EXCLUSIVE NERVE & DISC CENTERS | A NON-INVASIVE PRACTICE ®

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

Name _____ **Nickname**_____

Address_____

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

Phone _____ **Email** _____

We will need to contact you both by phone and 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 you 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 Disk
☐ Chemotherapy	☐ Poor Circulation	☐ Low Back Pain	☐ High blood pressure
☐ Vascular Problems	☐ Arthritis in Hands	☐ Joint Replacement	☐ Neck Pain
☐ Leg Pain	☐ Arthritis in Feet	☐ Pacemaker/Defibrillator	☐ Foot Surgery
☐ Foot Numbness	☐ Herniated Disc	☐ Poor wound healing	☐ Bulging Disc
☐ Morton's Neuroma	☐ Hand Numbness	☐ Excessive Thirst/Urination	☐ Sciatica
☐ Plantar Fasciitis	☐ Implanted Cord/Bladder Stimulator		

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Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:	List approximately how long you have noticed these problems:
1)_____	1)_____
2)_____	2)_____
3)_____	3)_____
4)_____	4)_____

Is there a certain time of day any of these problems are better or worse?	**List the thins you have used for these problems:**
_____	
_____ _____	☐ Gabapentin ☐ Neurontin ☐ Lyrica ☐ Cymbalta
_____ _____	☐ Physical Therapy ☐ Pain medication ☐ Aleve
_____ _____	☐ Tylenol ☐ Ibuprofen ☐ Motrin ☐ Creams
_____ _____	☐ Injections ☐ Chiropractic ☐ Physical Therapy. ☐ Massage Therapy

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Is your balance/walking ability affected?

☐ YES ☐ NO

If yes, please describe

_____

_____

_____

_____

_____

_____

_____

_____

What do you think is causing your problem?

_____

_____

_____

_____

_____

_____

_____

_____

Name of all doctors you have seen for these problems and treatment you received:

_____

_____

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	☐ Dead feeling	☐ Pins & Needles Pain	☐ Burning
☐ Tiredness	☐ Heavy Feeling	☐ Cold Hands/Feet	☐ Electric Shocks

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Is this condition interfering with any of the following?

Sleep	Work	Daily Activities	Housework
Walking	Standing	Recreational Activities	Shopping

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 WORST PAIN POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

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

NO PAIN WORST PAIN POSSIBLE

0 1 2 3 4 5 6 7 8 9 10

Previous health history

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. Please sign here indicating that we can release copies by your verbal request.

Name _____ **Signature**_____

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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*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____ _____ _____
_____ _____ _____

List all nutritional supplements (vitamins, herbs, homeopathies, etc):

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