# 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: _______________________________

# 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**

## SPINE AND WELLNESS CINCINNATI

**Patient Name** ___________________________________________ **Date** ______________________

## PATIENT GOALS

**At Spine and Wellness Cincinnati, our goal is to partner with you to achieve the life you want. Please tell us your top goals and priorities for your health.**

**Ex: I want to play with my grandkids, run a marathon, sleep through the night, have more energy, ect…**

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