Important News About Your Upcoming Consultation!

Dear Patient,

I want to be the first to welcome you to our clinic! We have you scheduled for a consultation and treatment qualification evaluation with Dr. Ammon Jacobson DC.

We have included a "***PN Intake Form***" along with this letter. We ask that you take the time to answer all the questions completely and honestly to the best of your knowledge. You will need to bring this form and your medications list along with you to your scheduled appointment. The information you provide will give the doctor a more detailed understanding about the history of your condition and will assist him in determining if you are a good candidate to undergo our specialized non surgical treatment.

In order for you to gain the most benefit from this consultation you are required to bring your spouse, partner, significant other or relative along with you. Due to the sheer volume of information from Dr. Terry Smith, DC about the nature of neuropathy, we have found that patients are unable to satisfactorily relay the necessary information to friends and family to make a treatment decision. If the doctor determines that your condition can be safely and effectively treated, he will then be revealing a great deal of information to you as it relates to his findings of your condition and the details of your customized treatment plan.

As a friendly reminder, if you've previously undergone an MRI, CT Scan, X-rays or Nerve

Conduction tests within the last three years that are associated with your current physical problem, we ask that you **bring these films and/or the medical radiology reports along with you.**

If you do not have possession of these films and reports you can simply contact the physician who ordered these tests or the radiology center where they were performed and you can request that the medical radiology reports be faxed to our office (at 719-390-8313) prior to your appointment. If you are unable to make this request from your previous doctor, we can easily assist you at the time of your appointment by making any necessary calls for you.

You are welcome to contact our office at **(719) 390-5404**. We look forward to meeting you soon!

Warmest Regards,

Dr. Ammon Jacobson DC and staff

SMITH CHIROPRACTIC CLINIC LLC

DR. AMMON JACOBSON D.C.

1825 MAIN ST – UNIT C

COLORADO SPRINGS, CO 80911

(719) 390-5404

Directions:

From the North:

Head south on I-25. Take exit 135. At the light turn left. Go .7 miles to the Bradley Rd exit. At the bottom of the off ramp there is a traffic circle. Go ¾ of the way around the circle and go east on Bradley (it is as if you are turning left onto Bradley without a traffic circle). Travel east to Hancock Rd sign and turn right. This road turns into Main St. We are on the left about 3 blocks down in a stucco building.

From South:

Head north on I-25. Take exit 135- South Academy. Turn right at the bottom of the ramp. Go .7 miles to the Bradley Rd exit. At the bottom of the off ramp there is a traffic circle. Go ¾ of the way around the circle and go east on Bradley (it is as if you are turning left onto Bradley without a traffic circle). Travel east to Hancock Rd sign and turn right. This road turns into Main St. We are on the left about 3 blocks down in a stucco building.

Please call us at 719-390-5404 if you have any trouble finding our office.

Please bring your paperwork completed and arrive 10 minutes early or your appointment may have to be rescheduled.

We look forward to seeing you then!

NeuroTCC
Neuropathy Treatment Center of Colorado

Dr. Ammon Jacobson DC

1825 Main St, Unit C ● Colorado Springs ● CO ● 80911

719-390-5404

(Please Print)

Patient Name: _____ Today's Date: _____

PATIENT INFORMATION					
Today's date:		**Primary Care Physician:**			
Patient's last name: First:		Middle:		Marital status (circle one) Single / Mar / Div / Sep / Wid / Sig Other	
Is this your legal name? ☐ **Yes** ☐ **No**	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ☐ M ☐ F
Street address:	Social Security No. :	Home phone no. : ( ) Cell phone no. : ( )			
P.O. Box:	City:	State:	ZIP Code:		
Occupation:	Employer:	Employer phone no. : ( )			
Chose clinic because / Referred to clinic by (please check one box): ☐ Dr. Referral ☐ newspaper ☐ Hospital ☐ Family/Friend ☐ TV ☐ Dinner Event ☐ Mailer ☐ Other					
Email:	Spouse's Name:				
Please List any other family members/friends involved in your health decisions:					
We often find our patients have the desire to help others suffering from nerve damage. List other family members/friends who's lives would improve with understanding of their condition: Name: Phone Number:					
Insurance Name:	☐ PPO ☐ HMO ☐ Other _____				

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address)	Relationship to patient:	Home phone no. : ( )	Work phone no. : ( )

The above information is true to the best of my knowledge.

