NEUROPATHY RELIEF
of Siouxland

Please fill out entirely and legibly.

Last Name _____ **First Name** _____ **Middle Initial** ___
Address_____
City _____ **State** _____ **Zip Code** _____
Cell Phone _____ **Home phone** _____
Email _____
Date of Birth _____/_____/_____ **Age** _____ **Gender** ___Male ___ Female

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____
Spouse's Name _____ Their Phone #_____
Emergency Contact _____ Their Phone #_____
Your Current/Previous Occupation(s) _____
Retired? ___YES ___ NO

REVIEW OF SYMPTOMS

Please check all that apply…	**If Currently (C)**	**If had in Past (P)**	**For Current <u>and</u> Past (CP)**
_____Foot pain	_____ High Blood Pressure		_____Neck Pain
_____Chemo Drugs (Oral)	_____ Open sore on foot		_____Poor Circulation
_____Chemotherapy	_____ Plantar Fasciitis		_____Bulging Disc
_____Low Back Pain	_____ Herniated Disc		_____ Implanted Cord
_____Cancer	_____ High Cholesterol		_____ Arthritis in Feet
_____Bladder Stimulator	_____ Stenosis (Neck or back)		_____ Pinched Nerve
_____Foot Surgery	_____ Diabetes		_____Hand Pain
_____Arthritis in Hands	_____ Foot Numbness		_____ Leg Pain
_____Blood Thinner	_____ Hand Numbness		_____ Blood Clot(s
_____Vascular Problems	_____ Morton's Neuroma		_____ Sciatica R or L leg
_____Poor Wound Healing	_____ Pacemaker/Defibrillator		_____ Heart Attack

_____Skin on feet so dry that it cracks open
_____Excessive Thirst/Urination
_____Degenerative Disc (Neck/low back)
_____Joint Replacement (Knee/Hip/Shoulder)
_____Diabetes (Last A1C#_____)

PRESENT HEALTH CONDITION

Where is your Neuropathy/Nerve pain located: (Circle all that apply) **Hands Feet Arms Legs**

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?

_____

Circle the things you have used for Neuropathy or Nerve Pain:

Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Medications Aleve
Tylenol Ibuprofen Motrin Injections Chiropractic Massage Therapy
Other: _____

Is your balance/walking affected? ___ Yes ___ No

I use a: (Circle) Cane Walker Wheelchair

I walk: (Circle) Unassisted I am slightly unsteady I am unsteady

Name of all doctors you have seen for Neuropathy 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 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
__Prickling/Itching	__Sensitive to touch	__Can't tell hot or cold	__Feel Week

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? (Check those 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, Feel run down, Get sick easily)
____I take (Nexium, Prilosec, Tums, etc.)
____Depend on coffee to get started/keep going
____Crave sweets/carbohydrates during the day
____Like salty foods

Have any of these above issues gotten worse since your Neuropathy started? ___ YES ___ NO

PREVIOUS HEALTH HISTORY

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

Item you react to:	Reaction:
_____	_____
_____	_____
_____	_____

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

Name of Medication:	Dose (mg or IU):	For what condition:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name:	Dose (mg or IU):	For what condition (if applicable):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 DISCOMFORT										WORST DISCOMFORT POSSIBLE
0	1	2	3	4	5	6	7	8	9	10

Please provide the name, office phone #, and address of your **Primary Care Physician**:
Name_____ **Phone #** _____
Address_____
When were you last seen there? _____
May we send them updates on your treatments? (Please initial one) _____YES _____NO

Please provide the name, office phone #, and address of your **Neurologist** (if any):
Name_____ **Phone #** _____
Address_____
May we send them updates on your treatments? (Please initial one) _____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.)

(1) Name_____ **Specialty**_____ **Phone #** _____
Address_____
(2) Name_____ **Specialty**_____ **Phone #** _____
Address_____
May we send them updates on your treatments? (Please initial one) _____YES _____NO

IMPACT OF NEUROPATHY/NERVE PAIN ON YOUR LIFE

What have you already tried doing to resolve your Neuropathy 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 are you concerned your Neuropathy might affect if it doesn't improve? (Please circle all that apply)

Ability to walk	Freedom	Balance worsens	Get around	Mobility
Sleep	Marriage	Driving a car	Taking care of yourself or others	
Arthritis	Disability	Weight gain	Depression	Other_____

What do you picture yourself like 5 years from now if your Neuropathy is NOT taken care of? Please be specific.

_____

_____

_____

What would be different or better without your Neuropathy/Nerve Pain? (Please circle all that apply)

Diminished Stress	Sleep	More Energy	Getting Around/Mobility
Self Esteem	Outlook	Confidence	Family

What hobbies or activites would you like to enjoy if your Neuropathy was no longer an issue?

