Neuropathy Consult ROF

blueprint to Neuropathy

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ **Nickname** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email** _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____ **Social Security** _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name _____ **Phone Number** _____

Your Occupation _____ **Retired?** Yes ☐ No ☐

REVIEW OF SYMPTOMS

Please check all that apply

☐ Foot Pain	☐ Diabetes	☐ Spinal Stenosis	☐ Cancer	☐ Pinched Nerve
☐ Hand Pain	☐ High Cholesterol	☐ Degenerative Disc	☐ Chemotherapy	☐ Poor Circulation
☐ Low Back Pain	☐ High Blood Pressure	☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacement
☐ Neck Pain	☐ Pacemaker/ Defibrillator	☐ Leg Pain	☐ Arthritis in Feet	☐ Foot Surgery
☐ Foot Numbness	☐ Herniated Disc	☐ Plantar Fasciitis	☐ Implanted Cord/ Bladder Stimulator	☐ Poor wound healing
☐ Hand Numbness	☐ Bulging Disc	☐ Morton's Neuroma	☐ Sciatica	☐ Excessive thirst or urination

PRESENT HEALTH CONDITION

In order of importance, list the health problems you are most interested in getting corrected:

1. _____
2. _____
3. _____
4. _____

List approximately how long you have noticed these problems:

1. _____
2. _____
3. _____
4. _____

Is there a certain time of day any of these problems are better or worse?

_____

_____

_____

_____

List the things you have used for these problems:

Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Medications Aleve Tylenol Ibuprofen Motrin Chiropractic Massage Therapy Injections Creams

Is your balance/walking ability affected? *If yes, please describe:*

_____

_____

_____

What do you think is causing your problem?

_____

_____

_____

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Have your symptoms: ☐ Improved ☐ Worsened ☐ Stayed the same

List anything that makes your condition worse _____

_____

List anything that makes your condition better _____

_____

How would you describe the symptoms? Please check ALL that apply

☐ Aching Pain	☐ Numbness	☐ Hot Sensation	☐ Cramping
☐ Stabbing Pain	☐ Tingling	☐ Throbbing Pain	☐ Swelling
☐ Sharp Pain	☐ Pins & Needles Pain	☐ Dead Feeling	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

Is this condition interfering with any of the following?

☐ Sleep	☐ Work	☐ Daily Activities
☐ Recreational Activities	☐ Walking	☐ Standing

SOCIAL HISTORY

Do you smoke? Yes ☐ No ☐ If yes, how many cigarettes daily? _____

Do you drink? Yes ☐ No ☐ If yes, how many drinks per week? _____

Do you exercise regularly? Yes ☐ No ☐ If yes, please describe type & how often: _____

_____

_____

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN POSSIBLE

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PREVIOUS HEALTH HISTORYHEALTH

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ ***Signature*** _____

Please give name, address, and office phone number of your primary care physician.

Name _____ ***Phone*** _____ ***Address*** _____

When were you last seen there?

_____

May we send them updates on your treatment/condition? Yes ☐ No ☐

List ALL allergies/sensitivities to medication, food, and other items here:

Item you react to:	*Reaction:*

List the prescription drugs you are currently taking (or you may attach a list):

Name	*Dose (mg or IU)*	*Times Daily*

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

Patient Quality Of Life Survey Example

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PRACTICE INFORMATION HERE

Patient Quality Of Life Survey

Name: _____ ***Date:*** _____

Please take several minutes to answer these questions so we can help you get better.
(Please circle as many that apply)

1. How have you taken care of your health in the past?
   - **a.** Medications
   - **b.** Emergency Room
   - **c.** Routine Medical
   - **d.** Exercise
   - **e.** Nutrition/Diet
   - **f.** Holistic Care
   - **g.** Vitamins
   - **h.** Chiropractic
   - **i.** Other (please specify): _____

2. How did the previous method(s) work out for you?
   - **a.** Bad results
   - **b.** Some results
   - **c.** Great results
   - **d.** Nothing changed
   - **e.** Did not get worse
   - **f.** Did not work very long
   - **g.** Still trying
   - **h.** Confused

