NEUROPATHY PAIN CENTER
CONFIDENTIAL PATIENT CASE HISTORY

PATIENT INFORMATION

Today's Date_____ Social Security # _____ Date of Birth _____Age___

Name_____ Home Phone _____

Address _____ Cell Phone _____

City _____State_____ Zip _____ Work Phone_____

Email _____ Sex □ Male □ Female

Marital Status **M S W D**

Height_____' _____" Weight _____ lbs No. of Children _____ Ages _____

Occupation_____ Employer _____

Spouse Name_____ Spouse Occupation _____

Primary Care Physician _____ Phone _____

Name of Doctors who have treated you for this condition? _____

How were you referred to our office? _____

Who should we contact in case of emergency? _____

CURRENT COMPLAINTS

1. Please **CIRCLE** all that apply:
PAIN IN FEET/LEGS/ARMS/HANDS • TINGLING FEET/LEGS/ARMS/HANDS • NUMBNESS FEET/LEGS/ARMS/HANDS
BURNING FEET/LEGS/ARMS/HANDS • WEAKNESS FEET/LEGS/ARMS/HANDS • NECK PAIN • LOW BACK PAIN

Other Complaints: _____

2. How long have you had this condition? _____

3. Activities that are affected: □ **Work** □ **Sitting** □ **Caring for myself / family** □ **Walking** □ **Driving** □ **Sleeping** □ **Stairs** □ **Housework**

4. Rate your **Pain** / **Dysfunction**: (LEAST) **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** (MOST)

5. Is this condition progressively getting worse? **Yes / No / Same**

6. How long has it been since you've really felt good? _____

7. Other Doctors you have seen for this condition: _____

8. List treatment, procedures, surgeries for this condition: _____

9. Have you had any of the following for this condition: MRI / CT scan / XRays / Injections / Nerve Test

10. Has any other treatment helped? If so, what treatment? _____

11. Is this condition due to an accident? If so, what type? _____

12. Have you been involved in an automobile accident within the □ Last year □ Five years □ Never

13. Date of last physical examination: _____ Doctor's Name: _____

HEALTH HISTORY (Check if current or in the past)

□ NEUROPATHY	□ FAINTING/SEIZURES/EPILEPSY	□ INSULIN
□ FREQUENT HEADACHES	□ CANCER	□ DIABETES
□ FREQUENT NECK PAIN	□ CHEMOTHERAPY	□ SHINGLES
□ LOWER BACK PROBLEMS	□ MITRAL VALVE PROLAPSE	□ HIV/AIDS
□ DISC PROBLEMS NECK/LOW BACK	□ HEART SURGERY OR PACEMAKER	□ HEPATITIS
□ WHIPLASH	□ VENEREAL DISEASE	□ ASTHMA
□ NUMBNESS/TINGLING ARMS/LEGS	□ TUBERCULOSIS	□ ANEMIA
□ SCOLIOSIS	□ EMPHYSEMA	□ OTHER
□ ARTHRITIS	□ PSYCHIATRIC PROBLEMS	_____
□ HEART ATTACK OR STROKE	□ KIDNEY PROBLEMS	
□ CONGENITAL HEART DEFECT	□ SINUS PROBLEMS	
□ ALCOHOL/DRUG ABUSE	□ DIFFICULTY BREATHING	
□ RHEUMATIC FEVER	□ ARTIFICIAL BONES/JOINTS	
□ HIGH/LOW BLOOD PRESSURE	□ HEART MURMUR	
□ ARTIFICIAL VALVES	□ ULCERS/COLINITIS	

FAMILY HISTORY

□ HEART DISEASE	□ HIGH BLOOD PRESSURE	□ STROKE
□ CANCER	□ DIABETES	□ SCOLIOSIS
□ OSTEOPOROSIS	□ NEUROPATHY	□ OTHER _____

ALLERGIES: Please list:

SURGICAL HISTORY: List surgeries and year performed:

SOCIAL HISTORY : Do you smoke? □ Yes □ No □ In the Past Alcohol use? □ Yes □ No

- We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform services needed during examination and treatment.
- I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my medical status.
- **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF:**
  Neuropathy Pain Center
  7809 Laurel Ave Suite 11, Cincinnati, OH 45243
- I acknowledge that this office is conducting research on the outcome of each patient's results. I agree to be interviewed on camera (audio and visual) before the start of treatment and at the completion of treatment.

