin B6 deficiency (or as a dietary supplement can lead to B6 toxicity)
Statins: Atorvastatin Pitavastatin Lovastatin Simvastatin Pravastatin Fluvastatin Rosuvastatin	 Lipitor Livalo Mevacor or Altocor Zocor Pravachol Lescol Crestor	Lower Cholesterol
Stavudine	Zerit	HIV infection
Suramin		Kaposi's sarcoma
Thalidomide	Thalomid	Multiple myeloma, discoid lupus erythematous
Vinblastine		Cancer
Vincristine	Marqibo	Cancer
Zalcitabine	Hivid	HIV infection