PERIPHERAL NEUROPATHY

APPLICATION FOR ADMISSION

Cenk Integrated Health and Spine Centers

If you are reading this you have taken the next step towards living and experiencing a better quality of life. This however does NOT mean that your case has been accepted.

Your exam today will determine if:

*You are a legitimate candidate for this program and your condition is serious enough to warrant your case being accepted for treatment.

* In the event your condition IS serious enough for acceptance and if the Doctor is UNABLE to oversee your treatment, you will be referred to another clinic.

Today's date ______________

Name: ____________________________________ Age: __________ DOB: _____________
Sex: M / F SS#:_____________________________ Marital Status: S / M / W / D
Address: ____
City: ____________________________ State: _____________ Zip: _______________
Home # __________________ Work # __________________ Cell # ___________________
Preferred way to contact you (circle one) Home / Work / Cell
May we leave a voice mail? Yes / No
Employer: __________________________ Occupation: ____________________________
Emergency Contact: ____________________ Phone #:______________ Relationship:__________
PCP: _____________________________________ Phone # ____________________________
Address: ____

I (signature) ___________________________ consent to allow Cenk Integrated Health & Spine Centers to speak with me and preform an examination in order to determine if I am a candidate for the Peripheral Neuropathy Program and also to determine if they are willing to accept my case. It is my understanding that this exam and/or further treatment is not covered by insurance and will not be billed as such.

How did you hear about Cenk Integrated Health and Spine Centers?

____

How serious do you think your problem is?

____

What is the main problem/symptom prompting your request for a consultation with the doctor?

____

Would you consider this problem…
MINIMAL (annoying but causing no limitations)
SLIGHT (tolerable but causing a little limitation)
MODERATE (sometimes tolerable but definitely causing limitations)
SEVERE (causing significant limitations)
EXTREME (causing near constant (80% or more of the time) limitations)

1. In spite of the fact that you are not a nerve specialist, you are in fact the person who knows more about your condition than anyone else. In your own words what do you think the real problem is?

____

____

2. What are you hoping happens today as a result of your consultation with the doctor?

____

____

3. Since your neurological problem has become so severe, what three things has it caused you to miss the most?

____

____

4. How long have you been like this?

____

____

5. How has your life changed since your neuropathy became a problem?

____

____

6. What kind of treatments have you received?

Medication	how many______	when______
Surgery	type____________	when______
Other ____		

7. When did you receive these treatments and for how long?

____

____

8. Do any of these medications work? If so which one(s)? For how long?

____

____

9. Is there anything that you can do that makes it feel better?

____

____

10. What activities/movements are guaranteed to make it worse?

____

____

11. Please describe the quality of pain. (sharp, achy, toothache, shooting, stabbing, numb, tingling, etc...)

____

____

12. Is it worse in the morning or does it get worse as the day progresses?

____

____

13. Is your balance getting worse and are you becoming afraid of falling?

____

____

14. What are you hoping the Doctor tells you today?

____

____

15. Describe what you hope or think he might be able to do for you.

____

____

16. Describe what will be better in your life if you can get better.

____

____

List in order of importance all OTHER health concerns NOT including your main problem above.

1.______________________ for how long?_____________
2.______________________ for how long?_____________
3.______________________ for how long?_____________
4.______________________ for how long?_____________

In reference to your main problem, how often are you aware of the problem?
Occasionally (25% of the time)
Intermittently (50% of the time)
Frequently (75% of the time)
Constantly (90-100% of the time)

Due to your main problem...
Have you lost any time from work? Yes No
How much time and from what tasks have you been limited?

____

Have you lost any time from your chores/tasks at home? Yes No
How much time and what tasks have been limited?

____

Have you lost time with your family? Yes No
How much time and what tasks have been limited?

____

Have you lost any time with your leisure activities? (hobbies, travel, sports, etc.) Yes No
How much time and what tasks have been limited?

____

Considering the amount of pain/discomfort you have experienced THIS week, how long has your problem been this severe?

