SF BAY PERIPHERAL NEUROPATHY

NEW PATIENT INFORMATION

Name: _____ **Date:** _____

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Email:** _____

Home Phone: (____) _____ **Cell Phone:** (____) _____

DOB: _____/_____/_____ **Age:** _____ **Height:** _____ **Weight:** _____

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

Spouse's/Significant Other's Name: _____

Emergency Contact: _____ **Phone:** (____) _____

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 Replacement
☐	Neck Pain	☐	Pacemaker/ Defibrillator	☐	Leg Pain	☐	Arthritis in Feet	☐	Foot Surgery
☐	Foot Numbness	☐	Herniated Disc	☐	Plantar Fasciitis	☐	Implanted Cord/ Bladder Stim	☐	Poor Wound Healing
☐	Hand Numbness	☐	Bulging Disc	☐	Morton's Neuroma	☐	Sciatica	☐	Excessive Thirst or Urination
☐	Burning	☐	Cramping	☐	Tingling (Pins & Needles)	☐	Coldness	☐	Shocking

PREVIOUS TREATMENTS AND PROCEDURES

Please check all that apply

☐	Gabapentin	☐	Neurotonin	☐	Lyrica	☐	Cymbalta	☐	Physical Therapy
☐	Pain Medications	☐	Aleve	☐	Tylenol	☐	Ibuprofen	☐	Motrin
☐	Chiropractic	☐	Massage Therapy	☐	Injections	☐	Creams (hands & feet)	☐	Joint Replacement
☐	Other: _____								

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PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

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

Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the Same

List anything that makes your condition worse: _____

_____

List anything that makes your condition better: _____

_____

Is this condition interfering with any of the following?

☐ Sleep ☐ Work ☐ Daily Activities ☐ Other: _____

☐ Recreational Activities ☐ Walking ☐ Standing

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

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?

1 2 3 4 5 6 7 8 9 10

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PREVIOUS HEALTH HISTORY

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

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

List the prescription drugs you are currently taking (or you may attach a list):

Name:	Dose (mg or IU):	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Name:	Dose (mg or IU):	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Is your balance/walking ability affected? If yes, please describe: _____

_____

What areas of your health/wellness are you hoping/expecting to address? _____

_____

_____

What have you tried in the past and how has it worked? (Well, not well, no change, etc.)

_____

_____

Please rate the following from 0 (not at all) to 10 (max):
How severe are your symptoms on a regular basis?

0 1 2 3 4 5 6 7 8 9 10

How satisfied are you with your current course of action?

0 1 2 3 4 5 6 7 8 9 10

How motivated are you to get this condition under control?

0 1 2 3 4 5 6 7 8 9 10

Is there anything that you can currently think of that would inhibit you or stop you from being able to address the condition for which you are here seeking health? _____

_____

_____

Do you have any of the following?

Pacemaker?	Y / N	**Pain Stimulator?**	Y / N
Epilepsy?	Y / N	**Automatic Defibrillator?**	Y / N
Implanted Cardiac Clips?	Y / N	**Pregnant or Breastfeeding?**	Y / N
Organ transplant?	Y / N		

PATIENT QUALITY OF LIFE SURVEY

How has your health condition affected your job, relationships, finances, family or other activities? (*Please give examples*) _____

_____

_____

What are you most concerned with regarding your problem? _____

_____

_____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? (*Please be specific*) _____

_____

_____

What would be different/better without this problem? (*Please be specific*) _____

_____

_____

What do you desire most to get from working with us? _____

_____

_____

What is it worth to you? _____

_____

_____

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DOCTOR'S NOTES (FOR DOCTOR USE ONLY)

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