Neuropathy Intake Form

Name: _____ **Date:** _____

Nickname: _____ **Date of Birth:** _____ **Age:** _____ **Sex: M** ☐ **F** ☐

Address: _____

City: _____ **State:** _____ **Zip:** _____

Mobile Phone #: _____ **Home Phone #:** _____

Email Address: _____

Occupation (Current or Previous): _____ **Retired: Yes / No**

Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse's Name: _____ **Marital Status: S M D W**

In Case of Emergency: Contact Name: _____ **Phone #:** _____

How did you hear about our office? _____

What is your main health concern / condition coming in today?

_____

Please check all that apply:

☐ Foot Pain	☐ Low Back Pain	☐ Bulging Disc	☐ High Blood Pressure	☐ Neck Pain
☐ Foot Numbness	☐ Sciatica	☐ Joint Replacement	☐ High Cholesterol	☐ Morton's Neuroma
☐ Foot Surgery	☐ Pinched Nerve	☐ Falls	☐ Diabetes	Last A1C: _____
☐ Leg Pain	☐ Herniated Disc	☐ Balance Issues	☐ Plantar Fasciitis	
☐ Hand Pain	☐ Spinal Stenosis	☐ Poor Circulation	☐ Cancer	
☐ Hand Numbness	☐ Spinal Arthritis	☐ Poor Wound Healing	☐ Chemotherapy	
☐ Arthritis in Hands/Feet	☐ Degenerative Disc Disease	☐ Pacemaker/Defibrillator	☐ Implanted Cord / Bladder Stimulator	

When did this begin? _____

What makes it worse? _____

What makes it better? _____

On a scale of 1 – 10; how committed and serious are you about fixing your condition?

Not Serious 0 1 2 3 4 5 6 7 8 9 10 Totally Committed

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How would you describe your symptoms? *(Circle any that apply)*

| Sharp Pain | Stabbing Pain | Aching Pain | Throbbing Pain | Numbness | Tiredness |

| Heavy Feeling | Dead Feeling | Swelling | Electric Shocks | Pins & Needles | Tingling |

| Cramping | Imbalance / Falls | Burning | Hot Sensation | Cold Hands / Feet |

How would you describe the physical appearance of your feet / legs? *(Circle any that apply)*

| Discoloration of Skin | Dry / Flaky Skin | No Hair Growth | Discoloration of Toe Nail(s) | Loss of Toe Nail(s) |

| Cyanosis (Blue Coloring of Skin) | Petechiae / Red Spots | Blisters / Sores | Fungal | Other |

Are your Symptoms over time *(Please Circle)*: Worsening Staying the Same Improving

Frequency of your Pain:

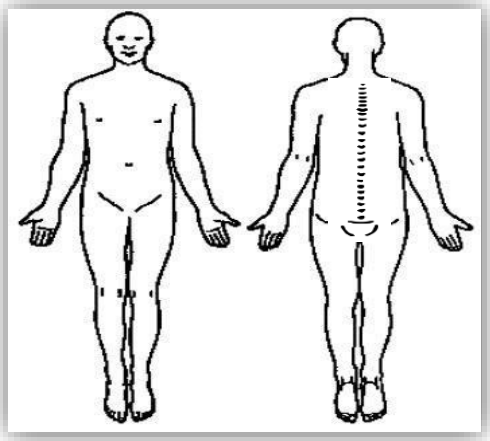
Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (0-25%) ___

On average what level would you rate your overall pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Is this condition interfering with any of the following? *(Circle any that apply)*

| Daily Activities | Hobbies | Walking | Standing | Work | Sleep | Relationships | Sex Life |



Please indicate on this drawing the area(s) where you are currently experiencing symptom(s):

Please circle the things you have used / tried to relieve your symptoms:

| Gabapentin | Amitriptyline | Neurontin | Cymbalta | Lyrica | Opioids | Injections |

| Aleve / Naproxen | Tylenol / Acetaminophen | Advil / Ibuprofen | Motrin |

| Creams | CBD / Hemp Products | Chiropractic | Physical Therapy | Massage Therapy |

Other: _____

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Please list any / all prescription medications you are currently taking (or you may attach a list):

Name	Dosage per Day

Please list any / all allergies and sensitivities: _____

_____

_____

Please list any / all supplements (vitamins, herbs, homeopathic, etc.) you are currently taking:

Name	Dosage per Day

Are you currently taking a Blood Thinner (Coumadin, Lovenox, Heparin, etc)? Yes No

Are you currently taking a Statin (Atorvastatin, Lipitor, Crestor, Simvastatin, etc)? Yes No

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you smoke cigarettes? Yes No If yes, how many cigarettes daily? _____

Do you exercise regularly? Yes No If yes, please describe type & how often? _____

Name of your Primary Care Physician: _____ **Clinic:** _____

May we contact them with updates regarding your treatment? Yes No

- I hereby authorize release of any medical information necessary to evaluate my case to Iowa Neuropathy and Pain Clinic.
- I understand that Iowa Neuropathy and Pain Clinic cannot file the Neuropathy treatments to insurance at this time.

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

Signature: _____ Date: _____

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FUNCTIONAL GOALS SURVEY

Please take several minutes to answer these questions so we can help you get better.

How many doctors have you seen for this condition? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

_____

_____

_____

Has what you've done to date for your condition helped?

☐ Yes, a lot ☐ Yes, some ☐ No, not at all ☐ Indifferent

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1._____
2._____
3._____
4._____
5._____

What is your honest vision of your life in the next few years if this problem continues to progress? _____

_____

_____

What would be different &/or better in your life without this problem? Please be specific.

_____

_____

_____

What is your biggest fear if this condition continues to progress? _____

_____

_____

_____

What would success mean to you in our office? _____

_____

_____

_____