# Neuropathy Paperwork

amplify HEALTH AND WELLNESS

## Please fill out application entirely and legibly.

Name _____ ☐ Male ☐ Female Age _____

Address _____

City _____ State _____ Zip _____

Phone _____ Email _____

Date of Birth _____ Last 4 of Social Security _____

Spouse's Name _____ Have you served in the military? Yes ☐ No ☐ **If yes,** when? _____ to _____

Your Occupation _____ Retired? ☐ Yes ☐ No

Name and Number of Emergency Contact _____Relationship _____

## Review of Symptoms

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

1. _____
2. _____
3. _____
4. _____

**List approximately how long you have noticed these problems:**

1. _____
2. _____
3. _____
4. _____

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

1. _____
2. _____
3. _____
4. _____

**Circle the things you have used for these problems:**

*Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Prescriptions Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections Creams*

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

1. _____
2. _____
3. _____
4. _____

**What do you think is causing your problem? Was there an injury?**

1. _____
2. _____
3. _____
4. _____

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**Names of all doctors you have seen for these problems and treatment received:**

_____

**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:**

| ***Item you react to:*** | ***Reaction:*** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

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

| ***Name*** | ***Dose:*** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**List all nutritional supplements you are currently taking (or you may attach a list):**

| ***Name*** | ***Dose:*** |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## Family History

1. **Does anyone in your family suffer with the same conditions?** ☐ **Yes** ☐ **No** **Whom? _____**
2. **Have they been treated for their condition?** ☐ **Yes** ☐ **No** ☐ **I don't know**
3. **Have you ever had any of the following conditions?**

**____ Broken Bone ____Dislocations ____Tumors ____Rheumatoid Arthritis ____Fracture _____Disability**
**____Cancer ____Heart Attack ____Osteo Arthritis ____Diabetes ____Cerebral Vascular**

**Other Serious Conditions: _____**

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## Outcome Assessment Tools

Please **CIRCLE** the number that best describes the question asked. If you have more than one complaint, please answer each question for each individual complaint and indicate the score of each complaint.

How would you rate your symptom (pain, numbness, etc.) level RIGHT NOW?

No pain _____ worst possible pain

1 2 3 4 5 6 7 8 9 10

On AVERAGE how would you rate your symptom (pain, numbness, etc.) level?

No pain _____ worst possible pain

1 2 3 4 5 6 7 8 9 10

What is your symptom (pain, numbness, etc.) level at its BEST?

No pain _____ worst possible pain

1 2 3 4 5 6 7 8 9 10

What is your symptom (pain, numbness, etc.) level at its WORST?

No pain _____ worst possible pain

1 2 3 4 5 6 7 8 9 10

## Notice of Privacy Practices Acknowledgement

I understand that I have certain rights of privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician's certifications.

I acknowledge that I may request your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I also understand that I may request, in writing, that you restrict how my private information is disclosed to carry out treatment, payment, or healthcare operation.

_____ _____ - _____ - _____

**Patient or Authorized Person's Signature** **Date Completed**

I hereby authorize payment to be made directly to Amplify Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application, or copies thereof, for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Amplify Chiropractic for any and all services I receive at this office.

_____ _____ - _____ - _____

**Patient or Authorized Person's Signature** **Date Completed**

## Informed Consent

I have been advised regarding chiropractic adjustments, modalities, and therapeutic procedures, like all forms of health care, holds certain risks. While the risks are most often very minimal, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke-which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives, as well as the risks associated with chiropractic adjustments and all other procedures provided at Amplify Health and Wellness have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____ _____

Patient Name (print) Patient Signature Date

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**REGARDING:** X-rays/Imaging Studies

As your healthcare provider, we are legally responsible for your records. We must maintain a record of your xrays in our files. At your request, we will provide you with a copy of your x-rays. The medical records request is a one-time $15 charge. Digital x-rays on a CD will be available within 72 hours of any regular practice hour day. Please note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. The doctor of Amplify Chiropractic does not diagnose or treat medical conditions; however, if any abnormalities are found we will bring it to your attention so that you can seek proper medical advice.

By signing below you are agreeing to the above terms and conditions.

_____

Patient Name (print)

_____ ____/____/____

Patient or Authorized Person's Signature Date

**Female Patients Only:** To the best of my knowledge, **I BELIEVE I AM NOT PREGNANT AT THE TIME THE X-RAYS ARE TAKEN AT AMPLIFY CHIROPRACTIC.**

_____ ____/____/____

Patient or Authorized Person's Signature Date

# Quality of Life Survey

What areas of your life is the health condition currently affecting or what are you concerned it may affect in the future (ie. Job, Family, Future Ability, Self-Esteem, Sleep, Finances, Freedom, etc.)? Please explain.

_____
_____
_____

How have others been affected by your health condition (ie. Spouse, Kids, Co-workers, etc.)?

_____
_____
_____

What are you most concerned with regarding your condition?

_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____