# 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. Terry Smith, DC.

We look forward to meeting you on:___________________________________________________________

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. Terry Smith, DC and Staff

**Dr. Terry Smith, DC 1825 Main St – Unit C, Colorado Springs, CO 80911**

## TELL US ABOUT YOU (Please Print Clearly)

| Name: | | | Social Security#: | | Date: |
|---|---|---|---|---|---|
| Date of Birth: | Age: | Sex: M F | Marital Status M S D W | # of children: | |
| Address: | | | | | |
| City: | | | State: | Zip: | |
| Home Phone #: | | | Cell #: | | |
| E-mail Address: | | | | | |
| Spouse's Name: | | | | | |
| Occupation (Current or Previous) | | | | | Retired: Y N |
| Current or Previous Work | Clerical: Y N | Light Labor: Y N | Moderate Labor: Y N | Heavy Labor: Y N | |
| In Case of Emergency Contact Name | | | Phone Number: | | |

**TELL US ABOUT YOUR PAST HEALTH:**

| Y | N | ← Lower Back Pain | Y | N | ← Diabetes (A1C = ______) | Y | N | ← High Cholesterol |
|---|---|---|---|---|---|---|---|---|
| Y | N | ← Leg or Foot Pain/Numbness | Y | N | ← Hand Problems | Y | N | ← Shingles |
| Y | N | ← Prior Spinal Surgeries | Y | N | ← Neuropathy | Y | N | ← Cancer - Chemotherapy |
| Y | N | ← Spinal Fractures | Y | N | ← Heart Attack | Y | N | ← Kidney issues or Dialysis |
| Y | N | ← Spinal Stenosis | Y | N | ← Heart Problems | Y | N | ← Gout |
| Y | N | ← Spinal Arthritis | Y | N | ← High / Low Blood Pressure | Y | N | ← Knee/Hip/Foot Surgery |
| Y | N | ← Sciatica | Y | N | ← Vascular Leg Problems | Y | N | ← Leg Fractures |
| Y | N | ← Neck Pain | Y | N | ← Vascular Surgery _______ | Y | N | ← Joint Replacement |
| Y | N | ← Herniated Disc | Y | N | ← Stroke | Y | N | ← Plantar Fasciitis |

**TELL US ABOUT ANY MEDICATIONS YOU CURRENTLY ARE TAKING OR HAVE PREVIOUSLY TAKEN:**

| **Y** | **N** | ← LIPITOR (Atorvastatin) | **Y** | **N** | ← ZETIA (Ezetimibe) | **Y** | **N** | ← CYMBALTA (Duloxetine) |
|---|---|---|---|---|---|---|---|---|
| **Y** | **N** | ← CRESTOR (Rosuvastatin) | **Y** | **N** | ← HYDROCHLOROTHIAZIDE | **Y** | **N** | ← ELAVIL (Amitriptyline) |
| **Y** | **N** | ← ZOCOR (Simvastatin) | **Y** | **N** | ← BLOOD PRESSURE MEDS | **Y** | **N** | ← EFFEXOR (Venlafaxine) |
| **Y** | **N** | ← ALTOCOR (Lovastatin) | **Y** | **N** | ← LYRICA (Pregabalin) | **Y** | **N** | ← OXYCONTIN (Oxycodone) |
| **Y** | **N** | ← MEVACOR (Lovastatin) | **Y** | **N** | ← NEURONTIN (Gabapentin) | **Y** | **N** | ← LIDODERM PATCH |
| **Y** | **N** | ← LESCOL (Fluvastatin) | **Y** | **N** | ← TRILEPTAL (Oxacarbaziine) | **Y** | **N** | ← CAPSAICIN (Zostrix) |
| **Y** | **N** | ← PRAVACHOL (Atorvastatin) | **Y** | **N** | ← TOPAMAX (Topiramate) | **Y** | **N** | ← OVER THE COUNTER MED |

**PLEASE LIST ANY MEDICATIONS AND/OR VITAMINS YOU ARE CURRENTLY TAKING:**

| PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD: | |
|---|---|
| | |
| NAME OF YOUR PRIMARY CARE PHYSCIAN: | |
| PLEASE LIST BELOW ANY **BACK** OR **LEG SURGERIES** YOU'VE HAD? | |
| | |
| HAVE YOU HAD AN **EMG** PERFORMED ON YOUR LEGS/FEET? ⑥ NO | ⑥ YES - WHEN: |
| DO YOU EXERCISE REGULAR? ⑥ NO | ⑥ YES - WHAT: |
| ARE YOUR SYMPTOMS **WORSE AT NIGHT**? ⑥NO | ⑥ YES – AROUND WHAT TIME: |