HOW COMMITTED ARE YOU TOWARDS GETTING RELIEF OF YOUR SYMPTOMS?

NOT COMMITTED 1 2 3 4 5 6 7 8 9 10 **VERY COMMITTED**

Patient or Legal Guardian Signature _____Date_____

Witness Signature _____

NEUROPATHY PAIN CENTER
ASSESSMENT OF ACTIVITIES OF DAILY LIVING

Patient Name_____ **Date**_____

Standing

- □ Able to stand as long as desired without pain
- □ Able to stand for 60 minutes without pain
- □ Able to stand for 45 minutes without pain
- □ Able to stand for 30 minutes without pain
- □ Able to stand for 25 minutes without pain
- □ Able to stand for 15 minutes without pain
- □ Able to stand for 10 minutes without pain
- □ Able to stand for 5 minutes without pain
- □ Unable to stand at all due to pain

Bending

- □ Able to bend as far as would like without pain
- □ Able to bend 80 degrees without pain
- □ Able to bend 70 degrees without pain
- □ Able to bend 60 degrees without pain
- □ Able to bend 50 degrees without pain
- □ Able to bend 40 degrees without pain
- □ Able to bend 30 degrees without pain
- □ Able to bend 20 degrees without pain
- □ Able to bend 10 degrees without pain
- □ Unable to bend at all due to pain

Driving

- □ Able to drive when necessary without pain
- □ Able to drive for 120 minutes without pain
- □ Able to drive for 90 minutes without pain
- □ Able to drive for 60 minutes without pain
- □ Able to drive for 45 minutes without pain
- □ Able to drive for 30 minutes without pain
- □ Able to drive for 20 minutes without pain
- □ Able to drive for 10 minutes without pain
- □ Unable to drive at all due to pain

Walking

- □ Able to walk as far as desired without pain
- □ Able to walk 2-3 miles without pain
- □ Able to walk 1 mile without pain
- □ Able to walk ½ mile without pain
- □ Able to walk ¼ mile without pain
- □ Able to walk 1 block without pain
- □ Able to walk 100 feet without pain
- □ Able to walk 50 feet without pain
- □ Unable to walk at all due to pain

Picking up Objects

- □ Able to pick up heavy objects without pain
- □ Able to pick up 45 pounds without pain
- □ Able to pick up 35 pounds without pain
- □ Able to pick up 25 pounds without pain
- □ Able to pick up 20 pounds without pain
- □ Able to pick up 15 pounds without pain
- □ Able to pick up 10 pounds without pain
- □ Able to pick up 5 pounds without pain
- □ Unable to lift anything due to pain

Sitting

- □ Able to sit without pain
- □ Able to sit 8 hours without pain
- □ Able to sit 7 hours without pain
- □ Able to sit 6 hours without pain
- □ Able to sit 5 hours without pain
- □ Able to sit 4 hours without pain
- □ Able to sit 3 hours without pain
- □ Able to sit 2 hours without pain
- □ Able to sit 1 hour without pain
- □ Able to sit 30 minutes without pain
- □ Unable to sit at all due to pain

Housework

- □ Able to do housework for 90 minutes without pain
- □ Able to do housework for 80 minutes without pain
- □ Able to do housework for 70 minutes without pain
- □ Able to do housework for 60 minutes without pain
- □ Able to do housework for 50 minutes without pain
- □ Able to do housework for 40 minutes without pain
- □ Able to do housework for 30 minutes without pain
- □ Able to do housework for 20 minutes without pain
- □ Able to do housework for 10 minutes without pain
- □ Unable to do housework at all due to pain

