NEW PATIENT APPLICATION

Legal Name _____ Preferred Name _____

Birth Date _____/_____/_____ Age _____ Height _____ Weight _____

Cell Phone _____ Email _____

Address _____

Occupation (Current or Previous) _____ Retired? Yes No

Marital Status: S M D W Spouse Name _____ Phone _____

Emergency Contact Name _____ Phone _____

Are there any other family members/friends who are involved in your health/financial decisions?

If so: Name/Contact Information _____

How did you hear about our office? TV Facebook Seminar Mailer Other: _____
YouTube TV

What is your main health concern for this appointment? _____

When did your symptoms begin? _____

Is there anything that makes it worse? _____

Is there anything that makes it better? _____

Please check the following symptoms if they apply to you…

- ☐ Foot Pain
- ☐ Foot Numbness
- ☐ Foot Surgery
- ☐ Leg Pain
- ☐ Hand Pain
- ☐ Hand Numbness
- ☐ Arthritis Hands/Feet
- ☐ Vascular Problems
- ☐ Deep Vein Thrombosis
- ☐ Poor Circulation
- ☐ Poor Wound Healing

- ☐ Low Back Pain
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Herniated Disc
- ☐ Spinal Stenosis
- ☐ Spinal Arthritis
- ☐ Degenerative Disc Disease
- ☐ Bulging Disc
- ☐ Joint Replacement
- ☐ Plantar Fasciitis

- ☐ Pacemaker/Defibrillator
- ☐ Implanted Cord/Bladder Stimulator
- ☐ Balance Issues / Falls
- ☐ Neck Pain
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Morton's Neuroma

How would you describe your symptoms?

- ☐ Aching Pain
- ☐ Balance Issues / Falls
- ☐ Burning
- ☐ Cold Hands
- ☐ Cold Feet
- ☐ Cramping
- ☐ Dead Feeling
- ☐ Electric Shocks
- ☐ Heavy Feeling
- ☐ Hot Sensation
- ☐ Numbness
- ☐ Pins & Needles
- ☐ Sharp Pain
- ☐ Stabbing Pain
- ☐ Swelling
- ☐ Throbbing Pain
- ☐ Tingling
- ☐ Tiredness

How would you describe the overall physical appearance of your feet and legs?

- ☐ Blisters or Sores
- ☐ Cyanosis (Blue or Purple Skin)
- ☐ Discoloration of Skin (Red or Pale)
- ☐ Discoloration of Toe Nails
- ☐ Dry or Flaky Skin
- ☐ Fungus (on skin or nails)
- ☐ No Hair Growth
- ☐ Loss of Toe Nails
- ☐ Petechiae (Red Spots)
- ☐ Other _____

How have your symptoms changed over time? Gotten Worse Stayed the Same Gotten Better

How frequent is your discomfort?

Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (0-25%) ___ **Is there a certain time of day that the symptoms seem to be worse?**

Morning _____ Mid-Day _____ Evening _____ Overnight _____ N/A _____

On an average day this past week, how severe would you rate your overall discomfort level?

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

If you still experienced some level of discomfort after completion of this program, what would be an acceptable level?

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

On a scale of 1-10, how committed / serious are you about getting your health concern corrected?

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

Does your condition interfere with your ability to perform any of the following?

- ☐ Daily Activities _____
- ☐ Exercise _____
- ☐ Hobbies _____
- ☐ Relationships
- ☐ Sleep
- ☐ Standing
- ☐ Walking
- ☐ Working

How many doctors have you seen for this condition? _____

Please indicate which of the following you have used to try to relieve your symptoms

- ☐ Advil / Ibuprofen
- ☐ Aleve / Naproxen
- ☐ Amitriptyline
- ☐ CBD / Hemp products
- ☐ Chiropractic Care
- ☐ Creams
- ☐ Cymbalta
- ☐ Gabapentin
- ☐ Injections
- ☐ Lyrica
- ☐ Massage Therapy
- ☐ Motrin
- ☐ Neurontin
- ☐ Opioids
- ☐ Physical Therapy
- ☐ Tylenol / Acetaminophen
- ☐ Other _____

Have the things you have tried so far helped? __ Yes, a lot __ A little __ Not at all __ Unsure

Primary Care Physician Name _____

Clinic Name / Phone Number _____

Do we have your permission to send them records of your visits here if they request us to? Yes No

Please list all **prescription medications** you are currently taking (or provide us with a list we can copy)

_____ _____

_____ _____

_____ _____

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

Please list all **allergies and sensitivities** below

_____ _____

_____ _____

_____ _____

Please list all **supplements** (vitamins, herbs, etc.) you currently take (or provide us with a list to copy)

_____ _____

_____ _____

Please list all **serious medical conditions or surgeries** you currently have or have had in the past with approximate dates if applicable.

_____ _____

_____ _____

Alcohol Use: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily # _____ ☐ Former User

Tobacco Use: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily # _____ ☐ Former User

Other Drug Use: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily # _____ ☐ Former User

Do you exercise regularly? Yes No If yes, what and how often? _____

Please list 2-4 activities you can no longer do or are struggling with because of your condition.

_____ _____

_____ _____

What do you feel your life will be like in the next few years if this problem continues to get worse?

_____

_____

How would your life be different if you no longer had this problem or if it were to improve?

_____

_____

What would need to happen in order for you to consider your treatments here to be successful?

