Date of Consult: ________________________________

Referring Doctor: _______________________________

Last Name: _____________________________ First Name: ___________________________________

Home Address: ____

City: ____________________ State: __________ Zip Code: _________________________

Home Phone: ____________________________ Cell: ___________________________________

DOB:________________ SS#: ____________________ Email:______________________________

Occupation: _____________________________ Employer: ___________________________________

Ethnicity: ____

INSURANCE

Primary Insurance: ____

Policy #: ____________________________ Group #: _______________________________________

Policy Holder's Name: _____________________________________ DOB: _______________________

Secondary Insurance: ____

Policy #: ____________________________ Group #: _______________________________________

Policy Holder's Name: _____________________________________ DOB: _______________________

How did you hear about us?: ____

Primary Care Doctor: _________________________ Phone: __________________________________

Pharmacy: ___________________________________ Phone: _________________________________

EMERGENCY CONTACT

Contact Name: ___________________________________ Relationship: ___________________________

Phone: _______________________ Patient Signature: _______________________________________

NEUROPATHY HISTORY

What is your concern with respect to nerve pain: (circle all that apply):

Pain Numbness Tingling Pain with Touch Shooting Shocks

Burning Aching Sensitivity Pins and needles Tightness

Where is your pain **AND** when did it begin?
____
____

Have you ever had a nerve conduction study? If yes, when and where was the study done?
____
____

Are you diabetic?
____
____

What else is important for us to know?
____
____

Please rate your overall pain on a scale from 0-10 over the 1-2 weeks. (0 no pain 10 severe pain)

Pain	**Numbness**	**Tingling**	**Burning**	**Tightness**

SOCIAL HISTORY

Tobacco use? YES/ NO/ FORMER If YES what is your typical usage per day?______________
Alcohol use? YES/ NO If YES how many drinks per day? Type________________
Illegal drug use? YES/ NO/ FORMER If YES what substance? ____________________________
Do you take NSAIDS (Motrin, Aleve, Advil, Naproxen, etc.) regularly? YES/ NO ____________________

IMPLANTS

Do you have Pacemaker? YES/ NO
Do you have a Defibrillator? YES/ NO
Pacemaker/ Defibrillator dependent? YES/ NO
Do you have a Spinal Cord Stimulator or other nervous system implant? YES/ NO
Do you have a seizure disorder? YES/ NO

NEUROPATHY
TREATMENT CLINICS OF TEXAS

MEDICAL HISTORY

Circle all that apply

HEAD:
Trauma

EYES:
Blindness
Cataracts
Glaucoma
glasses/contacts

EARS:
Hearing aids

NOSE/SINUSES:
Allergic Rhinitis
Sinus infections

MOUTH/THROAT:
Dentures

CARDIOVASCULAR:
Aneurysm
Angina
DVT (thrombosis)
Dysrhythmia
Hypertension
Murmur
Myocardial Infarction (heart attack)

RESPIRATORY:
Asthma
Bronchitis
COPD
Emphysema
Pleuritis
Pneumonia

GASTROINTESTINAL:
Cirrhosis
GERD
Gallbladder disease
Heartburn
Hemorrhoids
Hepatitis
Hiatal hernia
Jaundice
Ulcers

GENITOURINARY:
Hernia
Incontinence
Kidney Stones
Other Kidney Disease:
UTI (s)

MUSCULOSKELETAL:
Arthritis
Gout
Injury

DERMATOLOGICAL:
Dermatitis
Mole(s)
Other skin conditions
Psoriasis

NEUROLOGICAL:
Epilepsy
Seizures
Severe headaches/ Migraine
Stroke
TIA

PSYCHIATRIC:
Bipolar disorder
Depression
Hallucinations/ delusions
Suicidal Ideation
Suicide attempts

ENDOCRINE:
Goiter
Hyperlipidemia/cholesterol
Hypothyroidism
Thyroid disease
Thyroiditis
Type I DM
Type II DM

HEMATOLOGY/ONCOLOGY:
Anemia
Cancer: ________________

INFECTIOUS DISEASE:
HIV
STD
Tuberculosis (dz)
Tuberculosis (exposure)

AUTOIMMUNE/CUSTOM:
Amputation
Osteoporosis
Dialysis
Prostate (BPH):
Chronic Pain Syndrome
Fibromyalgia
Poor Circulation
Memory loss
Parkinson's
Neuropathy
Lupus
Bleeding disorders

Other Conditions:

____

____

____

____

____

NEUROPATHY
TREATMENT CLINICS OF TEXAS

SURGICAL HISTORY

Provide history for the past 5 years. **Include any distant surgeries relevant to current nerve pain**.

Procedure	Date of Surgery	Complications?

FAMILY HISTORY

(place a check for all that apply)

	FATHER	MOTHER	BROTHER	SISTER
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Please Circle	Alive/Deceased	Alive/Deceased	Alive/Deceased	Alive/Deceased
	Age _______	Age _______	Age _______	Age _______

FUNCTIONAL ASSESSMENT

Are you able to walk, stand, sit unassisted?	YES/ NO
Assistive devises used for walking?	YES/ NO
Can you get up out of a chair unassisted?	YES/ NO
Do you have difficulty with your balance?	YES/ NO

NEUROPATHY
TREATMENT CLINICS OF TEXAS

Patient Name ________________________________ **Date:** ____________________

ALLERGIES

____

____

____

____

MEDICATIONS

Name:	Dosage:

Do I Need a Test for PAD?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys become narrowed or clogged. It affects over 8 Million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk of stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Circle YES or NO:

1. Do you have foot, calf, buttock, hip or thigh discomfort when you walk which is relieved by rest?	**YES**	**NO**
2. Do you experience ongoing pain at rest in your lower legs or feet?	**YES**	**NO**
3. Do you experience foot or toe pain that often disturbs your sleep?	**YES**	**NO**
4. Do your toes or feet become pale, discolored, or bluish easily?	**YES**	**NO**
5. Do have you had skin wounds or ulcers on your feet or toes that are slow to heal?	**YES**	**NO**
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	**YES**	**NO**
7. Have you suffered a severe injury to the leg(s) or feet?	**YES**	**NO**
8. Do you have persistent infection of the leg(s) or feet that have become complicated (gangrenous/black skin tissue)?	**YES**	**NO**

Patient Signature: ____

Physician Signature: ______________________________ Date: ____________