Patient/Guardian signature: *Date:*

Personal History

Check all conditions that apply to you:

General	Neurological	Psychiatric	Respiratory
☐ Fatigue, tiredness ☐ Weakness ☐ Chills ☐ Fever ☐ Night sweat ☐ Appetite change ☐ Lived in foreign country ☐ Unexplained weight loss ☐ Unexplained weight gain ☐ Generalized pain ☐ Unable to tolerate heat ☐ Unable to tolerate cold ☐ Sedentary lifestyle ☐ Active lifestyle ☐ Other _____	☐ Fainting spells ☐ Seizures ☐ Paralysis ☐ Dizziness ☐ Tremor ☐ Chronic headaches ☐ Poor balance ☐ Fractured back or neck ☐ Numbness of face / arm / leg ☐ Peripheral neuropathy ☐ Stroke or Mini – stroke ☐ Other _____	☐ Depression ☐ Anxiety (abnormal) ☐ Panic attacks ☐ Alzheimer's ☐ Confusion (abnormal) ☐ Hospitalized for nervousness ☐ Substance abuse ☐ Anorexia ☐ Other _____	☐ Chronic obstructive disease ☐ Wheezing ☐ Chronic cough ☐ Coughing up blood ☐ Asthma ☐ Shortness of breath ☐ TB ☐ Lung Cancer ☐ Emphysema ☐ Chronic bronchitis ☐ Pneumonia ☐ Fluid in lungs ☐ Need to sleep sitting up ☐ Other _____
Cardiac	**Vascular**	**Gastrointestinal**	**Genitourinary**
☐ Angina (chest pain) ☐ Rapid heartbeat ☐ Past heart attacks ☐ Heart murmur ☐ Congestive heart failure ☐ High blood pressure ☐ Aortic aneurysm ☐ Other heart problem ☐ **Pacemaker** ☐ **Defibrillator** ☐ Other_____	☐ Leg pain walking over 1 block ☐ Leg pain walking less than 1 block ☐ Pain in legs while at rest ☐ Blood clots in legs ☐ Deep ☐ Superficial ☐ Cold feet or hands ☐ Amputation of toes ☐ Amputation of feet or legs ☐ Peripheral vascular disease ☐ Ulcers of lower legs ☐ Varicose viens ☐ Aneurysm of arteries ☐ Other _____	☐ Diarrhea ☐ Constipation ☐ Stool changes ☐ Bowel habits changes ☐ Hemorrhoids ☐ Indigestion ☐ Ulcers ☐ Irritable bowel ☐ Colon polyps ☐ Cramps/ pains ☐ Cancer of the stomach or bowel ☐ Diverticulitis ☐ Other _____	☐ Hesitancy / urgency of urine ☐ Need to urinate often at night ☐ Loss of bladder control ☐ Difficult urination ☐ Renal failure ☐ Impotence ☐ Current Dialysis ☐ Renal transplant ☐ Prostate enlargement ☐ Cancer of bladder/ kidneys ☐ Other _____
Blood & Lymph System	**Eyes, Ears, Nose & Throat**	**Musculoskeletal**	**Skin**
☐ Anemia ☐ Blood disease ☐ Transfusions ☐ Leukemia ☐ Bone marrow test ☐ Long term Coumadin use ☐ Blood clotting problems ☐ Other _____	☐ Pain ☐ Hearing loss ☐ Polyps ☐ Vertigo ☐ Ringing in ears (tinnitus) ☐ Sinus infections ☐ Deafness ☐ Other _____	☐ Arthritis ☐ Joint swelling ☐ Joint stiffness ☐ Muscle aches ☐ Muscle weakness ☐ Leg cramps ☐ Other _____	☐ Rashes ☐ Tumors ☐ Sensitivity to sunlight ☐ Malignant melanoma ☐ Squamous cell carcinoma ☐ Basal cell carcinoma ☐ Easy bruising ☐ Fungal infections ☐ Non-healing sores ☐ Excessive rough or dry skin ☐ Other _____
Endocrine	**Abnormal Organs**		
☐ Thyroid problems ☐ **Diabetes – Type 1** ☐ **Diabetes – Type 2**	☐ Hepatitis ☐ Cirrhosis (Liver) ☐ Gallbladder disease	Height: _____ Weight: _____	

Medications – Please list all medications you are currently taking:

Name	Dosage	Name	Dosage

If you need additional space, Please use the back of this page.

Patient Name: _____ Today's Date: _____

What is your major complaint?

_____
_____
_____

How long have you had this problem?

_____
_____

Before you began having this problem was there an earlier condition, accident, or injury that could have brought this problem about? ☐ Yes ☐ No If so please describe:

_____
_____
_____

What have you tried for treatment that did not work?

_____
_____

Have you seen a M.D. , P.T. , or a D.C. for this problem?
☐ Yes ☐ No

Doctor's Name	Specialty	Year(s) Seen

How does this problem interfere with your daily day life?

_____
_____
_____

Have you been worried about getting this problem resolved?
☐ Yes ☐ No If yes, please describe:

_____
_____
_____

What is your main concern about your symptoms?

_____
_____
_____

On a scale from 1 to 10 (with 10 being the highest), what is your interest in getting help for the problem?

	0	1	2	3	4	5	6	7	8	9	10