NEUROPATHY
AND PAIN SOLUTIONS

Date___/____/____

Demographics:

Name_____ _____ _____ M ☐ F ☐

Social Security Number_____-_____-_____ Birth Date____/_____/_____

Address_____ City _____ST _____ Zip_____

Home Phone ( ) _____Cell ( ) _____

Would you like appointment reminders? ☐ Yes ☐ No

Email Address _____@_____

*IN SUBMITTING MY E-MAIL, I AUTHORIZE NEUROPATHY AND PAIN SOLUTIONS TO UTILIZE THE E-MAIL ADDRESS LISTED ABOVE FOR CORRESPONDENCE OF MONTHLY NEWLETTERS, APPOINTMENT REMINDERS, AND FUTURE MARKETING MATERIAL.

Ever had this same condition? ☐ Yes ☐ No

Single☐ Married☐ Divorced☐ Widowed☐

EMERGENCY CONTACTS AND PERSONAL INFORMATION AUTHORIZATION

I authorize the following individual(s) to have access to my records, as necessary.

_____ _____ _____

Name Phone # Relationship

How did you hear about our office? _____

Insurance Information:

Primary: _____ Member ID: _____

RELATION TO POLICYHOLDER: _____ POLICYHOLDER DOB: _____

Secondary: _____ Member ID: _____

RELATION TO POLICYHOLDER: _____ POLICYHOLDER DOB: _____

☐_____ **(If no insurance, please initial)** I do not have health insurance and wish to receive time-of-service fees. I understand that the reduced fee is offered to non-insured patients and is extended to those with current accounts only. Past due accounts will be billed at the regular rate.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider's office. I authorize the doctor to release all information necessary to communicate with personal physicians and or other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of care, regardless of insurance coverage. I also understand 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. I understand that interest is charged on overdue accounts at the annual rate of 15%.

_____ **Date** _____/_____/_____

Patient Signature

_____ **Date** _____/_____/_____

Parent/Guardian Signature

NEW PATIENT INTAKE

Please Print all information

Name: _____ DOB:_____ Height:_____ Weight:_____ lbs.

Social History:

Do you smoke? YES / NO Quantity/Day: _____

Consume Alcohol? YES / NO Quantity: _____

Have an implanted device? YES / NO If yes, type: _____

Pharmacy location and phone number: _____

Primary Care Doctor: _____ Phone: _____

Neurologist: _____ Phone: _____

Cardiologist: _____ Phone: _____

Surgical History:

Procedure	Surgery Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History:	MOTHER	FATHER	BROTHER	SISTER
ARTHRITIS	☐	☐	☐	☐
CANCER	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐
THYROID	☐	☐	☐	☐
NEUROPATHY	☐	☐	☐	☐

Diabetic History:

Are you a Diabetic? YES / NOWhen were you diagnosed? _____

Current A1C: _____ Current fasting sugars: _____

Are your blood sugars controlled? YES / NO

Does your PCP treat your diabetes? YES / NO If not, who does? _____

I, THE UNDERSIGNED, HAVE REVIEWED THE ABOVE AND CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Sign Name: _____ Date: _____

