CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE RECEPTIONIST

PATIENT INFORMATION Today's Date:________________ Date of Birth___________________

Name: ____

Address____ City___________________ State______Zip________________

Home Phone: ___________________ Work Phone _____________________ Cell /Pager: __________________ Age _____

☐Male ☐Female email address __________________________________

Marital Status: ☐Married ☐Single ☐Divorced ☐Separated ☐Other ______________________

Mother's Name if minor___________________________Father's Name if minor_________________________________

Name of Individual to contact in case of emergency: __________________________Phone : ________________________

Number of Children: ____ Names and ages of children: ____

Your Occupation: ___________________________ Your Employer ____

Employer's Address_______________________________________Employer's Number _(____)_____________________

Who is your Primary Care Physician? ____

Referred to this office by: ☐TV ☐Healthbeat ☐Mailing ☐Star News ☐ Location ☐Internet

☐Google ☐Natural Awakening ☐Health & Medical Magazine ☐Dr. Graf's Book

☐Friend – Name? _______________________ ☐MD – Name? ____________________ ☐Other______________________

Have you been treated by a physician for any health condition in the last year? ☐Yes ☐No

Describe Condition ____ Date of Last Physical Exam ____________________

SURGICAL HISTORY

1. ____ Date _____________________
2. ____ Date_____________________
3. ____ Date_____________________

Have you ever had a metal implant? ☐Yes ☐No Ever been gunshot? ☐Yes ☐No

Do you have a Pacemaker? ☐Yes ☐No Do you have a Defibrillator? ☐Yes ☐No

ACCIDENT HISTORY

☐ Job ☐ Auto ☐ Other: 1. ____ Date_____________________

☐ Job ☐ Auto ☐ Other: 2. ____ Date_____________________

What type of care are you looking for? ☐ Temporary Relief ☐ Maximum Recovery

PLEASE DESCRIBE PRESENT MAJOR COMPLAINTS:

1. ____
2. ____
3. ____
4. ____

THIS PROBLEM IS: ☐ RAPIDLY IMPROVING ☐ SLOWLY IMPROVING ☐ GRADUALLY WORSENING ☐ FLUCTUATES BUT GETTING BETTER ☐ REMAINS THE SAME ☐ RAPIDLY WORSENING

SYMPTOMS ARE WORSE IN THE ☐ Morning ☐ Afternoon ☐ Evening

WHEN AND HOW OCCURRED? ____

____

SYMPTOMS DEVELOPED FROM: ☐ Job related injury ☐ Auto Accident ☐ Diabetes ☐ Other

☐ ILLNESS ☐ UNKNOWN CAUSE ☐GRADUAL ONSET DATE OCURRED: _________________________________

SYMPTOMS HAVE PERSISTED FOR #_____HOUR(S) _____DAY(S)_____WEEK(S)_____MONTH(S)_____YEAR(S)

SYMPTOMS/COMPLAINTS: ☐COME & GO ☐ARE CONSTANT

HAVE YOU EVER HAD THIS BEFORE: ☐NO ☐YES WHEN? ____

NAME AND LOCATION OF DOCTORS PREVIOUSLY SEEN FOR PRESENT CONDITION(S):

____

____

HAVE YOU BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?:
☐PERIPHERAL NEUROPATHY ☐DIABETES (TYPE I) ☐DIABETES (TYPE II) ☐P.A.D.
☐CARPAL TUNNEL ☐DISC DEGENERATION ☐DISC BULGE/HERNIATION

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐NO ☐YES WHAT KIND? ______________________________
ARE YOU TAKING ANY MEDICATIONS? ☐NO ☐YES WHAT KIND? ______________________________
ARE YOU PREGNANT? ☐NO ☐YES DATE OF LAST MENSTRUAL PERIOD_______

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT AGGRAVATE YOUR CONDITION:
☐STANDING ☐WALKING ☐STRAINING AT STOOL ☐COUGHING ☐SITTING
☐LIFTING ☐SNEEZING ☐LYING DOWN ☐BENDING FORWARD ☐BENDING BACKWARD

PLEASE CHECK THE FOLLOWING ACTIVITIES THAT RELIEVE YOUR CONDITION:
☐SITTING ☐BENDING FORWARD ☐BENDING BACKWARD ☐MASSAGE ☐WALKING
☐LYING DOWN ☐STANDING ☐MEDICATIONS ☐ORTHOTICS ☐SPECIAL CREAMS/RUBS

PLEASE CHECK ANY ADDITONAL SYMPTOMS YOU MAY BE EXPERIENCING
☐BLURRED VISION ☐BUZZING IN EARS ☐COLD FEET ☐COLD HANDS ☐COLD SWEATS
☐CONCENTRATION LOSS/CONFUSION ☐CONSTIPATION ☐DEPRESSION ☐DIARRHEA
☐DIZZINESS ☐FACE FLUSHED ☐FAINTING ☐FATIGUE ☐FEVER
☐HEAD HEAVY ☐HEADACHES ☐INSOMNIA ☐LIGHT BOTHERS EYES
☐LOSS OF BALANCE ☐LOSS OF SMELL ☐LOSS OF TASTE ☐EASILY COLD ☐STIFF NECK
☐MUSCLE JERKING ☐NUMBNESS IN FINGERS ☐NUMBNESS IN TOES
☐RINGING IN EARS ☐SHORTNESS OF BREATH ☐STOMACH UPSET
☐PINS AND NEEDLES IN ARMS/HANDS ☐PINS AND NEEDLES IN LEGS/FEET

PLEASE EXPLAIN WHAT YOU HAVE DONE TO TRY TO FIX THE PROBLEM.
____
____
____

HAVE ALL OF THESE TREATMENTS FAILED TO FIX YOUR PROBLEM? ____ YES ____ NO

HOW HAS THIS PROBLEM AFFECTED YOUR DAILY ACTIVITIES?
____
____
____

PLEASE CIRCLE YOUR LEVEL OF DISCOMFORT ON THE SCALE BELOW.

NO DISCOMFORT 1 2 3 4 5 6 7 8 9 10 WORST DISCOMFORT

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Doctors Jason Graf & Aaron Richardet and appointed staff to administer such treatment as is necessary, and to perform services and or procedures as are considered necessary on the basis of findings during the course of said treatment.
I hereby certify that I have read and fully understand the above AUTHORIZATION TO TREAT, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative mode of treatment which were explained to me.
I also certify that no guarantee or assurance has been made as to the results that may be obtained.

Patient Signature ____ Date ___________________________

Guardian Signature ____ Relationship _____________________

Witness Signature**(STAFF)** ____ Date ___________________________

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. Circle **yes** or **no** based on how you usually feel. Thank you.

Question		
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 unable to tell the hot water from the cold water with your feet?	Yes	No
8. Do you ever have any sharp, staving, 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. Are you experiencing any balance problems?	Yes	No
15. Have you ever had electric shock-like pain in your feet or legs?	Yes	No