NEUROPATHY
TREATMENT CLINICS OF TEXAS

16300 ADDISON RD. SUITE 300, ADDISON, TX 75001

Date of Consult: _____

Referring Doctor: _____

Last Name: _____ First Name: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

DOB:_____ SS#: _____ Email:_____

Occupation: _____ Employer: _____

Ethnicity: _____

INSURANCE

Primary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____

Secondary Insurance: _____

Policy #: _____ Group #: _____

Policy Holder's Name: _____ DOB: _____

How did you hear about us?: _____

Primary Care Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

EMERGENCY CONTACT

Contact Name: _____ Relationship: _____

Phone: _____ Patient Signature: _____

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NEUROPATHY HISTORY

What is your concern with respect to nerve pain: (circle all that apply):

Pain	Numbness	Tingling Pain with Touch	Shooting Shocks
Burning	Aching Sensitivity	Pins and needles	Tightness

Where is your pain **AND** when did it begin?

_____
_____

Have you ever had a nerve conduction study? If yes, when and where was the study done?

_____
_____

Are you diabetic?

_____
_____

What else is important for us to know?

_____
_____

Please rate your overall pain on a scale from 0-10 over the 1-2 weeks. (0 no pain 10 severe pain)

Pain	Numbness	Tingling	Burning	Tightness

SOCIAL HISTORY

Tobacco use? YES/ NO/ FORMER If YES what is your typical usage per day?_____
Alcohol use? YES/ NO If YES how many drinks per day? Type_____
Illegal drug use? YES/ NO/ FORMER If YES what substance? _____
Do you take NSAIDS (Motrin, Aleve, Advil, Naproxen, etc.) regularly? YES/ NO _____

IMPLANTS

Do you have Pacemaker? YES/ NO
Do you have a Defibrillator? YES/ NO
Pacemaker/ Defibrillator dependent? YES/ NO
Do you have a Spinal Cord Stimulator or other nervous system implant? YES/ NO
Do you have a seizure disorder? YES/ NO

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MEDICAL HISTORY

Circle all that apply

HEAD:
Trauma

EYES:
Blindness
Cataracts
Glaucoma
glasses/contacts

EARS:
Hearing aids

NOSE/SINUSES:
Allergic Rhinitis
Sinus infections

MOUTH/THROAT:
Dentures

CARDIOVASCULAR:
Aneurysm
Angina
DVT (thrombosis)
Dysrhythmia
Hypertension
Murmur
Myocardial Infarction (heart attack)

RESPIRATORY:
Asthma
Bronchitis
COPD
Emphysema
Pleuritis
Pneumonia

GASTROINTESTINAL:
Cirrhosis
GERD
Gallbladder disease
Heartburn
Hemorrhoids
Hepatitis
Hiatal hernia
Jaundice
Ulcers

GENITOURINARY:
Hernia
Incontinence
Kidney Stones
Other Kidney Disease:
UTI (s)

MUSCULOSKELETAL:
Arthritis
Gout
Injury

DERMATOLOGICAL:
Dermatitis
Mole(s)
Other skin conditions
Psoriasis

NEUROLOGICAL:
Epilepsy
Seizures
Severe headaches/ Migraine
Stroke
TIA

PSYCHIATRIC:
Bipolar disorder
Depression
Hallucinations/ delusions
Suicidal Ideation
Suicide attempts

ENDOCRINE:
Goiter
Hyperlipidemia/cholesterol
Hypothyroidism
Thyroid disease
Thyroiditis
Type I DM
Type II DM

HEMATOLOGY/ONCOLOGY:
Anemia
Cancer: _____

INFECTIOUS DISEASE:
HIV
STD
Tuberculosis (dz)
Tuberculosis (exposure)

AUTOIMMUNE/CUSTOM:
Amputation
Osteoporosis
Dialysis
Prostate (BPH):
Chronic Pain Syndrome
Fibromyalgia
Poor Circulation
Memory loss
Parkinson's
Neuropathy
Lupus
Bleeding disorders

Other Conditions:

_____
_____
_____
_____
_____

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SURGICAL HISTORY

Provide history for the past 5 years. **Include any distant surgeries relevant to current nerve pain**.

Procedure	Date of Surgery	Complications?

FAMILY HISTORY

(place a check for all that apply)

	FATHER	MOTHER	BROTHER	SISTER
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Thyroid	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Please Circle	Alive/Deceased	Alive/Deceased	Alive/Deceased	Alive/Deceased
	Age _____	Age _____	Age _____	Age _____

FUNCTIONAL ASSESSMENT

Are you able to walk, stand, sit unassisted?	YES/ NO
Assistive devises used for walking?	YES/ NO
Can you get up out of a chair unassisted?	YES/ NO
Do you have difficulty with your balance?	YES/ NO

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Patient Name _____ **Date:** _____

ALLERGIES

_____

_____

_____

_____

MEDICATIONS

Name: **Dosage:**

_____

_____

_____

_____

_____

_____

_____

_____

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Do I Need a Test for PAD?

Peripheral Artery Disease (PAD) is a serious circulatory problem in which the blood vessels that carry blood to your arms, legs, brain, or kidneys become narrowed or clogged. It affects over 8 Million Americans, most over the age of 50. It may result in leg discomfort with walking, poor healing leg sores/ulcers, difficult to control blood pressure, or symptoms of stroke. People with PAD are at significantly increased risk of stroke and heart attack. Answers to these questions will determine if you are at risk for PAD and if a vascular exam will help us better assess your vascular health status.

Circle YES or NO:

1. Do you have foot, calf, buttock, hip or thigh discomfort when you walk which is relieved by rest?	**YES**	**NO**
2. Do you experience ongoing pain at rest in your lower legs or feet?	**YES**	**NO**
3. Do you experience foot or toe pain that often disturbs your sleep?	**YES**	**NO**
4. Do your toes or feet become pale, discolored, or bluish easily?	**YES**	**NO**
5. Do have you had skin wounds or ulcers on your feet or toes that are slow to heal?	**YES**	**NO**
6. Has your doctor ever told you that you have diminished or absent pedal (foot) pulses?	**YES**	**NO**
7. Have you suffered a severe injury to the leg(s) or feet?	**YES**	**NO**
8. Do you have persistent infection of the leg(s) or feet that have become complicated (gangrenous/black skin tissue)?	**YES**	**NO**

Patient Signature: _____

Physician Signature: _____ Date: _____