_____

_____

On a scale of 1-10 (10 being the highest) Rate how important is it for you to resolve your health concerns? _____

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

_____

PRIVACY OF HEALTHCARE INFORMATION

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care consultation, examination, or treatment, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. You (the "patient") understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, if requested, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a compliance officer has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our compliance officer about any possible violations of these policies and procedures.

7. If you (the patient) refuses to sign this consent for the purpose of treatment, payment or health care operations, the providers of this office have the right to refuse care.

CONSENT FOR TREATMENT

Informed Consent for Medical, Physical Therapy, Chiropractic, Massage, PEMF (Pulsed Electric Magnetic Field) Therapy, Mild Hyperbaric Oxygen Chamber, Class IV Laser LLLT (Low Level Light Therapy), NeuroMed Electrical Analgesia Stimulation, Infrared and Red Light Therapy, Whole

Body Micro-Vibration Therapy, SoftWave ESWT (Extracorporeal Shockwave Therapy), Soft Tissue Oscillation Therapy and Authorization and Release

I hereby request and consent to the treatment by any of the providers listed, along with various modes of therapy as described, on myself (or on the patient named below for whom I am legally responsible) at the direction of the licensed professionals. I have had the opportunity to discuss with my doctor the nature and purpose of care and other procedures and understand that if indicated and performed, examination, physical therapy, chiropractic spinal manipulation, and certain therapies as described involves the doctor placing his or her hands on my spine or extremities. I also understand and am informed that, as in the practice of medicine, in the practice of physical therapy and chiropractic there are some risks to treatment including, but not limited to: fractures, disc injuries, strokes, dislocations, sprains, soreness, and physical therapy burns. I understand and comprehend all such risks and complications. I, by my signature below, confirm and accept care and therefore consent to and agree to those treatments deemed necessary by my doctor to be in my best interest.

With my signature below, I also acknowledge that all my concerns and questions have been expressed and competently and thoroughly answered by the staff of Neuropathy Relief of Siouxland. I understand the objectives of this program being to relieve my pain and increase bodily function as well as increase my neurological well-being. I fully understand that there is not a cure promised for my condition. And while it is expected that we will meet our objectives for my improvement, I also understand that I may have a severe, degenerative and chronic condition, and as such, I understand that, as with any health treatment, there is no guarantee. Pain at any time may be better, worse, or unaffected. I am entering into a program hopeful yet with the full understanding that my expectations may not be met and fully aware of these possible outcomes.

If providing insurance information, I hereby authorize payment of insurance benefits directly to Multicare Health Clinic who is affiliated with Neuropathy Relief of Siouxland. I understand and agree to allow this office to use my Confidential Patient Health Information forms for the purpose of treatment, payment, healthcare operations and coordination of care and authorize any personnel Multicare Health Clinic or Neuropathy Relief of Siouxland to communicate with my medical physician(s) about my condition and treatment. I understand and agree that I am responsible for all costs of care, regardless of insurance coverage. I also understand and agree that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable at retail cost.

FINANCIAL AGREEMENT

We reserve the right to use any or all of the following modalities and/or treatments during the course of your treatment; including but not limited to initial comprehensive qualification physical exam, initial treatment plan workup, Re-examination, Medical Treatments, Physical Therapy, Chiropractic Care, Massage, PEMF (Pulsed Electric Magnetic Field) Therapy, Mild Hyperbaric Oxygen Chamber, Class IV Laser LLLT (Low Level Light Therapy), NeuroMed Electrical

Analgesia Stimulation, Infrared and Red Light Therapy, Whole Body Micro-Vibration Therapy, SoftWave ESWT (Extracorporeal Shockwave Therapy), Cupping, Radial Pulse Wave and Soft Tissue Oscillation Therapy. A twenty-four-hour cancellation notice is kindly requested for any appointment. Some or all of the therapies you may have requested, or have been recommended, may not be FDA approved and may have limited to no research or publications of effectiveness or safety for your condition.

I understand the Federal Government has deemed it mandatory to notify my doctor of any other party or insurance company who may be responsible for reimbursement for my treatment. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures. I have also read, or have had read to me, the above informed consent, authorization, and release. I have had an opportunity to ask any and all questions about its content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for future condition(s) for which I seek treatment in this office.

STATEMENT

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

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

We invite you to discuss with us any questions regarding our services and or fees. the best health services are based on friendly, mutual understanding between the provider and patient.

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 or insurance status.

Printed Name_____

Signature_____ Date Signed _____