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.

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