NAPLES HEALTH INSTITUTE

Room#: _____
Video Playing? Yes_____ NO_____
Video Started @ _____

Outcome of Appointment

Today's Date: _____

Legal Name: _____ Email: _____

Birthdate: _____ Sex: M____ F_____ Work status: (Circle) Employed Retired

Marital Status (Circle): Single Married Widowed Separated Other: _____

Address: _____ City: _____ State: _____ Zip_____

Home: _____ Cell: _____ Work: _____

Emergency Contact: Name: _____ Relationship: _____Phone: _____

How did you hear about us: _____

Please provide Insurance Card and ID at the front desk

Do you have health insurance: Yes No Do you have Primary and secondary Insurance: Yes No

Primary Insurance Company: _____ Policy ID: _____

Secondary Insurance Company: _____ Policy ID: _____

Medical Information Release Form (HIPPA Release Form) Release of information

() I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

() Spouse _____

() Other _____

This *Release of information* will remain in effect until terminated by me in writing.

Patient Signature: _____ Date: _____

How has this health condition affected your job, relationships, finances, family, or other activities?

Please give examples:

_____

_____

_____

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

1_____ 2._____ 3._____

What are you most concerned with regarding your problem?

_____

_____

_____

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

_____

_____

_____

How have you taken care of your health in the past? (Circle)

A. Medication C. Routine Medical E. Exercise G. Emergency Room I. Nutrition/Diet
B. Vitamins D. Chiropractic F. Holistic Care H. other _____

How did these methods above workout for you? (Circle)

A. Bad Results C. Great results E. Did not work for very long.
B. No Results D. Nothing changed F. Sill trying

How have others been affected or are you concerned by your health condition? (circle)

A. No one is affected C. They tell me to do something about it.
B. Have not noticed any problem D. People avoid me.

What are you afraid this might be (or beginning) to affect (or will affect)? Circle all that apply.

A. Job B. Kids C. Future ability D. Marriage E. Self-esteem F. Sleep G. Time H. Finance I. Freedom

Informed Consent

I hereby consent to the examination process.

_____ ___/___/___ _____

Patient or Authorized Person's signature Date Witness Initials

Please circle all that apply.

Diabetes Pacemaker Balance issues Foot/ Leg Pain Foot Numbness Chemo/ Cancer

Vascular Problems Hand Pain Hand Numbness Arthritis /Hands or Feet Pain/ Neck -Low back

How would you describe your symptoms: Please circle all that apply?

Aching Pain Numbness Cramping Burning Heavy Feeling /Tiredness

Stabbing Pain Tingling Swelling Throbbing Pain Hot sensation

Sharp Pain Pins and Needles Pain Dead Feeling Cold Hands /Feet Electric Shocks

How would you rate your pain in the last week on a scale 1-10 most pain possible _____

Is this condition interfering with any of the following? Please circle all that apply.

Sleep Work Daily Activities Walking Standing Recreational activities.

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

_____

In order of importance list the health problems you are most interested in getting corrected. List Approximately how long you have noticed these problems. DO NOT LEAVE BLANK

1._____ How Long: _____

2._____ How Long: _____

3._____ How Long: _____

Have you had previous or are in current treatment for Neuropathy. If so please list the type of treatment.

_____

Do you use any tobacco products? Yes No **Type of Product?** Pipe Chew Cigars Dip Cigarettes

If no, did you use tobacco in the past Yes No

Do you drink alcohol Yes No

How many drinks in a week? 7 7-14 14

Do you use any recreational substances? (circle) Marijuana Cocaine Pills Steroids inhalants

Hallucinogens Other: _____

List any Drug, Environment of food allergies if none please write NONE: _____

Please list medications, vitamins, and nutritional supplements that you are currently taking:

**********************If you have a Med list we can make a copy************************

Medication/Vitamin/Supplement	Dosage	Reason for Taking