# Application for Neuropathy Treatment

**Name:**_____ **Date:**_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Social Security #:_____-____-_____ Date of Birth:____/____/____ Age:_____

Spouse's Name:_____

Occupation (Current or Previous):_____Retired: Y N

## Review of Systems

**Please check all that apply**

| | | | | |
|---|---|---|---|---|
| □ Foot Pain | □ Diabetes | □ Spinal Stenosis | □ Cancer | □ Pinched Nerve |
| □ Hand Pain | □ High Cholesterol | □ Degenerative Discs | □ Chemotherapy | □ Poor Circulation |
| □ Low Back Pain | □ High Blood Pressure | □ Vascular Problems | □ Arthritis in Hands | □ Joint Replacements |
| □ Neck Pain | □ Pacemaker/ Defibrillator | □ Leg Pain | □ Arthritis in Feet | □ Foot Surgery |
| □ Foot Numbness | □ Herniated Disc | □ Plantar Fasciitis | □ Implanted Cord/ Bladder Stimulator | □ Poor wound healing |
| □ Hand Numbness | □ Bulging Disc | □ Morton's Neuroma | □ Sciatica | □ 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)_____
5)_____

**List approximately how long you have noticed these problems:**

1)_____
2)_____
3)_____
4)_____
5)_____

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

_____
_____
_____

**Is your balance/walking ability affected? □ Y □ N**
**If yes, please describe:** _____
_____
_____

**List the things you have used for these problems:**

□Gabapentin □Neurontin □Lyrica □Cymbalta
□Physical Therapy □Pain Medications □ Alleve
□Tylenol □Ibuprofen □Motrin □Chiropractic
□Massage Therapy □Injections □Creams on Hands/Feet
□Other Medications or Treatments:_____
_____
_____

**What do you think is causing your problem?:** _____
_____

**Names of all 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:** _____
_____
_____

**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 and 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 □ Housework □ Recreational Activities □ Walking □ Standing □ Shopping

# Social History

Do you smoke? □ Yes □ No If yes, how many packs/daily:_____
Do you drink? □ Yes □ No If yes, how many drinks/week:_____
Do you exercise regularly? Yes No If yes, describe what type and how often:_____
_____

# Current Pain Levels

**How would you rate your pain in the last week:**

No Pain Worst Pain 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

# Previous Health History

**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:**

**Name:**_____ **Signature:**_____**Date:**_____

**Please give name, address, and office phone of your primary care physician/family doctor?:**

**Name:** _____

**When were you last seen there:**_____

**May we send them updates on your treatment/condition: □Yes □No**

List ALL Allergies (or Sensitivities) to Medicines, Foods, and other items:

| Item you react to: | Reaction: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Please list the prescription drugs you are currently taking, or attach list:**

| **Name:** | **Dose (MG or IU)** | **Times Daily** |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**List all Nutritional Supplements (vitamins, herbs, homeopathics, etc.) as above:**

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Date of Above List:** _____

# Insurance Information

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

Policy Holder Name: _____D.O.B._____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____
Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Advanced Health Solutions and Regenerative Medicine of South Alabama (Please initial one of the following options and sign below.)

_____ I wish to receive a paper copy of Privacy Notice.

_____ I do not request a copy of the Privacy Notice at this time. I acknowledge that I can request a copy at any time and the Privacy Notice is posted in the office. If I should have a problem or question in regard to my rights, I may speak with the Privacy Officer about my concerns.

I acknowledge that it is the policy of this office to leave reminder messages via text, email, and/or phone (with or without voicemail). I may make a request of an alternative means of communication (within reason) in writing.

X_____ _____
**Signature of Patient/Guardian** Date
X_____ _____
Witness (Office Staff) Date

# Informed Consent to Care

A patient coming to the doctor gives him/her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician. This office does not perform breast, pelvic, prostate, rectal, or full skin evaluations. These examinations should be performed by your family physician, GYN, and dermatologist to exclude cancers, abnormal skin lesions that should undergo biopsy/removal or other treatments. This clinic does not provide care for any condition (such as high blood pressure, diabetes, high cholesterol) other than those addressed in your physical medicine care plan.

We also do not prescribe or refill ANY controlled substances. All such prescriptions should be refilled by your original prescriber. The patient assumes all responsibility/ liability if the patient does not report on health forms any past medical history, illnesses, medicines, or allergies.

I agree to settle any claim or dispute I may against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

**Sign here:** X_____I have read and understand the above consent form.