ADVANCED NERVE & HEALTH CENTER INTAKE FORM

Date:_____/_____/_____

Name:_____ Birthday: _____/_____/_____ Age: _____

Preferred to be called: _____ Spouse's Name: _____

E-Mail:_____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____

Zip Code: _____ Home #: _____ Cell #: _____

Occupation: _____ Employer: _____ Retired: ☐ Y ☐ N

How Did You Hear About Us? _____

EMERGENCY NOTIFICATION INFORMATION

In the event of an emergency, whom should we contact?

Name: _____ Relation to patient: _____

Home #: _____ Cell #: _____ Work #: _____

PREFERRED PAYMENT METHOD

❑ Care Credit ❑ Credit Card ❑ Other ❑ Cash/Check ❑ Insurance Only

Primary Insurance: _____ Secondary Insurance: _____

Please provide a copy of your insurance card and driver's license.

TRANSPORTATION/APPOINTMENTS

- **Are you able to drive yourself to and from your scheduled appointment times? ☐ Y ☐ N**
- **If No, do you have someone that can bring you to your appointments? ☐ Y ☐ N**
- **Which TWO days works best for you to attend your appointments?**

What time of Day?

- ☐ **Monday**
- ☐ **Tuesday**
- ☐ **Wednesday**
- ☐ **Thursday**
- ☐ **Friday**

- ☐ **Early Morning**
- ☐ **Mid-Morning**
- ☐ **Noon**
- ☐ **Afternoon**

DOCTOR(S) YOU'VE SEEN FOR THIS CONDITION

Names of All Doctors & Facilities You Have Seen for CURRENT CONDITION and Treatment Received.

Doctor & Facility Name:	Treatment:	Phone Number:
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS

Name:	Dose (MG or IU):	Purpose (ex: high blood pressure):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List of Medications Attached: ☐

Are You Using:

- ☐ **Pain Creams: _____**
- ☐ **Pain Killers: _____**
- ☐ **Blood Thinners: _____**
- ☐ **Neurontin: (_____mg/times per day _____)**
- ☐ **Gabapentin: (_____mg/ times per day _____)**
- ☐ **Lyrica**
- ☐ **Cymbalta**

ALLERGIES

List ALL Allergies (or Sensitivities) to Medicines, Foods, and other items.

Item you react to:	Reaction:
_____	_____
_____	_____
_____	_____

PERSONAL HEALTH HISTORY

CHECK ALL THAT APPLIES:

- ☐ **Do You Smoke? Packs Per Day: _____**
- ☐ **Do You Drink? _____ Drinks per Day / Week / Month**
- ☐ **Exercise Regularly: Type: _____**
- ☐ **Unable to Walk For 30 Minutes Without Symptoms**
- ☐ **Sit to Stand with Difficulty**
- ☐ **Able to Work**
- ☐ **Deemed Disabled: Year _____**

On A Scale of 0 To 10, How Would You Rate Your Pain Level: 0 = No Pain 10 = Worse Pain

How Would You Rate Your Symptoms in The LAST WEEK? _____ TODAY? _____

AFTER Completing the Treatment Plan, What Would Be an Acceptable Level of Pain? _____

What is Your CHIEF COMPLAINT that You Want Addressed? _____

PRESENT HEALTH CONDITION

CERVICAL /Neck Year_____
- ☐ Stenosis
- ☐ Herniated Discs
- ☐ Degenerative Discs

THORACIC/upper back Year _____
- ☐ Stenosis
- ☐ Herniated Discs
- ☐ Degenerative Discs

LUMBAR/lower back Year _____
- ☐ Stenosis
- ☐ Herniated Discs
- ☐ Degenerative Discs

FOOT # of Years _____
- ☐ Foot Drop
- ☐ Swelling
- ☐ Gout
- ☐ Balance Issues

HAND # of Years _____
- ☐ Difficulty Grasping Things
- ☐ Carpal Tunnel Syndrome

DO YOU USE A:
- ☐ Walker
- ☐ Wheel Chair
- ☐ Cane
- ☐ Brace

SURGERIES
- ☐ Laminectomy Area _____ Year _____
- ☐ Discectomy Area _____ Year _____
- ☐ Fusion Area _____ Year _____
- ☐ Other: _____
- ☐ Hip Replacement Year _____
- ☐ Knee Replacement Year_____
- ☐ Foot Surgery Year _____
- ☐ Amputation Year _____

