



## New Patient Neuropathy Form

Full Name: \_\_\_\_\_ Called Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Divorced Sex: \_\_\_ M \_\_\_ F

Spouse Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### **Review of Symptoms**

**Please Check all that apply:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Foot Pain                   | <input type="checkbox"/> Herniated Disc                        | <input type="checkbox"/> Arthritis in Hands               |
| <input type="checkbox"/> Hand Pain                   | <input type="checkbox"/> Bulging Disc                          | <input type="checkbox"/> Arthritis in Feet                |
| <input type="checkbox"/> Low Back Pain               | <input type="checkbox"/> Spinal Stenosis                       | <input type="checkbox"/> Plantar Fasciitis                |
| <input type="checkbox"/> Neck Pain                   | <input type="checkbox"/> Degenerative Disc                     | <input type="checkbox"/> Sciatica                         |
| <input type="checkbox"/> Foot Numbness               | <input type="checkbox"/> Vascular Problems                     | <input type="checkbox"/> Pinched Nerve                    |
| <input type="checkbox"/> Hand Numbness               | <input type="checkbox"/> Leg Pain                              | <input type="checkbox"/> Poor Circulation                 |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Morton's Neuroma                      | <input type="checkbox"/> Joint Replacement                |
| <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Cancer                                | <input type="checkbox"/> Foot Surgery                     |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Chemotherapy                          | <input type="checkbox"/> Poor Wound Healing               |
| <input type="checkbox"/> Pacemaker/<br>Defibrillator | <input type="checkbox"/> Implanted Cord/<br>Bladder Stimulator | <input type="checkbox"/> Excessive Thirst or<br>Urination |
| <input type="checkbox"/> Neck Surgery                | <input type="checkbox"/> Back Surgery                          |   |

**Present Health Condition**

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

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_

List approximately how long you have noticed these problems in your life:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Circle the things you have used for these problems:

Gabapentin	Neurontin	Lyrice	Cymbalta
Pain Medications	Aleve	Tylenol	Ibuprofen
Motrin	Creams	Chiropractic	Injections
Massage Therapy	Physical Therapy		

What do you think is causing your problem?

\_\_\_\_\_  
\_\_\_\_\_

**Name all of the doctors you have seen for these problems and treatment you received**

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**Have your symptoms:**  Improved     Worsened     Stayed the same

**List anything that makes your condition worse:** \_\_\_\_\_

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**List anything that makes your condition better:** \_\_\_\_\_

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**How would you describe the symptoms? Please check ALL that apply:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Aching Pain   | <input type="checkbox"/> Tingling/Electric Shocks | <input type="checkbox"/> Dead Feeling    |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Pins & Needles Pain      | <input type="checkbox"/> Cold Hands/Feet |
| <input type="checkbox"/> Sharp Pain    | <input type="checkbox"/> Heavy Feeling            | <input type="checkbox"/> Cramping        |
| <input type="checkbox"/> Tiredness     | <input type="checkbox"/> Hot Sensation            | <input type="checkbox"/> Swelling        |
| <input type="checkbox"/> Numbness      | <input type="checkbox"/> Throbbing Pain           | <input type="checkbox"/> Burning         |

**Is this condition interfering with any of the following?**

- |  |                                  |   |
|--|----------------------------------|---|
| <input type="checkbox"/> Sleep                   | <input type="checkbox"/> Work    | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing         |

**Social History**

**Do you smoke?**    \_\_\_ Yes    \_\_\_ No    If yes, how many cigarettes daily? \_\_\_\_\_

**Do you drink?**    \_\_\_ Yes    \_\_\_ No    If yes, how many drinks per week? \_\_\_\_\_

**Do you exercise?**    \_\_\_ Yes    \_\_\_ No    If yes, please describe type and how often?

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**Current Pain Levels**

**How would you rate your pain in the last week?**

NO PAIN    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?**

NO PAIN    1    2    3    4    5    6    7    8    9    10

**Previous Health Conditions**

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal consent.

**Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

Please give name, address, and office phone number of your primary care physician.

**Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**When were you last seen there?** \_\_\_\_\_

**May we send them updates on your treatment/condition?** \_\_\_ Yes \_\_\_ No

**List all allergies/sensitivities to medication, food, and other items here”**

Items you react to:

Reaction:

_____	_____
_____	_____
_____	_____
_____	_____

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

Name

Dose (mg or IU)

Time Daily

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List all nutritional supplements (Vitamins, herbs, homeopathic, etc.) as above:**

_____	_____	_____
_____	_____	_____

## Consent to Treat and HIPAA Privacy Information

### The nature of the chiropractic adjustment

The primary treatment used as a Doctor of Chiropractic is spinal manipulative therapy. I will use this procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. This may cause an audible “pop” of “click”, much as you have experienced when you “crack” your knuckles. You may feel a sense of movement.

### Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures. **Please initial each treatment that you are consenting to.**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Spinal manipulative therapy | <input type="checkbox"/> Palpation            | <input type="checkbox"/> Vital signs                |
| <input type="checkbox"/> Range of motion testing     | <input type="checkbox"/> Orthopedic testing   | <input type="checkbox"/> Basic neurological testing |
| <input type="checkbox"/> Muscle strength testing     | <input type="checkbox"/> Postural testing     | <input type="checkbox"/> NES Scan                   |
| <input type="checkbox"/> Radiographic studies        | <input type="checkbox"/> Spinal decompression |   |

### The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to, or contributing to, serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform the Doctor.

### The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during the examination and X-Ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in five million cervical adjustments. Other complications that may arise are also generally described as rare.

### The availability and nature of other treatment options:

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Prescription drugs such as anti-inflammatory, muscle relaxers, and pain-killers
- Medical Care or Hospitalization
- Surgery

If you choose to use one of the above noted "other treatment" options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

**The risks and dangers attendant to remaining untreated:**

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

**DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.**

**PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW**

I have read |            | or have had read to me |            | the above explanation of the chiropractic adjustment and related treatment. I have discussed with Dr. Dolan and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I am also aware that Dolan Chiropractic has made the HIPAA Privacy Practices readily available for my viewing.

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Patient/Guardian Signature

Date

## Quality of Life Survey

Please take several minutes to answer these questions so we can help you get better.  
**(Please check all that apply)**

### How have you taken care of your health in the past?

Medications  Nutrition/ Diet

Emergency Room  Holistic Care

Routine Medical  Vitamins

Exercise  Chiropractic

Other (please specify): \_\_\_\_\_

### How did the previous method(s) work out for you?

Bad Results  Did not get worse

Some Results  Did not work very long

Great Results  Still Trying

Nothing Change  Confused

### How have others been affected by your health conditions?

No one is affected  They tell me to do something

Haven't noticed any problem  People avoid me

### What are you afraid this might be (or beginning) to affect (or will affect)?

Job  Sleep  Time

Kids  Future Ability  Finances

Marriage  Freedom  Self-Esteem

**Are there health conditions you are afraid this might turn into?**

\_\_\_ Family Health Problems

\_\_\_ Fibromyalgia

\_\_\_ Heart Disease

\_\_\_ Depression

\_\_\_ Cancer

\_\_\_ Chronic Fatigue

\_\_\_ Diabetes

\_\_\_ Need Surgery

\_\_\_ Arthritis

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

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**What has that cost you? (Time, money, happiness, freedom, sleep, promotion, etc.?)  
Give 3 examples:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**What are you most concerned with regarding your problem?**

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

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**What would be different/better without this problem? Please be specific.**

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

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**What would that mean to you?**

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