3. How have others been affected by your health condition?
   - **a.** No one is affected
   - **b.** Haven't noticed any problem
   - **c.** They tell me to do something
   - **d.** People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?
   - **a.** Job
   - **b.** Kids
   - **c.** Future ability
   - **d.** Marriage
   - **e.** Self-esteem
   - **f.** Sleep
   - **g.** Time
   - **h.** Finances
   - **i.** Freedom

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5. Are there health conditions you are afraid this might turn into?

   a. Family health problems
   b. Heart disease
   c. Cancer
   d. Diabetes
   e. Arthritis
   f. Fibromyalgia
   g. Depression
   h. Chronic Fatigue
   i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What would that mean to you?

FINANCIAL POLICY

For Champaign Chiropractic Clinic

The following statement is our Financial Policy. It is required that the patient and/or responsible party read and sign this statement prior to any treatment.

Co-Pays

All co-pays and deductibles are due at time of service. If you are unable or unwilling to pay the co-pay, your appointment will be rescheduled until such a time that you can pay the co-pay.

Workers' Compensation

You must notify us prior to being seen by the physician if we are seeing you for a work related injury. Your employer must complete and sign an "employer's worker's compensation acknowledgement" form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number if applicable). This information must be provided to us prior to treatment.

Liability Injury

If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

*auto accident: if you were injured in your own car you must provide us with the name and address of your auto insurance company, your agent/adjuster's name, telephone number, your claim number and date of accident. If your injury occurred in someone else's car, we require all of the above information "and" the following, their name, the name and address of their auto insurance company, their agent/adjuster's name, telephone number and their claim number. We do not bill 3rd party insurance.

*slip and fall, etc: if you were injured on residential property or in a residential dwelling, we require the following, homeowner's name, the name and address of their homeowner's insurance company, their agent/adjuster's name, telephone number, their claim number and the date of accident. If your injury occurred at a place of business, please provide basically the same information.

Delinquent Account

You understand that your balance is due upon receipt of your statement. If you do not pay the balance in full within 60 days of the statement, your account will become delinquent. You agree to pay a finance charge at the rate of 1 1\2% per month (18% per year) on all unpaid balances commencing 60 days from the date of service. You also agree to pay a $20.00 service charge on all returned checks.

Collection Costs and Procedures

I agree to pay all reasonable costs you incur to collect this debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency costs, service fees, and other related collection costs or contingencies. I understand that if any unpaid balance is turned over to our collection agency that a fee ranging from 30%-50% will be added to the total balance due. I hereby give you or any of your agents or assignees to whom you turnover any unpaid balance permission to obtain a report from a credit reporting agency and to take reasonable steps to verify my credit and or employment information. I give you or any of your agents or assignees to whom you turnover any unpaid balance to contact me regarding this transaction or any future transaction at any telephone numbers of which they are aware including cellular telephones by manually dialing, using an auto-dialer or pre-recorded message. **By signing below you affirm that you read and understood our Financial Policy and that you agree to its contents.**

No-show, Cancellation, and Late Arrival Policy

Effective 7/22/2019 all appointments must be cancelled if you are unable to attend within a 24-hour period. Failure to notify any of our staff that you will not be coming to your scheduled appointment will result in a $25.00 no-show fee. You will also be considered a no-show if you arrive 30 minutes or greater for your scheduled appointment time. This will also result in a $25.00 no-show fee. CMS and all other medical insurance companies will not cover late cancellation, missed appointments, or late arrivals, therefore the patient will be financially liable.

Champaign Chiropractic Clinic will be enacting this new policy to ensure that all of our patients have a positive experience in our office as well as allowing someone else your appointment time. The new policy will ensure that our staff and doctors can work more efficiently without having to alter their schedules due to one or two patients.

We sincerely hope our patients never have to be charged for such events. However, when multiple patients are waiting days and in some cases a week or more for an appointment, a last minute cancellation/no-show/late patient affects not only the doctors but also other patients.

Thank you for understanding!

Kindly,

Champaign Chiropractic Clinic

Signature:_____