_____

_____

By signing this form, I…

- Certify that all information I have listed is accurate and complete to the best of my knowledge

- Agree to allow the doctor to discuss any relevant information with other practitioners or staff in order to better serve me.

_____ _____

Patient Signature Date

PRIVACY NOTICE – HIPAA CONSENT FORM

We want you to know how your Patient Health Information (PHI) will be used in this office and what your rights are concerning those records.

Before we begin any health care operations, you are required to read and sign this consent form stating that you understand and agree with how your records will be used.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing.

1. I understand and agree to allow this office to use my PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. Example: This office may submit requested PHI to other physician's offices upon receipt of a request form signed by the patient or guardian.

2. I, the patient, have the right to examine and obtain my own health records at any time and request corrections. If I require any further restrictions on the use of my PHI, I will submit it to this office in writing, and I understand that this office is not obligated to agree to those restrictions.

3. This office is only required to retain medical records (including X-Ray imaging, test results, appointment notes, etc.) for a period of seven (7) years, after which they may be disposed of.

4. My written consent need only be obtained by this office one time for all subsequent care given.

5. I may provide a written request to revoke consent at any time during care. This would not affect the use of records for care given prior to the written request to revoke consent, but only to care provided after receipt of the request.

6. For the security and right to privacy of the patient, all staff has been trained in the area of patient records privacy, and these procedures are enforced by this office. All precautions are taken to assure that patient records are not readily available to those who do not require them to provide care to the patient.

7. I, the patient, have the right to file a formal complaint with the manager of this office about any possible violations of these policies and procedures.

8. If I, the patient, refuse to sign this consent for the purpose of treatment, payment, and health care operations, the physician has the right to refuse to provide care.

By signing this form, I agree that I have read and understand how my Patient Health Information will be used, and I agree to the above policies and procedures.

_____

Name of Patient

_____ _____

Signature of Patient and/or Guardian Date

Life Quality and Goals Survey

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

1. **How many providers have you seen for this condition?**
   _____

2. **What medications/tests/treatments/supplements did they prescribe/recommend for you?**
   _____
   _____
   _____
   _____
   _____
   _____

3. **Has what you've done to date for your condition helped?**
   a. **Yes, a lot** b. **Yes, slightly** c. **No, not at all** d. **Indifferent**

4. **What are a few activities you can no longer do or are struggling to do because of this condition? Please be specific.**
   1._____
   _____
   2._____
   _____
   3._____
   _____
   4._____
   _____
   5._____
   _____

5. **What is your honest vision of your future if this problem continues to progress?**
   _____
   _____
   _____

6. **What in your life would be better without this problem? Be specific as possible please.**
   _____
   _____
   _____
   _____

7. **What is your biggest fear if this condition does not go away or gets worse?**

8. **What does success look like for you in our office?**

These questions ask about limitations you may be experiencing due to your symptoms during the last 10 days. For each question, please circle only **ONE** answer that best describes your degree of limitation.

Symptom Severity	**Never /not experiencing**	**Sometimes experiencing**	**Frequently experiencing**	**Constantly experiencing**
Numbness or lack of sensation	1	2	3	4
Tingling or "pins and needles" sensation	1	2	3	4
Burning sensation	1	2	3	4
Sharp or shooting pain	1	2	3	4
Sensitivity to touch or pressure	1	2	3	4
Muscle cramping or twitching in the feet	1	2	3	4
Muscle weakness	1	2	3	4
Balance difficulties	1	2	3	4
Cold or freezing feet	1	2	3	4
Functional Abilities	**Never Affected**	**Sometimes Affected**	**Frequently Affected**	**Constantly Affected**
Walking without assistance	1	2	3	4
Ability to use stairs	1	2	3	4
Standing or walking prolonged	1	2	3	4
Carrying groceries or moderate	1	2	3	4

lifting				
Ability to wear shoes or socks	1	2	3	4
Ability to bathe oneself.	1	2	3	4
Ability to walk barefoot	1	2	3	4
Impact on Daily Living	**Never**	**Sometimes**	**Frequently**	**Constant**
How much do your symptoms interfere with your ability to walk?	1	2	3	4
How much do your symptoms interfere with your social or work life?	1	2	3	4
Do your symptoms disturb your sleep?	1	2	3	4
How concerned are you about falling due to your symptoms?	1	2	3	4
How frustrated are you by your symptoms?	1	2	3	4

In clinic use re-exam grading: Patient improved _____ / 21 in function categories since starting care.

Name: _____ Date: _____

Cleveland Neuropathy

Life Quality and Goals Survey

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

1. **How many providers have you seen for this condition?**
   _____

2. **What medications/tests/treatments/supplements did they prescribe/recommend for you?**
   _____
   _____
   _____
   _____
   _____
   _____

3. **Has what you've done to date for your condition helped?**
   a. Yes, a lot **b. Yes, slightly** **c. No, not at all** **d. Indifferent**

4. **What are a few activities you can no longer do or are struggling to do because of this condition? Please be specific.**
   1._____
   2._____
   3._____
   4._____
   5._____

5. **What is your honest vision of your future if this problem continues to progress?**
   _____
   _____
   _____

6. **What in your life would be better without this problem? Be specific as possible please.**
   _____
   _____
   _____
   _____

7. **What is your biggest fear if this condition does not go away or gets worse?**

Name: _____ Date: _____

_____
_____
_____
_____

8. **What does success look like for you in our office?**

_____
_____
_____
_____