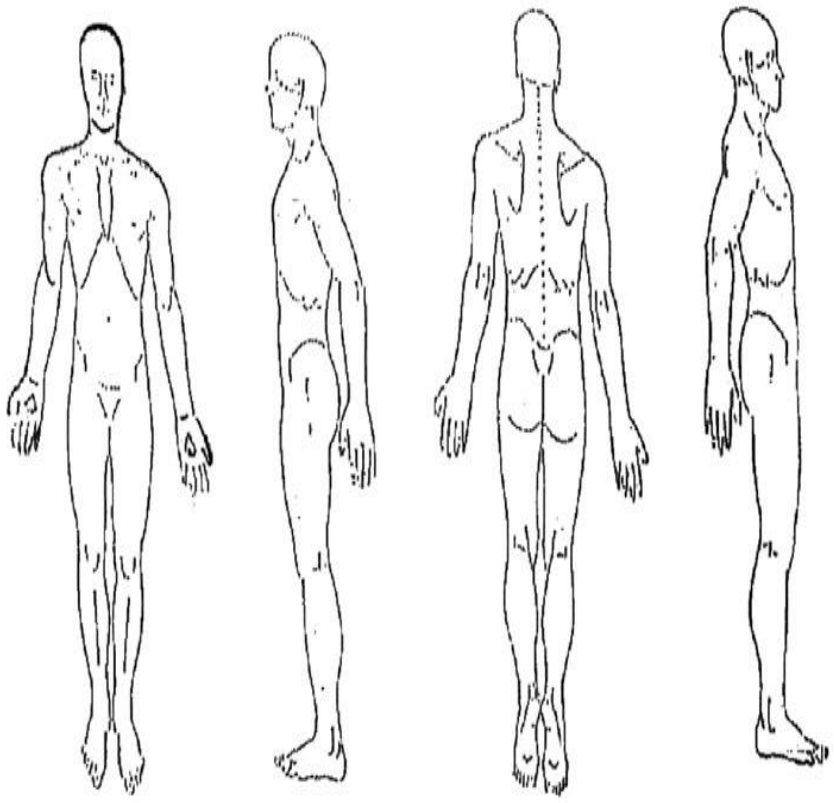
NEW PATIENT INTAKE

Please Print all information

Name: _____ DOB:_____

1. Mark off where your pain is with an 'X'.
2. Draw a line in the direction(s) your pain travels or radiates.
3. Mark the words to describe your pain and symptoms.

Symptoms
Fainting
Headaches
Pins and needles in arms/legs
Back pain
Dizziness
Ringing in ear
Numbness in fingers/toes
Fatigue
Tension
Sleeping Problems
Cold hands/feet
Neck pain
Loss of balance
Neck stiffness



Pain description
Can't Describe
Aching
Burning
Catching
Clicking
Cold
Cramping
Dull
Chawing
Numb
Stabbing
Throbbing
Tightness
Tingling
Unstable
Weakness
Other?

Are the following affected? **Daily activities?** ☐ Yes ☐ No **Posture?** ☐ Yes ☐ No **Gait?** ☐ Yes ☐ No

PEG Score: A Three-Item Scale Assessing Pain Intensity and Impairment. Using the scale below, answer the following questions.

1. What number best describes your pain on average in the past week? _____
2. What number describes how, during the past week, pain has interfered with your enjoyment of life? _____
3. What number best describes how in the past week pain has interfered with your general activity? _____

What activities aggravate your symptoms? _____

Is there anything that relieves your symptoms? ☐ Yes ☐ No

What works best? _____

NEW PATIENT INTAKE

Please Print all information

Name: _____ DOB:_____

Does the pain radiate into your: ☐Arm ☐ Leg ☐Does not radiate.

How long have you been experiencing pain? ☐Less than 3 months ☐More than 3 months ☐Less than 6 months ☐More than 6 months ☐More than a year

Do you wear orthotics? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

History of Seizures? ☐ Yes ☐ No

Medication Name	**Dosage & MG**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies: _____

NOTICE OF PRIVACY PRACTICES AND INFORMED CONSENT FOR EXAMINATION AND TREATMENT ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

Patient Name (***please print***) _____ Birth Date _____

I acknowledge that I was provided with a copy of the *Neuropathy and Pain Solutions* Notice of Privacy Practices.

✓ Patient Signature _____ _____
(if under 18) parent/guardian's signature & relationship) *Relationship*

I acknowledge that I was provided with a copy of the *Neuropathy and Pain Solutions* Informed Consent for Examination and Treatment.

✓ Patient Signature _____ _____
(if under 18) parent/guardian's signature & relationship) *Relationship*

I acknowledge that I was provided and read the *Neuropathy and Pain Solutions* Appointment Cancellation Policy.

✓ Patient Signature _____ _____
(if under 18) parent/guardian's signature & relationship) *Relationship*

I acknowledge that I was provided and read the *Neuropathy and Pain Solutions* Photo Release Disclosure. Currently, I…

_____ Accept _____ Decline.

✓ Patient Signature _____ _____
(if under 18) parent/guardian's signature & relationship) *Relationship*

For *Neuropathy and Pain Solutions* use only.
Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of *Neuropathy and Pain Solutions* Notice of Privacy Practices but was unable to for the following reason:

☐ Patient refused to sign.
☐ Patient unable to sign.
☐ Other _____

_____ _____
Employee Name Date

This form should be placed in the patient's medical record.