



## 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 ☐ Apply For Financing

### 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

- ☐ 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:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Name: \_\_\_\_\_ Initials: \_\_\_\_\_

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## MEDICATIONS

Name:

Dose (MG or IU):

Purpose (ex: high blood pressure):

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List of Medications Attached: 

Are You Currently 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:

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## PERSONAL HEALTH HISTORY

CHECK ALL THAT APPLIES:

☐ Do You Smoke? Packs Per Day: \_\_\_\_\_

☐ Unable to Walk For 30 Minutes Without Symptoms

☐ Do You Drink?

☐ Sit to Stand with Difficulty

☐ \_\_\_\_\_ Drinks per Day / Week / Month

☐ Able to Work

☐ Exercise Regularly:

☐ Deemed Disabled: Year \_\_\_\_\_

Type: \_\_\_\_\_

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?

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Patient Name: \_\_\_\_\_ Initials \_\_\_\_\_

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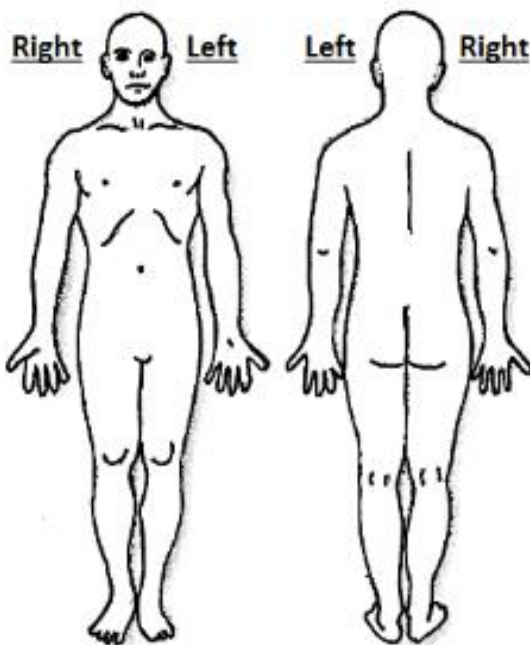
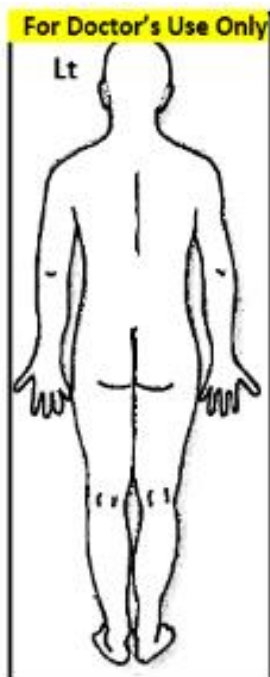
## PRESENT HEALTH CONDITION

<b>CERVICAL /Neck</b> Year _____ <input type="checkbox"/> Stenosis <input type="checkbox"/> Herniated Discs <input type="checkbox"/> Degenerative Discs	<b>THORACIC/upper back</b> Year _____ <input type="checkbox"/> Stenosis <input type="checkbox"/> Herniated Discs <input type="checkbox"/> Degenerative Discs	<b>LUMBAR/lower back</b> Year _____ <input type="checkbox"/> Stenosis <input type="checkbox"/> Herniated Discs <input type="checkbox"/> Degenerative Discs
<b>FOOT</b> # of Years _____ <input type="checkbox"/> Foot Drop <input type="checkbox"/> Swelling <input type="checkbox"/> Gout <input type="checkbox"/> Balance Issues	<b>SURGERIES</b> <input type="checkbox"/> Laminectomy Area _____ Year _____ <input type="checkbox"/> Discectomy Area _____ Year _____ <input type="checkbox"/> Fusion Area _____ Year _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Hip Replacement      Year _____ <input type="checkbox"/> Knee Replacement      Year _____ <input type="checkbox"/> Foot Surgery      Year _____ <input type="checkbox"/> Amputation      Year _____	<div style="border: 1px dashed black; padding: 5px;"> <input type="checkbox"/> Pacemaker      Year _____  <input type="checkbox"/> Stents      Year _____  <input type="checkbox"/> Bypass      Year _____  <input type="checkbox"/> Defibrillator      Year _____         </div>
<b>HAND</b> # of Years _____ <input type="checkbox"/> Difficulty Grasping Things <input type="checkbox"/> Carpal Tunnel Syndrome <b>DO YOU USE A:</b> <input type="checkbox"/> Walker <input type="checkbox"/> Wheel Chair <input type="checkbox"/> Cane <input type="checkbox"/> Brace		<b>TESTS:</b> <input type="checkbox"/> Cervical MRI      Year: _____ <input type="checkbox"/> Lumbar MRI      Year: _____ <input type="checkbox"/> Doppler Study      Year: _____ <input type="checkbox"/> NCV / EMG      Year: _____ <input type="checkbox"/> X-Ray      Year: _____ <input type="checkbox"/> CT Scan      Year: _____
<b>ENDOCRINE</b> <b>Diabetes:</b> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> How Many Years? _____ Fasting Blood Sugar _____ A1C _____	<b>HEART</b> <input type="checkbox"/> High Blood Pressure (BP: _____/_____) <input type="checkbox"/> Congestive Heart Failure: Year _____ <input type="checkbox"/> Heart Attack: Year _____ <input type="checkbox"/> Stroke: Year _____	<b>CANCER</b> <input type="checkbox"/> Type _____ Active <input type="checkbox"/> Remission <input type="checkbox"/> <input type="checkbox"/> Chemo or Radiation: Year _____ <hr/> <input type="checkbox"/> 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



DOCTOR NOTES ONLY:

