Vizuri
HEALTH CENTER

Neuropathy Registration

Please fill out the registration entirely and legibly so we can best serve you.

Name ______________________ DOB __________ Date __________

Address ______________________ City __________ State _____ Zip _____

Phone ______________ Email ______________________

Spouse Name ______________________ Spouse Phone ______________

How did you hear about us? ☐ Friend/Family ☐ TV ☐ Mail ☐ Facebook/Instagram ☐ Newspaper ☐ Doctor ☐ Other __________

REVIEW OF SYMPTOMS

Please check all that apply

- ☐ Foot Pain
- ☐ Hand Pain
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Foot Numbness
- ☐ Hand Numbness
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Vascular Problems
- ☐ Poor Circulation
- ☐ Poor Wound Healing
- ☐ Pacemaker/Defibrillator
- ☐ Herniated/Bulging Disc
- ☐ Spinal Stenosis
- ☐ Degenerative Disc
- ☐ Sciatica
- ☐ Pinched Nerve
- ☐ Joint Replacement
- ☐ Foot Surgery
- ☐ Plantar Fasciitis
- ☐ Leg Pain
- ☐ Morton's Neuroma
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Implanted Cord/ Bladder Stimulator
- ☐ Arthritis in Hands
- ☐ Arthritis in Feet
- ☐ Excessive Thirst/Urination

CURRENT PAIN LEVELS

How would you rate your pain in the last week?

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

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

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

SOCIAL HISTORY

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

Do you drink? ☐ Yes ☐ No If yes, how many drinks per week? __________

Do you exercise? ☐ Yes ☐ No If yes, please describe type and how often:

____

PRESENT HEALTH CONDITION

01 **In order of importance, list the health problems you are most interested in getting corrected and how long you've noticed these problems in your life:**

Health Problem	How long?
1. ______	______
2. ______	______
3. ______	______
4. ______	______

02 **Is there a certain time of day any of these problems are better or worse?**

______

03 **Is your balance/walking ability affected? If yes, please describe:**

______

04 **Mark the things you have used for these problems.**

- ☐ Gabapentin
- ☐ Cymbalta
- ☐ Neurontin
- ☐ Lyrica
- ☐ Injections
- ☐ Creams
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Message Therapy
- ☐ Pain Medications/NSAIDs
- ☐ Other: ______

______

05 **Name all doctors you have seen for these problems and treatment you received:**

Doctor	Treatment
______	______
______	______
______	______

06 **In the last 3 months, have your symptoms:** ☐ Improved ☐ Worsened ☐ No Change

What makes your condition WORSE ______

What makes your condition BETTER ______

07 **How would you describe the symptoms? Check ALL that apply:**

- ☐ Aching Pain
- ☐ Stabbing Pain
- ☐ Sharp Pain
- ☐ Tiredness
- ☐ Numbness
- ☐ Cramping
- ☐ Heavy Feeling
- ☐ Hot Sensation
- ☐ Throbbing Pain
- ☐ Dead Feeling
- ☐ Swelling
- ☐ Burning
- ☐ Tingling/Electric Shocks
- ☐ Pins & Needles Pain
- ☐ Cold Hands/Feet

08 **Is this condition interfering with any of the following? Check ALL that apply:**

- ☐ Sleep
- ☐ Work
- ☐ Walking
- ☐ Standing
- ☐ Family Time
- ☐ Daily Activities
- ☐ Recreational Activities

PREVIOUS HEALTH CONDITIONS

Primary Health Provider Information:

Name ______________________________ Phone ______________

When were you last seen? ______________ May we send them updates on your condition? ☐ Yes ☐ No

Please list ALL allergies/sensitivities to medication, food, and other items here:

Items you react to	Reaction

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Time(s) Daily

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

QUALITY OF LIFE

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Routine Medical
- ☐ Exercise
- ☐ Vitamins
- ☐ Emergency Room
- ☐ Chiropractic
- ☐ Holistic Care
- ☐ Nutrition/Diet
- ☐ Other: ______________________________

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Great Results
- ☐ Still Trying
- ☐ Did Not Get Worse
- ☐ Some Results
- ☐ Nothing Changed
- ☐ Confused
- ☐ Did Not Work Very Long

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ They Tell me To Do Something
- ☐ Haven't Noticed Any Problem
- ☐ People Avoid Me

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- [ ] Job
- [ ] Marriage
- [ ] Time
- [ ] Kids
- [ ] Self-Esteem
- [ ] Finances
- [ ] Future Ability
- [ ] Sleep
- [ ] Freedom

05 **Are there health conditions you are afraid this might turn into?**

- [ ] Family
- [ ] Cancer
- [ ] Depression
- [ ] Health Problems
- [ ] Arthritis
- [ ] Chronic Fatigue
- [ ] Heart Disease
- [ ] Fibromyalgia
- [ ] Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

____

____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. ______________________________
2. ______________________________
3. ______________________________

08 **What are you most concerned with regarding your problem?**

____

____

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

____

____

10 **What would be different/better without this problem? Please be specific.**

____

11 **What do you desire most to get from working with us?**

____

12 **What would that mean to you?**

____