NEUROPATHY INTAKE FORM

Name: ______________________ Date: ______________

Nickname: ______________ Date of Birth: __________ Age: ______ Sex: M F Weight: ______

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 #: ______________

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	
☐ Hand Pain	☐ Spinal Stenosis	☐ Poor Circulation	☐ Cancer	
☐ Hand Numbness	☐ Spinal Arthritis	☐ Poor Wound Healing	☐ Chemotherapy	
☐ Arthritis in Hands/Feet	☐ Degenerative Disc Disease	☐ Pacemaker/Defibrillator	☐ Implanted Cord / Bladder Stimulator	

When did this begin? ______________________

What makes it worse? ______________________

What makes it better? ______________________

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:

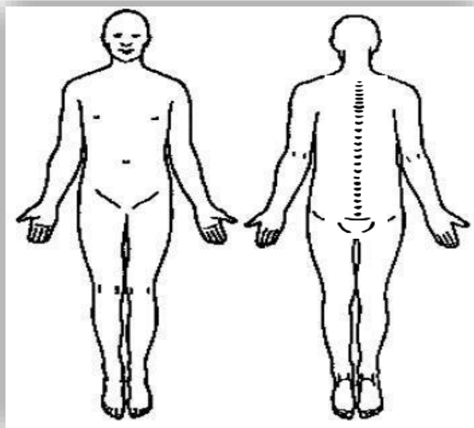
Constant (75-100%) ___ Frequent (51-75%) ___ Occasional (25-50%) ___ Intermittent (0-25%) ___

On average what level would you rate your overall pain?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Possible

Is this condition interfering with any of the following? *(Circle any that apply)*

| Daily Activities | Hobbies | Walking | Standing | Work | Sleep | Relationships | Sex Life |



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: ______________________________

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? ____________

Do you exercise regularly? Yes No If yes, please describe type & how often? ____________

Did this start/progress after COVID or receiving the COVID vaccine? Yes No If yes, when? ____________

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 Wilmington Back & Spine.
- Wilmington Back & Spine will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patients' responsibility to contact their insurance provider.

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. I understand the above information, and guarantee this form was completed correctly, to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical or insurance status.

Signature: ______________________________ Date: ______________

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 &/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? ____
____
____
____

CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Stephen A. Jensen or other licensed doctors of chiropractic who now or in the future work at Wilmington Back & Spine or any other office or clinic.

I understand that chiropractic care, as is the case with other therapies, is not always 100% successful in treating health conditions. I also understand that results at Wilmington Back & Spine are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To the best of my knowledge I am ***NOT*** pregnant and the Dr. Stephen A. Jensen has my permission to x-ray me for diagnostic interpretation.

By signing this authorization, I am also agreeing to have text and/or email sent to the number or email I have provided, from Wilmington Back & Spine and its employees.

I understand that there is no implied cure or guarantee of improvement by my agreeing to the Doctor's recommendations. I further understand that my failure to comply fully with these recommendations will limit my results from the treatment received. I also acknowledge that I am responsible for services and/or products that are rendered.

X ____ ________________

Patient's Signature or person acting on patient's behalf **Date**

X ____ ________________

Witness Signature **Date**

Wilmington Back & Spine 978-988-9588

Dr. Stephen A. Jensen

OFFICE FINANCIAL POLICY

We welcome you and your family to our office. We take pride in providing quality chiropractic care for patients of all ages. Please take time to review our Office Financial Policy, as these guidelines have been designed to better serve your individual needs.

PAYMENT POLICY

- Payment is due the day service is provided.
- A ***3.95% processing fee is built into our fees*** and applies to debit and credit card payment transactions.
- The ***3.95% fee is waived*** when paying by ACH (electronic transfer), cash or check. _____ (Initial)
- Our doctor participates in many insurance plans, but not all of our therapies are covered by insurance. Our staff will be happy to contact your insurance company to check your insurance benefits and deductible, but this is **not a guarantee of coverage.**
- Please communicate with the receptionist and present your photo ID and current insurance card to the receptionist for her to make a copy.
- If at any time you change insurance companies, please notify the receptionist immediately so we may update your records. All insurance claims are filed weekly on Thursday or Friday. We will not enter into any dispute with your insurance company.
- If coverage problems arise, you will be expected to directly assist your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services.
- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, payment in full is due; regardless of any claims submitted.

MY FINANCIAL RESPONSIBILITY

I understand that I am personally **financially responsible** for all services not covered by Insurance or by Medicare and Medicaid. I am also responsible for applicable annual deductibles or copayments.

CANCELLATION POLICY

We are an extremely busy clinic and need every available time slot for patients who are hurting and NEED care. If for any reason you cannot make your pre-scheduled appointment time we ask for **24-hour advance notice**. If we do not hear from you to cancel your appointment at least one hour before your appointment, more than three times an administrative fee of $25.00 will be charged to your account*. No further treatments will be administered until this fee is paid.
*If you consistently miss your appointments you may be **dismissed** from our practice. We will give you the names of other chiropractors within the area who may better suit your needs. We thank you for your understanding.

I have read and understand the Financial Office Policy and agree to abide by these terms.

x____ ____________________

Patient's Signature or person acting on patient's behalf **Date**