Neuropathy Intake Form

Name: _____ (Last Name / First Name / Middle Initial) **Date:** ___/___/___ (MM DD YYYY)

Nickname: _____ **Date of Birth:** ___/___/___ (MM DD YYYY) **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 **# of Children:** _____

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

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	☐ Cancer	☐ Blood Thinners
☐ Leg Pain	☐ Herniated Disc	☐ Balance Issues	☐ Chemotherapy	
☐ Hand Pain	☐ Spinal Stenosis	☐ Poor Circulation	☐ Diabetes	Last A1C: _____
☐ Hand Numbness	☐ Spinal Arthritis	☐ Poor Wound Healing	☐ Implanted Cord / Bladder Stimulator	
☐ Arthritis in Hands/Feet	☐ Degenerative Disc Disease	☐ Pacemaker/Defibrillator		

When did this begin? _____

What makes it worse? _____

What makes it better? _____

How did you hear about our office? _____

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:

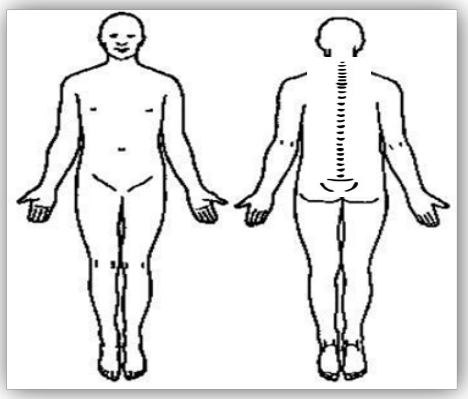
Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (0-25%) ___

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 use pencil tool/drawing tool or circle tool to circle areas of discomfort. (Or when you are done, print this document and circle spots with a pen)

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?** _____

Did this start/progress after COVID or receiving the COVID vaccine? **Yes** ◯ **No** ◯ **If yes, when?** _____

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 _____.
- I understand that _____ cannot file the knee treatments to insurance at this time.
- _____ will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patients' responsibility to contact their in insurance.

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: ___/___/_____
MM DD YYYY

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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? _____

_____

_____

_____

Accelerated Chiropractic & Natural Healing Center, LLC

Randy Hamling, D.C
707 Atlantic Ave.
Morris, MN 56267
(320) 585-7246
acceleratedchiro@gmail.com

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Hamling and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with Dr. Hamling and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask 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 any future condition(s) for which I seek treatment.

To the best of my knowledge I am ***NOT*** pregnant and Dr. Hamling has my permission to x-ray me for diagnostic interpretation.

By signing this authorization, I am also agreeing to have text and/or email sent to the number or email I have provided, from Accelerated Chiropractic and its employees.

I understand that there is no implied cure or guarantee of improvement by my agreeing to the Doctors recommendations. I further understand that my failure to comply fully with these recommendations will limit my results from the treatment received. I also acknowledge that I am responsible for services and/or products that are rendered.

X _____ _____

Patient's Signature or person acting on patient's behalf **Date**

X _____ _____

Witness Signature **Date**