ADVANCED NERVE & HEALTH CENTER PATIENT INTAKE

Date:_____/_____/_____

Name:_____ Birthday: _____/_____/_____ Age: _____

Preferred to be called: _____ Spouse's Name: _____

E-Mail:_____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____

Zip Code: _____ Home #: _____ Cell #: _____

Occupation: _____ Employer: _____ Retired: Y ☐ N ☐

How Did You Hear About Us? _____

☐ Good Morning Texas ☐ D Magazine ☐ Doctor Referral ☐ Patient Referral ☐ Commercial ☐ Internet

EMERGENCY NOTIFICATION INFORMATION

In the event of an emergency, whom should we contact?

Name: _____ Relation to patient: _____

Home #: _____ Cell #: _____ Work #: _____

TRANSPORTATION/APPOINTMENTS

- Are you able to drive yourself to and from your scheduled appointment times? ☐ Y ☐ N
- If No, do you have someone that can bring you to your appointments? ☐ Y ☐ N
- Which TWO days works best for you to attend your appointments? What time of Day?

☐	Monday	Early Morning	☐
☐	Tuesday	Mid-Morning	☐
☐	Wednesday	Noon	☐
☐	Thursday	Afternoon	☐

CURRENT MEDICATIONS:_____

MEDICATION + DOSAGE	FOR THE TREATMENT OF	PRESCRIBED BY

PATIENT MEDICAL HISTORY (please add year diagnosed or started)

HEAD:	RESPIRATORY:	MUSCULOSKELETAL	ENDOCRINE:
☐ Trauma	☐ Asthma	☐ Arthritis	☐ Goiter
EYES:	☐ Bronchitis	☐ Gout	☐ High Cholesterol
☐ Blindness	☐ COPD	☐ M/S Injury	☐ Hypothyroidism
☐ Cataracts	☐ Pleuritis	☐Thyroid disease	
☐ Glaucoma	☐ Pneumonia	☐ Osteoarthritis	☐ Thyroiditis
☐ Glasses/contacts	☐ Lung disease	☐ Rheumatoid arthritis	☐ Type I Diabetes
EARS	**GASTROINTESTINAL:**	☐ Osteoporosis	☐ Type II Diabetes
☐ Hearing aids	☐ Cirrhosis		
NOSE/SINUSES:	☐ Gallbladder disease	**SKIN**	**HEME / ONC:**
☐ Allerigies	☐ Heartburn	Dermatitis	☐ Anemia
☐ Sinus Infection	☐ Hemorrhoids	Mole(s)	☐ Cancer
MOUTH/THROAT/TEETH:	☐ Hepatitis	Other	☐ Bleeding disorder
☐ Dentures	☐ Hiatal Hernia	Psoriasis	☐ Bleeds easily
CARDIOVASCULAR:	☐ Jaundice		☐ Blood clots
☐ High Blood Pressure	☐ Stomach Ulcer	**NEUROLOGICAL:**	**FEET**
☐ Angina	**GENITOURINARY:**	☐ Epilepsy	☐ Foot Drop
☐ DVT	☐ Hernia	☐ Seizures	☐ Swelling
☐ Dysrhythmia	☐ Incontinence	☐ Severe headaches, migraines	☐ Gout
☐ Hypertension	☐ Nephrolithiasis	☐ Stroke	☐ Balance Issues
☐ Murmur	☐ Other kidney disease	☐ TIA	**HAND**
☐ Myocardial Infarction (heart attack)	☐ Liver disease	☐ Alzheimer' s	☐ Difficulty Grasping ☐ Carpel Tunnel
☐ Heart Failure (CHF)	**LUMBAR / Low Back**	**CERVICAL / NECK**	**THORACIC**
☐ Other heart disease	☐ Stenosis	☐ Stenosis	☐ Stenosis
CANCER	☐ Herniated Discs	☐ Herniated Discs	☐ Herniated Discs
☐ Type _____ ☐ Active? Yes / No ☐ Remission? Yes / No	☐ Degenerative Discs	☐ Degenerative Discs	☐ Degenerative Discs
☐ Chemo or Radiation YEAR: _____			

Patient Name: _____ Initials _____ **Page**

PAST SURGICAL HISTORY – Common Surgeries:	**(Circle All That Apply & Add Date)**		
Aneurysm repair	Cataract/ lens surgery	Knee replacement Knee scope	Sinus surgery
Appendectomy	Cesarean section	LASIK	Skin cancer excision
Back surgery	Cholecystectomy/ bile duct surgery	Laminectomy	Spinal fusion
Bariatric surgery/ Gastric bypass	Dilation & curettage	Nasal Surgery	TAH-BSO
Bilateral tubal litigation	Hemorrhoid surgery	PTCA/PCI	TURP
Breast resection /mastectomy	Hip scope	Pacemaker/ defibrillator	Tonsillectomy/ adenoidectomy
CABG	Hip Replacement	Prostate surgery	Vasectomy
Carotid endarterectomy (stent)	Hysterectomy	Prostatectomy	
Carpal tunnel release	Inguinal hernia repair.	Rotator cuff surgery	

PHYSICIAN INFORMATION

Names of All Doctors & Facilities You Have Seen for CURRENT CONDITION and Treatment Received.

