

625 Jenks Avenue - Panama City, Florida 32401 Office: (850) 215-5657 Fax (850) 215-5658

Neuropathy Pain/Numbness Questionnaire

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_ ST\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your pain or numbness the result of an accident? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, where did it occur? Circle one: Home Work Vacation Car Other

(Describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain / Numbness / Neuropathy Information**:

What is the main problem for which you are seeking treatment at Green Wave?

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Please describe the location of your pain or numbness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long have you had your current pain or numbness problem:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How did your current pain or numbness start? Was there a precipitating event?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How do the following affect your pain, numbness or tingling? (please circle one for each item)

**Lying Down**  Decrease No Effect Increase

**Standing** Decrease No Effect Increase

**Sitting**  Decrease No Effect Increase

**Walking** Decrease No Effect Increase

**Exercise** Decrease No Effect Increase

**Medication** Decrease No Effect Increase

Are there other factors that make your pain, numbness or tingling

 better?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are the weight you desire? \_\_\_\_\_Underweight \_\_\_\_\_Good weight \_\_\_\_\_Overweight

Have you ever been in treatment for misuse of alcohol or drugs? \_\_\_\_Y \_\_\_\_N

If yes, where and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your pain, numbness or tingling intensity on a scale from 0 (no pain) to 10 (excruciating, incapacitating, worst possible). Rate your pain, numbness or tingling during the past month.

 Your pain, numbness at its worst \_\_\_\_\_

 Your pain, numbness at its least \_\_\_\_\_

 Your average pain, numbness \_\_\_\_\_

 Your current pain, numbness \_\_\_\_\_

How often do you have your pain, numbness or tingling?

 \_\_\_\_\_Constantly (100% of the time) \_\_\_\_\_Nearly constantly(60-95% of time)

 \_\_\_\_\_Intermittently (30-60% of time) \_\_\_\_\_Occasionally (less than 30% of time)

Have you ever had psychiatric, psychological, or social work evaluations or treatments for any problem, including your current pain? \_\_\_\_Y \_\_\_\_N

If yes, what and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please circle all of the treatments you have tried for your pain, numbness or tingling:**

Hospital bed rest Traction Surgery Exercise

Nerve block or injection TENS(electrical stimulator) Physical Therapy

Psychotherapy

Which ones helped you the most? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which ones helped you the least? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Circle or mark the areas on the picture above where you are experiencing your pain, numbness or tingling. Indicate your pain or numbness type by labeling the circled or marked areas above with a letter or letters describing the sensations as noted in the following list:

 a) deep (inside)

 b) Superficial (on the skin)

 c) constant (all the time)

 d) intermittent (starts and stops)

 e) aching

 f) burning

 g) shooting

Your signature below indicates that you understand that you are solely responsible for any treatment rendered in the Neuropathy program packages. All services rendered to you are charged directly to you once you become a neuropathy program package patient, and you are personally responsible for payment. Other than the chiropractic services, the neuropathy program is a package that is not reimbursed by insurance due to the natural, alternative approaches used. Your signature also indicates that you authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I provided.

**X** Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Use Only:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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History:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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