Application for Neuropathy Treatment

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

Address:_____

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

Work Phone:_____ Cell Phone:_____ Emergency Contact Name:_____

Social Security #:_____-____-_____ Date of Birth:____/____/____ Emergency Contact Phone: _____

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: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed the Notice of Privacy Practices of Advanced Health Solutions.
(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

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures if determined necessary by our doctors:I have been advised that chiropractic care and the other services performed, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Advanced Health Solutions have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my 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.

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.