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Name ______________________________________ Date_______________

REASON FOR THIS VISIT:

| WHAT KIND OF PROBLEM(S) ARE YOU HAVING: |
|---|
| |
| |
| ON A SCALE, HOW WOULD YOU RATE YOUR SYMPTOMS (10 is the worst) 1 2 3 4 5 6 7 8 9 10 |
| WHEN DID THIS BEGIN: |
| WHAT MAKES IT BETTER: |
| |
| WHAT MAKES IT WORSE: |
| |

| HOW WOULD YOU DESCRIBE YOUR SYPMTOMS (Circle any that apply) | Stabbing-Sharp | Electric Shocks | Cold | Tingling | Pins + Needles | Dead Feeling | Throbbing |
|---|---|---|---|---|---|---|---|
| | Burning | Stings | Ache | Numbness | Swelling | Tiredness | Cramping |

| WHAT DO YOU THINK IS CAUSING YOUR PROBLEM: |
|---|
| |

| IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING: (Circle any that apply) | | | | | | |
|---|---|---|---|---|---|---|
| WORK | SLEEP | DAILY ROUTINE | CHORES | WALKING | STANDING | SHOPPING |

**How would you describe your average back/leg pain over the past week?**

No pain Worst possible pain

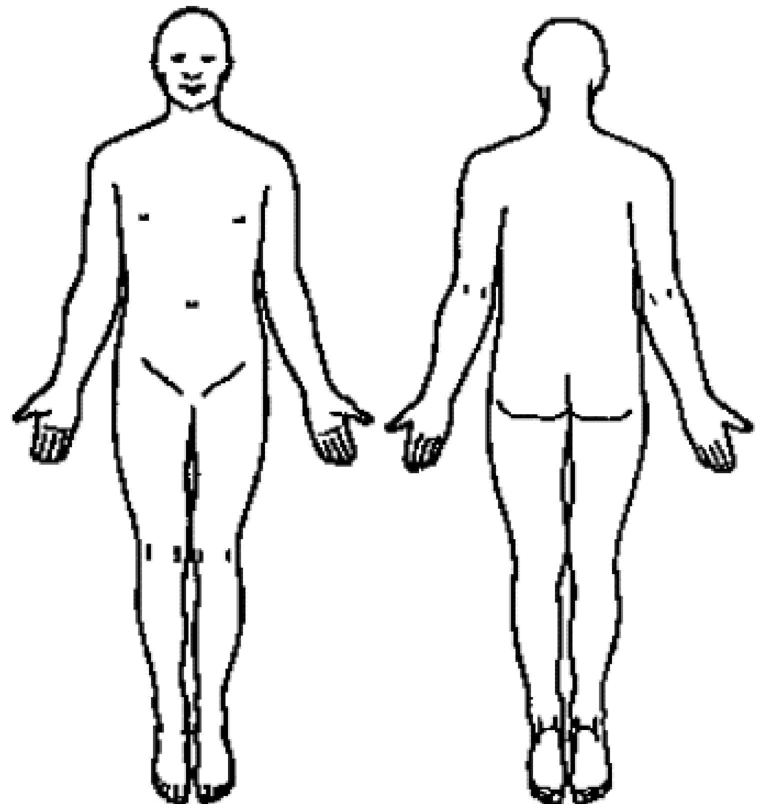
0 1 2 3 4 5 6 7 8 9 10

**Please indicate what you consider to be an acceptable level of pain after completion of the treatment, if you have to accept some pain?**

No pain Worst possible pain

0 1 2 3 4 5 6 7 8 9 10

**Please indicate on these drawings the body area(s) where you are currently experiencing symptoms:**



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**Name __________________________________ Date______________**

**TELL US ABOUT HOW THIS IS AFFECTING YOU:**

| What are your symptoms like at their worst: | | |
|---|---|---|
| | | |
| | | |
| Is your **balance** or **walking ability** starting to be affected? ⑥ NO If yes, describe below in what way(s): | | |
| | | |
| | | |
| Which of the following is **true** for your condition: (check one of the following) | | |
| ____ It's getting better on it's own | ____ It's staying the same | ____ It's getting worst as time goes by |
| List any daytime activities (you **used to be able to do** when you were feeling better) that are now limited: | | |
| | | |
| | | |
| | | |
| List the three main "health goals" that you would like to accomplish: | | |
| 1) | | |
| 2) | | |
| 3) | | |

A. I hereby authorize release of any medical information necessary to evaluate my case or process any future claims.
B. I authorize payment of any medical benefits from third parties for any future charges submitted to be paid directly to this office.
C. I understand and agree that health policies are an arrangement between an insurance carrier and myself. Therefore I understand that all future services are charged directly to me and agree to be personally responsible for payment.

