Soltis Family CHIROPRACTIC

Name: _____ **Date:** _____

☐ ☐

Nickname: _____ **Date of Birth:** _____ **Age:** _____ **Sex: M F**

Address:

_____

_____

City: _____ **State:** _____

Zip: _____

Mobile Phone #: _____ **Home Phone #:** _____

Email Address:

_____

_____

Occupation (Current or Previous): _____

Retired: Yes / No

Current or Previous Work Type: Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N

Spouse's Name: _____ **Marital Status: S M D W # of Children:** _____

In Case of Emergency: Contact Name: _____**Phone #:** _____

Soltis Family CHIROPRACTIC

How did you hear about our office?

What is your main health concern / condition coming in today?

_____

_____

Please check all that apply:

☐ Foot Pain	☐ Low Back Pain	☐ Bulging Disc	☐ High Blood Pressure	☐ Neck Pain
☐ Foot Numbness	☐ Sciatica	☐ Joint Replacement	☐ High Cholesterol	☐ Morton's Neuroma
☐ Foot Surgery	☐ Pinched Nerve	☐ Falls	☐ Diabetes	Last A1C: _____
☐ Leg Pain	☐ Herniated Disc	☐ Balance Issues	☐ Plantar Fasciitis	☐ Charley Horses
☐ Hand Pain	☐ Spinal Stenosis	☐ Poor Circulation	☐ Cancer	☐ Restless legs
☐ Hand Numbness	☐ Spinal Arthritis	☐ Poor Wound Healing	☐ Chemotherapy	☐ Restless feet
☐ Arthritis in Hands/Feet	☐ Degenerative Disc Disease	☐ Pacemaker/ Defibrillator	☐ Implanted Cord / Bladder Stimulator	

When did this begin?

_____

_____

_____

On a scale of 1 – 10; how committed and serious are you about fixing your condition?

Not Serious 0 1 2 3 4 5 6 7 8 9 10 Totally Committed

How would you describe your symptoms? *(Circle any that apply)*

| Sharp Pain | Stabbing Pain | Aching Pain | Throbbing Pain | Numbness | Tiredness |

| Heavy Feeling | Dead Feeling | Swelling | Electric Shocks | Pins & Needles | Tingling |

| Cramping | Imbalance / Falls | Burning | Hot Sensation | Cold Hands / Feet |

How would you describe the physical appearance of your feet / legs? *(Circle any that apply)*

| Discoloration of Skin | Dry / Flaky Skin | No Hair Growth | Discoloration of Toe Nail(s) | Loss of Toe Nail(s) |

| Cyanosis (Blue Coloring of Skin) | Petechiae / Red Spots | Blisters / Sores | Fungal | Other |

Are your Symptoms over time *(Please Circle)* :Worsening Staying the Same Improving

Frequency of your Pain:

Constant (75-100%) ____ Frequent (51-75%) ____ Occasional (25-50%) ____ Intermittent

Please indicate on this drawing the area(s) where you are currently experiencing symptom(s):

Please circle the things you have used / tried to relieve your symptoms:

| Gabapentin | Amitriptyline | Neurontin | Cymbalta | Lyrica | Opioids | Injections |

| Aleve / Naproxen | Tylenol / Acetaminophen | Advil / Ibuprofen | Motrin |

| Creams | CBD / Hemp Products | Chiropractic | Physical Therapy | Massage Therapy |

Other:

_____

_____

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Please list any / all prescription medications you are currently taking (or you may attach a list):

Name	Dosage per Day

Please list any / all allergies and sensitivities:

_____

_____

_____

_____

_____

_____

Please list any / all supplements (vitamins, herbs, homeopathic, etc.) you are currently taking:

Name	Dosage per Day

Are you currently taking a Blood Thinner (Coumadin, Lovenox, Heparin, etc)? Yes No

Are you currently taking a Statin (Atorvastatin, Lipitor, Crestor, Simvastatin, etc)? Yes No

Do you drink alcohol? Yes No If yes, how many drinks per week? _____

Do you smoke cigarettes? Yes No If yes, how many cigarettes daily? _____

Name of your Primary Care Physician: _____ Clinic: _____

May we contact them with updates regarding your treatment? Yes No

- I hereby authorize release of any medical information necessary to evaluate my case to Soltis Family Chiropractic._____
- I understand that Soltis Family Chiropractic cannot file the Neuropathy treatments to insurance at this time.
- Soltis Family Chiropractic will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patients' responsibility to contact their in insurance.