Headaches

- □ Having no headaches
- □ Having 2 headaches per month
- □ Having 1 headache per month
- □ Having 1 headache per day
- □ Having 5 headaches per week
- □ Having 3-4 headaches per week
- □ Having 1-2 headaches per week
- □ Having constant headaches

Opening Jars

- □ Able to open any jar without pain
- □ Able to open very tight jars without pain
- □ Able to open medium tight jars without pain
- □ Able to open lightly closed jars without pain
- □ Unable to open any jar due to pain

Lying Down

- □ Able to lay as long as would like without pain
- □ Able to lay for 120 minutes without pain
- □ Able to lay for 90 minutes without pain
- □ Able to lay for 60 minutes without pain
- □ Able to lay for 30 minutes without pain
- □ Able to lay for 20 minutes without pain
- □ Able to lay for 10 minutes without pain
- □ Unable to lay at all without pain

Patient Signature_____

Physician Signature_____

NEUROPATHY PAIN CENTER
REVIEW OF SYSTEMS

Do you have: (please check all that apply):

Constitutional:
□Fevers □Weight loss □Difficulty sleeping □Tiredness or fatigue □Chills □Night sweats □**None**

Eyes:
□Flashing lights or "stars" □Blind spots □Double vision □**None**

Ears, Nose, Throat, Mouth:
□Earache or discharge □Ringing in ears □Difficulty hearing □Nose bleeds □Sinusitis □Hoarseness □Sores in mouth □Sore throats □**None**

Cardiovascular:
□Chest pain □Squeezing or tightness in chest □ Angina □Need to sleep with head of the bed elevated □Cramps in buttocks, thighs or calves when walking □Shortness of breath at rest or walking/climbing □Palpitations or fluttering heart □Poor circulation □Gangrene □Swelling of hands, face, legs or feet □High cholesterol □**None**

Respiratory:
□Cough □Sputum production □Coughing up blood □Pleurisy □Wheezing □Asthma □**None**

Gastrointestinal:
□Nausea or vomiting □Diarrhea □Constipation □Abdominal pain □Vomiting of blood □Very dark or light stool □Jaundice □Liver or gall bladder problems □Colitis or other bowel problems □Bleeding from rectum □Ulcer □**None**

Genitourinary:
□Blood in urine or very dark urine □Get up at night to urinate □Burning with urination □Unusual urgency to urinate □Difficulty in getting urine stream started □Kidney stones □Prostate problems □Bladder problems □Albumin or protein in urine □Pus in urine □Infection in urine □Large amounts of urine or very frequent urination □**None**

Musculoskeletal:
□Low back pain □Neck pain □Muscle ache □Joint pain □Mid back pain □Shoulder/arm pain □Hip/leg pain □Arthritis □**None**

Neurological:
□Headaches □Drooping of face □Loss of strength in hands, arms, legs, feet □Numbness/tingling □Seizures □Loss of consciousness □Dizziness □Fainting spells □**None**

Skin:
□Rashes □Skin ulcers □Nodules on skin □**None**

Emotional/Psychiatric:
□Depression □Anxiety □Psychiatric problems □**None**

Endocrine:
□Enlarged thyroid □Sweating □Diabetes □Excess thirst □Change in appetite □Feeling unusually hot or cold □Flushing □Abnormal menses □Post-menopausal □**None**

Hematologic/Lymphatic/Oncologic:
□Anemia □Iron deficiency □Enlarged lymph glands □Easy bruising □Cancer □**None**

Allergic/Immunologic:
□Hay fever □Seasonal allergies □Other_____ □**None**

Patient Signature **Date** **Physician Signature**

NEUROPATHY PAIN CENTER

7809 Laurel Ave Suite 11
Cincinnati, OH 45243
513-428-9355

Walking Scale Questionnaire

These questions ask about limitations to your walking due to peripheral neuropathy during the past 2 weeks. For each statement, please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start or your consultation.