Primary Care Doctor: _____ Facility: _____
Phone: _____ Diagnosis: _____

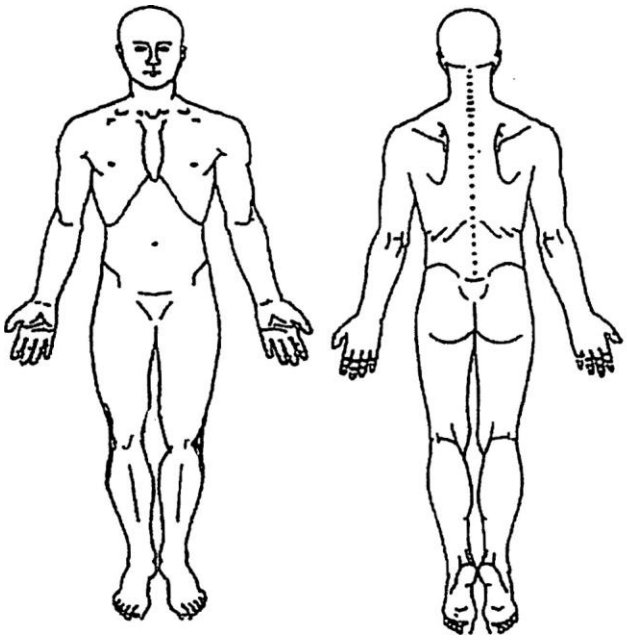
Chiropractor: _____ Facility: _____
Phone: _____ Diagnosis: _____

Oncologist: _____ Facility: _____
Phone: _____ Diagnosis: _____

Neurologist: _____ Facility: _____
Phone: _____ Diagnosis: _____

Please mark the types of symptoms on the drawing below using the codes listed:

N- Numbness T- Tingling S- Soreness P- Pain A- Ache St- Stiffness



Pain level with medication? _____/10_____

Pain level w/o medication? _____/10_____

What aggravates your pain? _____

When relieves your pain? _____

Where is your worst area of pain located? _____

When did your pain begin? _____

List any additional areas of pain: _____

_____

What word **best describes** the frequency of your pain?

☐ Constant ☐ Intermittent

When is your pain at its **worst?** ☐ Mornings

☐ During the day ☐ Evenings ☐ Middle of the night

PRESENT HEALTH CONDITION

Is This Condition Interfering with Any of The Following?

□ Sleep □ Walking □ Recreational Activities □ Standing □ Work □ Housework □ Daily Activities

CIRCLE all that describe your pain TODAY:

Aching Hot/Burning Spasms Throbbing Cold Numb Squeezing Tingling/Pins & Needles Shock-Like Tiring/Exhausting Dull Shooting Cramping Stabbing/Sharp

What neuropathy treatment have you tried prior to this visit? (check all that apply)

____Hormone Replacement ___Tens Unit ___Stem Cell or Other Injections ___ IV Therapy ___ CBD

____ Physical Therapy ___ Cold Laser Therapy ___ Infrared Light Therapy ___Other, Not Listed

Did any of the treatments you checked work for you? _____

Over the Past 6 months to a Year, Have Your Symptoms: □ Improved □ Worsened □ Stayed the Same

How do you usually get relief for your discomfort? _____

Additional Notes for the Doctor :

_____

_____

PREFERRED PAYMENT METHOD

❑ **Care Credit** ❑ **Credit Card** ❑ **Other** ❑ **Cash/Check** ❑ **Apply For Financing**

Unfortunately for neuropathy patients, insurance coverage is not up to speed on the latest and most effective technology that we now have available for you. Our patients appreciate a one-time, up-front investment for our team to begin work in your healing process. We have kept patients cost low, understanding it is mainly out of pocket. For this reason, we know how important it is to GET YOU RESULTS.

Medical History and Consent for Treatment

I certify that the above information is accurate, complete, and true.

I authorize Advanced Nerve & Health Center DFW and any associates, assistants, and other health care providers it may deem necessary, to treat my condition. I understand that no warranty or guarantee has been made of a specific result or cure. I agree to actively participate in my care to maximize its effectiveness.

I give my consent for Advanced Nerve & Health Center DFW to retrieve and review my medication history. I understand that this will become part of my medical record. I acknowledge that I have had the opportunity to review Advanced Nerve & Health Center DFW's Notice of Privacy Practices, which is displayed for public inspection at its facility. This Notice describes how my protected health information may be used and disclosed, and how I may access my health records.

I authorize the Advanced Nerve & Health Center DFW to release my Protected Health Information (medical records) in accordance with its Notice of Privacy Practices. This includes, but is not limited to, release to my referring physician, primary care physician, and any physician(s) I may be referred to. I also authorize Advanced Nerve & Health Center DFW to release any information required in obtaining procedure authorization or the processing of any insurance claims. I understand that Advanced Nerve & Health Center DFW will not release my Protected Health Information to any other party (including family) without my completing a written "Patient Authorization for Use and Disclosure of Protected Health Information" form, available at its facility.

Signature: _____ Date: _____

HIPAA Right of Access Form for Family Member/Friend

Name: _____ Date Of Birth: _____

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

- Spouse: _____
- Child(ren): _____
- Other: _____

[ ] Information is not to be released to anyone.

This authorization shall be in effect until terminated by myself in writing.

Please Call: [ ] My Home [ ] My Work [ ] My Cell

If unable to reach me:

- You may leave a detailed message
- Please leave a message asking me to return your call
- Please text me a detailed message
- Other

Signed: _____ Date: _____

HIPAA Authority for Right of Access: 45 C.F.R.