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.

Signature: _____ Date: _____

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Neuropathy Function Questionnaire

These questions ask about limitations you may be experiencing due to your symptoms during the last 10 days. For each question, please circle only ONE answer that best describes your degree of limitation.

Symptom Severity	Never /not experiencing	Sometimes experiencing	Frequently experiencing	Constantly experiencing
Numbness or lack of sensation	1	2	3	4
Tingling or "pins and needles" sensation	1	2	3	4
Burning sensation	1	2	3	4
Sharp or shooting pain	1	2	3	4
Sensitivity to touch or pressure	1	2	3	4
Muscle cramping or twitching in the feet	1	2	3	4
Muscle weakness	1	2	3	4
Balance difficulties	1	2	3	4
Cold or freezing feet	1	2	3	4
Functional Abilities	**Never Affected**	**Sometimes Affected**	**Frequently Affected**	**Constantly Affected**
Walking without assistance	1	2	3	4
Ability to use stairs	1	2	3	4
Standing or walking prolonged	1	2	3	4
Carrying groceries or moderate lifting	1	2	3	4
Ability to wear shoes or socks	1	2	3	4
Ability to bathe oneself.	1	2	3	4
Ability to walk barefoot	1	2	3	4
Impact on Daily Living	**Never**	**Sometimes**	**Frequently**	**Constant**
How much do your symptoms interfere with your ability to walk?	1	2	3	4
How much do your symptoms interfere with your social or work life?	1	2	3	4
Do your symptoms disturb your sleep?	1	2	3	4
How concerned are you about falling due to your symptoms?	1	2	3	4
How frustrated are you by your symptoms?	1	2	3	4

In clinic use re-exam grading: Patient improved _____ / 21 in function categories since starting care.

FUNCTIONAL GOALS SURVEY

Please take several minutes to answer these questions so we can help you get better.

How many doctors have you seen for this condition? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

_____

_____

_____

Has what you've done to date for your condition helped?

☐ **Yes, a lot** ☐ **Yes, some** ☐ **No, not at all** ☐ **Indifferent**

What are 3 – 5 activities you can no longer do or are struggling to do because of this condition? *Please be specific.*

1._____

2._____

3._____

4._____

5._____

What is your honest vision of your life in the next few years if this problem continues to progress? _____

_____

_____

What would be different and/or better in your life without this problem? Please be specific.

_____

_____

_____

What is your biggest fear if this condition continues to progress? _____

_____

_____

_____

What would success mean to you in our office? _____

_____

_____

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Acknowledgment of Receipt of Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. These rights are more fully described in **Soltis Family Chiropractic's** Notice of Privacy Practices. **Soltis Family Chiropractic** is permitted to revise its Notice of Privacy Practices at any time. We will provide you with a copy of the revised Notice of Privacy Practices upon your request.

Those individuals or parties that could have access to Patient Health Information at **Soltis Family Chiropractic** include but may not be limited to:

The Staff of **Soltis Family Chiropractic** this includes:

Dr. Jeff Soltis, Dr. Leah Soltis, Lindsay Zabel Office Manager, Jamie Bergstrom and Jamie Thomas CA's.

By signing below, you are acknowledging that you have reviewed a copy of Soltis Family Chiropractic's Notice of Privacy Practices.

Patient Name: _____

Patient Date of Birth: _____

Patient Representative: _____

If signed by Patient Representative, state authority to act on behalf of patient: _____

_____

Signature: _____ Date: _____

Soltis Family Chiropractic USE ONLY

I, _____, attempted to obtain the patient's acknowledgement of receipt of the Notice of Privacy Practices, but was unable to do so.

Reason acknowledgment not obtained: _____

_____

Signature: _____ Date: _____