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?
____

Please describe the location of your pain or numbness:_______________________________
____

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

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

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:

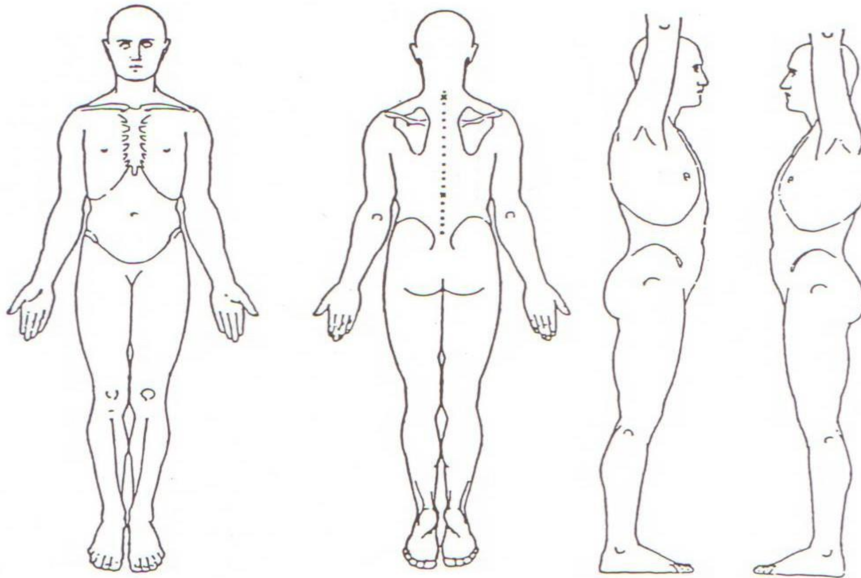
Hospital bed rest Traction Surgery Exercise

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:____

____

____

____

____

____

History:____

____

____