Patient Name: \_\_\_\_\_ Initials \_\_\_\_\_

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## PRESENT HEALTH CONDITION

### 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 treatment have you had prior to this visit? (check all that apply)

\_\_\_\_ Hormone Replacement \_\_\_\_ Tens Unit \_\_\_\_ Stem Cell or Other Injections \_\_\_\_ IV Therapy \_\_\_\_ CBD  
\_\_\_\_ Physical Therapy \_\_\_\_ Cold Laser Therapy \_\_\_\_ Infrared Light Therapy \_\_\_\_ Other, Not Listed

Did any of the treatments you checked work for you? \_\_\_\_\_

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

How do you usually get relief for your discomfort? \_\_\_\_\_

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

Did Your Doctor explain Neuropathy to you? \_\_\_\_\_

Were You Told That Neuropathy Will Improve Over Time? \_\_\_\_\_

Additional Notes for the Doctor :

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## Medical History and Consent for Treatment

I certify that the above information is accurate, complete and true.

I authorize Advanced Nerve & Health Center DFW and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Advanced Nerve & Health Center DFW to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review Advanced Nerve & Health Center DFW's Notice of Privacy Practices, which is displayed for public inspection at its facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Advanced Nerve & Health Center DFW to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Advanced Nerve & Health Center DFW to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that Advanced Nerve & Health Center DFW will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Initials \_\_\_\_\_

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## What is Neuropathy?

Approximately 20 million Americans are living with peripheral neuropathy. While the term "neuropathy" simply means "nerve damage," peripheral neuropathy is the impairment of the nerves in the body's outer extremities -- such as the hands and feet. While the explanation for an individual's neuropathy is sometimes unknown, a wide range of factors can cause it. Here are some causes of this chronic neurological disease.

- Trauma from injury and repetitive stress is the most common cause, and medical treatments, like certain types of chemotherapy and surgeries, can damage nerves.
- Nearly 70 percent of people with diabetes live with some level of neuropathy.
- Inflammation from autoimmune diseases like lupus and rheumatoid arthritis can destroy nerve fibers.
- The majority of people on dialysis for kidney disease develop neuropathy because excess toxic chemicals accumulate and damage nerves.
- Infections, both bacterial and viral, are a major cause of neuropathy.
- Heavy drinking can cause nerve damage.

### But What About Insurance? Medicare Won't Cover This?!

We understand how hard it is to live with neuropathy. We only wish that our innovative treatment services were available to everyone through Medicare and insurance. Many people often mistake that we as a clinic CHOOSE to not accept Medicare or major insurance. The nature of our treatment process is regenerative, which is to restore and generate nerve function.

We believe that we can no longer be dependent on insurance companies to determine what type of care and treatments we are able to give. The reality is, it is up to you on choosing how you want to treat your body and chronic pain, not an insurance company. Traditional medicine is needed, but it's time we move beyond it and no longer use just medication and surgery to heal ourselves. The use of regenerative medicine can be exactly what you are looking for to help you achieve your functional goals.

A few different reasons why insurance companies do not pay for regenerative medicine treatment is a result of the Medicare guideline, section 2251.3: This states ***"if a treatment is designed to help prevent disease, promote health, and extend and improve the quality of life; or a therapy is being used to either maintain or prevent deterioration of a chronic condition, it is essentially believed to be not medically necessary."*** And when it comes to regenerative medicine, the goal is to help prevent further deterioration, which fits in this statement.

Even if you don't have Medicare, most insurance companies have the same viewpoint as Medicare guidelines, which again says, because it's a "regenerative process" and is supposed to prevent additional deterioration that Medicare will not cover the cost.

Because we have years of success in treating our patients by regenerating and rejuvenating nerves and relieving nerve related pain; it is our continued mission to educate, innovate and treat all those that suffer from neuropathy.

## Insurance coverage should never dictate your quality of life.

We're here to help.

Patient Name: \_\_\_\_\_ Initials \_\_\_\_\_

# PATIENT FINANCING: Every Patient Is Approved

## What You Need to Know Before Your In-Office Neuropathy Consultation

During your consultation, your Doctor and/or Nurse will spend whatever time is necessary to respond to your questions and address all your concerns. He or she wants to make sure you have all the information you need to make an informed decision on the personalized neuropathy treatment plan, with realistic expectations about the outcome.

Finally, you will be informed about available treatment dates that will accommodate your schedule. You will also meet with your patient advocate to discuss the investment involved in your treatment plan.

We have found options to help our patients take on the financial obligation, along with providing incentives and savings opportunities. If you wish to try financing, please fill out the following information.

Please note: **We will not proceed with any financing until you have all your options.** The choice is always yours.

### Do You Have a Lender Preference?

\_\_\_\_\_ CareCredit \_\_\_\_\_ LendingUSA

### Patient Name:

\_\_\_\_\_

### Patient Social Security:

\_\_\_\_\_

### CO-APPLICANT NAME (not mandatory)

\_\_\_\_\_

### Co-Applicant Social Security:

\_\_\_\_\_

### Gross Monthly Income

(please check one box):

- ☐ \$2200 – \$3500
- ☐ \$3600 - \$4200
- ☐ \$4300 - \$5000
- ☐ \$5100 - \$6000

Do you RENT or OWN (circle one please)

Monthly Rent/Mortgage: \_\_\_\_\_

### Employment Status of Patient:

- ☐ Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Military
- ☐ Self Employed

### Employment Status of Co-Applicant:

- ☐ Employed
- ☐ Unemployed
- ☐ Retired
- ☐ Military
- ☐ Self Employed

### Current or Previous Employer:

\_\_\_\_\_

Years With Employer: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Initials \_\_\_\_\_

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