In the past 2 weeks, how much has your peripheral neuropathy….	**Not at all**	**A little**	**Moderately**	**Quite a bit**	**Extremely**
Limited your ability to walk?	**1**	**2**	**3**	**4**	**5**
Limited your ability to run?	**1**	**2**	**3**	**4**	**5**
Limited your ability to climb up/down stairs?	**1**	**2**	**3**	**4**	**5**
Made standing when doing things more difficult?	**1**	**2**	**3**	**4**	**5**
Limited your balance when standing or walking?	**1**	**2**	**3**	**4**	**5**
Limited how far you are able to walk?	**1**	**2**	**3**	**4**	**5**
Increased the effort needed for you to walk?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use support when walking indoors, eg holding on to furniture, using a cane, etc?	**1**	**2**	**3**	**4**	**5**
Made it necessary for you to use support when walking outdoors, eg using a cane or walker, etc?	**1**	**2**	**3**	**4**	**5**
Slowed down your walking?	**1**	**2**	**3**	**4**	**5**
Affected how smoothly you walk?	**1**	**2**	**3**	**4**	**5**
Made you concentrate on your walking?	**1**	**2**	**3**	**4**	**5**

Thank you for completing this questionnaire **Total _____**

WALKING SCALE DISABILITY SCORE: <12 NORMAL, 13-27 MILD, 28-45 MODERATE, >60 SEVERE DISABILITY

NEUROPATHY PAIN CENTER

Subjective Peripheral Neuropathy Screen Questionnaire

Full Name: _____ **Date**: _____

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check **yes** or **no** based on how you usually feel. Thank you.

1. Do you ever have legs and/or feet that feel numb?	□ Yes □ No
2. Do you ever have any burning pain in your legs and/or feet?	□ Yes □ No
3. Are your feet too sensitive to touch?	□ Yes □ No
4. Do you get muscle cramps in your legs and/or feet?	□ Yes □ No
5. Do you ever have any prickling or tingling feelings in your legs or feet?	□ Yes □ No
6. Does it hurt at night or when the covers touch your skin?	□ Yes □ No
7. When you get into the tub or shower, are you unable to tell the hot water from the cold water with your feet?	□ Yes □ No
8. Do you ever have any sharp, stabbing, shooting pain in your feet or legs?	□ Yes □ No
9. Have you experienced an asleep feeling or loss of sensation in your legs or feet?	□ Yes □ No
10. Do you feel weak when you walk?	□ Yes □ No
11. Are your symptoms worse at night?	□ Yes □ No
12. Do your legs and/or feet hurt when you walk?	□ Yes □ No
13. Are you unable to sense your feet when you walk?	□ Yes □ No
14. Is the skin on your feet so dry that it cracks open?	□ Yes □ No
15. Have you ever had electric shock-like pain in your feet or legs?	□ Yes □ No
16. Have you fallen in the last 6 months? If so, how many times?	□ Yes □ No _____

Diagnostic utility of the subjective peripheral neuropathy screen in HIV-infected persons with peripheral sensory polyneuropathy. Venkataramana AB, Skolasky RL, Creighton JA, McArthur JC. AIDS Read. 2005 Jul;15(7);341-4. 348-9,354.

Current Medications List

Name _____ Date _____

Prescription Medications:

Name of Medication	Strength and Frequency	Condition Medication is taken for	Physician who Prescribed Med

Vitamins: _____

_____

Neuropathy Pain Center
7809 Laurel Ave Suite 11
Cincinnati, OH 45243

CONSENT FOR TREATMENT

Patient Name: _____

I voluntarily give my permission to the health care providers of the **Neuropathy Pain Center** and such assistants and other health care providers as they deem necessary to provide health care services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from **Neuropathy Pain Center**, or until I withdraw my consent in writing.

Patient or Authorized Signature X **Date**

FINANCIAL POLICY

I understand there is a fee of **$77.00** for the initial consultation and examination. I agreed to pay at the time of service. This fee also includes an oral report of findings. The purpose of the consultation and examination is to determine if you are a candidate for our treatment program. If treatment is recommended, any and all additional charges will be discussed outlining, in detail, all cost and payment options.

Patient or Authorized Signature X **Date**

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I, _____ have read a copy of **Neuropathy Pain Center's** notice of **Patient Privacy Practices**.