- ☐ Pacemaker Year _____
- ☐ Stents Year _____
- ☐ Bypass Year _____
- ☐ Defibrillator Year _____

TESTS:
- ☐ Cervical MRI Year: _____
- ☐ Lumbar MRI Year: _____
- ☐ Doppler Study Year: _____
- ☐ NCV / EMG Year: _____
- ☐ X-Ray Year: _____
- ☐ CT Scan Year: _____

ENDOCRINE

Diabetes:
Type 1 ☐ Type 2 ☐
How Many Years? _____
Fasting Blood Sugar _____
A1C _____

HEART
- ☐ High Blood Pressure
- ☐ (BP: _____/_____)
- ☐ Congestive Heart Failure: Year _____
- ☐ Heart Attack: Year _____
- ☐ Stroke: Year _____

CANCER
- ☐ Type _____ Active ☐ Remission ☐
- ☐ Chemo or Radiation: Year _____

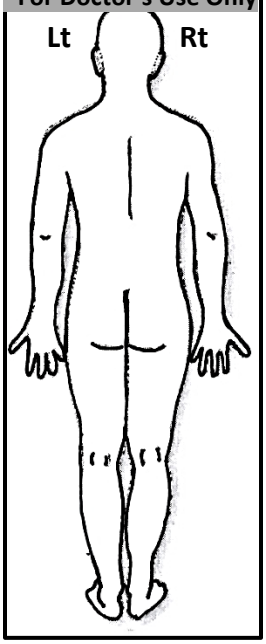
- ☐ Parkinson's/Alzheimer's/MD

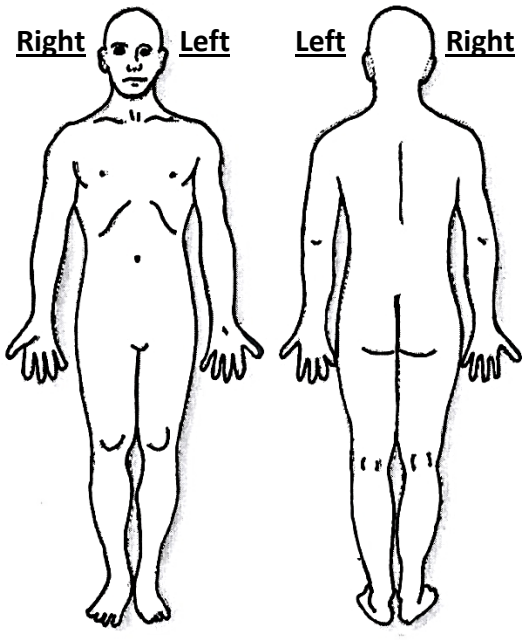
AREAS & TYPES OF PAIN

Please mark the types of symptoms on the drawing below using the codes listed:

N- Numbness T- Tingling S- Soreness P- Pain A- Ache St- Stiffness

For Doctor's Use Only





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Is This Condition Interfering with Any of The Following?

□ Sleep □ Walking □ Recreational Activities □ Standing □ Work □ Housework □ Daily Activities

How Long Have You Been Searching for Answers for this Problem? _____

What brings you here today? Information? Treatment? _____

What treatment have you had prior to this visit? _____

What Do You Think Is Causing Your Problem? _____

Over the Past 6 months to a Year, Have Your Symptoms: □ Improved □ Worsened □ Stayed the Same

Anything That Makes Your Condition Worse? _____

Anything That Makes Your Condition Better? _____

Is There A Certain Time of Day Any of These Problems Are Better or Worse? _____

What Do You Know or Understand About Neuropathy? _____

Do You Understand That Neuropathy Only Gets Worse Without Treatment? _____

What additional treatment options have you tried? _____

____Hormone Replacement ___Tens Unit ___Stem Cell Injections ___ IV Therapy ___ CBD ___ Injections

Notes :

_____

_____

_____

_____