____

On a scale of 0-10 (10 being unbearable, 0 being no pain or discomfort at all) Please rate the following.

The highest your pain gets WITHOUT medication. ________
The lowest your pain gets WITHOUT medication ________
The highest your pain gets WITH medication. ________
The lowest your pain gets WITH medication. _______

List ANY surgeries that you have had and the corresponding dates.

____
____

Have you had any of these in the last 12 months or currently?
(mark C for currently and X for in the last 12 months)

GENERAL

Chills___ Convulsions____ dizziness____ fainting____ fatigue____ fever____ headache____
loss of sleep____ allergy____(to what___________) loss of weight_____ nervousness____
wheezing____ bronchitis____ numbness in both hands and feet_____

CARDIOVASCULAR

High blood pressure____ low blood pressure____ pain over heart____ poor circulation____
rapid heartbeat____ previous heart problems____ describe__________________) slow
heartbeat____ stroke____ TIA____ swollen ankles____ varicose veins____ aortic
aneurysm____ bruise easily____

DISEASE/CONDITIONS

Appendicitis____ anemia____ arthritis____ alcoholism____ abdominal surgery____
bleeding disorder____ blood clot____ breathing difficulty____ cancer____ cholesterol high____
colon problems____ diabetes____ depression____ epilepsy____ eczema____ eating
disorders____ glaucoma____ HIV+____ heart disease____ hernia____ headaches____
influenza____
kidney disease____ liver disease____ low back pain____ mental illness____ measles____
mumps____ pleurisy____ pneumonia____ polio____ prostate problems____ hyperthyroid____
hypothyroid____ rectal surgery____

EARS/EYES/NOSE/THROAT

Asthma____ crossed eyes____ double vision____ blurred vision____ difficulty swallowing____
deafness____ hearing loss____ ear pain____ thyroid problems____ nose bleeds____
sinus problems____ sore throats____

GASTRO-INTESTINAL

Gas____ colon trouble____ constipation____ diarrhea____ gallbladder trouble____
hemorrhoids____ liver trouble____ nausea____ stomach ache____ poor appetite____ poor
digestion____ vomiting____ vomiting blood____ rectal bleeding____ bloating____

GENITO-URINARY

Blood in urine____ frequent urination____ inability to control urine____ kidney infection____
painful urination____ prostate trouble____

FOR MEN ONLY

Lump in testacies____ penis discharge____

FOR WOMEN ONLY

Menstrual cramps____ excessive menstrual flow____ hot flashes____ irregular cycle____
painful periods____ birth control pills____ abnormal pap smear____

MUSCLE/JOINT/BONE

Backache____ foot trouble____ pain between shoulders____ painful tailbone____ stiff neck____
spinal curvature____ swollen joints

NEUROLOGIC

Seizures____ dizziness____ hand trembling____ weakness____ difficulty with speech____
loss of memory____ loss of coordination____

RESPIRTORY

Chest pain____ chronic cough____ difficulty breathing____ coughing/spitting blood____

NEUROPATHY SCREENING INSTRUMENT

HISTORY: PLEASE CIRCLE ALL SYMPTOMS YOU EXPERIENCE ON A NORMAL BASIS.

NUMBNESS **BURNING** **TINGLING**

SHARP PAIN **ELECTRICAL PAIN** **CRAMPING**

PRICKLING **WEAKNESS** **BACK PAIN**

TEMPERATURE SENSITIVITY **DIFFICULTY WALKING**

DIFFICULTY SLEEPING **CRACKED SKIN**

OTHER:

____

____

____

1. **What time of day are your symptoms the worst?**

   ____

2. **Have you ever had an open sore or wound?**

   ____

3. **Can you sense your feet when you walk?** **YES** **NO**
4. **Does it hurt when bed covers touch you?** **YES** **NO**
5. **Has your doctor ever told you that you have diabetic neuropathy?** **YES** **NO**
6. **Have you ever had an amputation?** **YES** **NO**