The patient understands and agrees to allow this healthcare facility to use their **Patient Health Information** for the purpose of treatment, payment, healthcare operations and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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 this consent. The following person(s) have my permission to receive my personal health information: _____

Patient or Authorized Signature X **Date**

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

AUTHORIZATION AND RELEASE: I authorize Neuropathy Pain Center to release all information necessary to communicate with personal physicians and other health care providers. I understand this consent is voluntary and I may revoke this authorization at anytime by written and signed communication. I also understand that my medical records may contain mental health information, drug/alcohol and/or HIV information.

In addition, I have read and agree to the above **Consent for Treatment, Financial Policies, Notice of Privacy Practice act, and Medical Record Release.**

The undersigned certifies that he/she has read and understands each of the above paragraphs and accepts these terms.

A photocopy or facsimile will be considered valid and same as original.

Patient or Authorized Signature X **Date**

SPINE AND WELLNESS CINCINNATI

Patient Name _____ Date _____

PATIENT INFORMED CONSENT

Before you receive care as a patient of Neuropathy Pain Center, it is important that you read this Consent and understand the nature of treatment. Neuropathy Pain Center utilizes a multidisciplinary approach to health and wellness. Treatment usually involves a blend of laser therapy, acupuncture, herbal medicine, and manual medicine. To understand the risk associated with care, you need to understand these unique modalities.

Laser Therapy is a non-surgical application of laser light. Unlike most other forms of therapy, laser therapy is classified "actinotherapy" as it results in a chemical/metabolic change of the involved tissues. Thus, laser therapy can relieve pain, decrease inflammation, accelerate tissue healing (biostimulation), increase blood flow and decrease tissue swelling.

Like all forms of medical treatment, there are associate risks as well as benefits. Laser exposure to the eyes during the procedure may result in damage of the retina. Under certain situations a superficial burn of the skin could occur. This is based upon skin pigmentation, skin discolorations (i.e. tattoos), or the use of topical creams, lotions or analgesic balms. To prevent adverse reactions to laser therapy, all patients must adhere to the guidelines for care supplied separately.

"Acupuncture" means a form of health care performed by the insertion and removal of specialized needles, with or without the use of supplemental techniques, to specific areas of the human body. *See* Ohio Statute 4762.

Manual medicine (or chiropractic care) involves the adjustment, manipulation and treatment of your body in which vertebral subluxations and other malpositioned articulations may be interfering with the normal generation, transmission and expression of nerve impulse between the brain, organs and tissue cells, thereby causing disease. Chiropractic adjustments, manipulations, and treatments are intended to restore the normal flow of nerve impulse which produces normal function and consequent health.

"Chiropractic physicians" examine, analyze, and diagnose the human living body and its disease by use of (a) any physical, chemical, electrical or thermal methods, (b) x-ray for diagnosing, (c) blood tests and (d) other chiropractic methods. *See* Ohio Statute 4734.01.

The undersigned Patient understands and acknowledges that there are risks associated with the application of laser chiropractic medicine, chiropractic care, acupuncture, therapy including, but not limited to ataxia, bruising, thermal injuries, dislocations/subluxations, dizziness, fracture(s), mobility disruption, paralysis, pneumothorax, spinal injury, stroke, vision disturbances and others. The most common side effect following any treatment is an ache or stiffness at the site of the treatment.

I, hereby give authorization for **consent of treatment** to **Neuropathy Pain Center** and whomever they may designate as their assistants to perform and administer therapy and treatment as they deem necessary.

I, the undersigned Patient, understand the risks and limitations associated with treatment at Laser Pain Center and applicati on of therapeutic modalities such as Laser, heat, ice, ultrasound, traction, muscle stimulation, acupuncture, herbal medicine, chiropractic and others treatments by **Neuropathy Pain Center**. **All my questions have been answered in detail and I fully understand and certify that no guarantee or assurances have been made to the results or outcome from treatment that may or will be rendered.**

Patient or Authorized Signature X **Date**