We invite you to discuss with us any questions regarding our services and or fees. The best health services are based on a friendly, mutual understanding between the provider and patient.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature ________________________________________ Date _________________________

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

☐ Referral ☐ Colorado Springs Gazette ☐ Internet ☐ Health Fair
☐ Other ___________________________

# Subjective Peripheral Neuropathy Screen Questionnaire

Full name:______________________________________________ Date ___________

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check **yes** or **no** based on how you usually feel. Thank you

1. Do you ever have legs and/or feet that feel numb? ☐ Yes ☐ No

2. Do you ever have any burning pain in your legs and/or feet? ☐ Yes ☐ No

3. Are your feet too sensitive to touch? ☐ Yes ☐ No

4. Do you get muscle cramps in your legs and/or feet? ☐ Yes ☐ No

5. Do you ever have any prickling or tingling feelings in your legs or feet? ☐ Yes ☐ No

6. Does it hurt at night or when the covers touch your skin? ☐ Yes ☐ No

7. When you get into the tub or shower, are you <u>unable</u> to tell the hot water from the cold water with your feet? ☐ Yes ☐ No

8. Do you ever have any sharp, stabbing, shooting pain in your feet or legs? ☐ Yes ☐ No

9. Have you experienced an asleep feeling or loss of sensation in your legs or feet? ☐ Yes ☐ No

10. Do you feel weak when you walk? ☐ Yes ☐ No

11. Are your symptoms worse at night? ☐ Yes ☐ No

12. Do your legs and/or feet hurt when you walk? ☐ Yes ☐ No

13. Are you unable to sense your feet when you walk? ☐ Yes ☐ No

14. Is the skin on your feet so dry that it cracks open? ☐ Yes ☐ No

15. Have you ever had electric shock-like pain in your feet or legs? ☐ Yes ☐ No

Diagnostic utility of the subjective peripheral neuropathy screen in HIV-infected persons with peripheral sensory polyneuropathy. Venkataramana AB, Skolasky RL, Creighton JA, McArthur JC. AIDS Read. 2005 Jul;15(7):341-4, 348-9, 354.

## Walking Scale Questionnaire

Name ______________________________ Date ____________________

These questions ask about limitations to your walking due to peripheral neuropathy during the past 2 weeks . For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of you consultation.

| In the past 2 weeks how much has your peripheral neuropathy… | Not at all | A little | Moderately | Quite a bit | Extremely |
|---|---|---|---|---|---|
| Limited your ability to walk? | 1 | 2 | 3 | 4 | 5 |
| Limited your ability to run? | 1 | 2 | 3 | 4 | 5 |
| Limited your ability to climb up or down stairs? | 1 | 2 | 3 | 4 | 5 |
| Made standing when doing things more difficult? | 1 | 2 | 3 | 4 | 5 |
| Limited your balance when standing or walking? | 1 | 2 | 3 | 4 | 5 |
| Limited how far you are able to walk? | 1 | 2 | 3 | 4 | 5 |
| Increased the effort needed for you to walk? | 1 | 2 | 3 | 4 | 5 |
| Made it necessary for you to use support when walking indoors, eg holding on to furniture, using a cane, etc? | 1 | 2 | 3 | 4 | 5 |
| Made it necessary for you to use support when walking outdoors, eg using a cane or walker, etc? | 1 | 2 | 3 | 4 | 5 |
| Slowed down your walking? | 1 | 2 | 3 | 4 | 5 |
| Affected how smoothly you walk? | 1 | 2 | 3 | 4 | 5 |
| Made you concentrate on your walking? | 1 | 2 | 3 | 4 | 5 |

Thank you for completing this questionnaire

WALKING SCALE DISABILITY SCORE: < NORMAL, 13-27 MILD, 28-45 MODERATE, >63 SEVERE DISABILITY

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