BREAKTHROUGH NEUROPATHY SOLUTIONS

Pain/Numbness Questionnaire

Name: ____________________________________ Date:_____/_____/______

Phone: (___) ____-________ Address: ____________________________________

City: __________________ State: _______Zip:___________Weight:__________LBS

Social security #: ____-____-________ D.O.B.: ______________ Age: __________

Marital Status: Single____ Married____Divorced____Widowed____ for ___years

Number of Children: ______ Ages of children: ____________________________

Current Occupation or Last position held: _________________________________

Current employment status: ____Full time ____Part time ____Unemployed

For how long: _________ ____Homemaker _____Retired ____Student

Is your pain or numbness the result of an accident? ____Yes ___No

If yes, where did it occur? Circle one: Home work Vacation Car Other

(Describe):____

____

Pain/Numbness/Neuropathy Information

What is the main problem for which you are seeking treatment at **Breakthrough Neuropathy Solutions?** ____

Please describe the location of your pain and numbness? __________________

____

How long have you had your current pain/numbness? _____________________

How did your pain/numbness start? Was there a precipitating event? _________

____

Are there any factors that make your pain, numbness or tingling:

Better? ____

Worse? ____

Please rate your pain, numbness or tingling intensity on a scale from 0 (no pain) to 10 (excruciating, incapacitating, worst possible). Rate your pain, numbness or tingling during the last 30 days. _____________

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Are you taking any of the following medications? **Please circle all that apply.**

Nerve Pills   Pain killers   Muscle relaxers   Stimulants

Blood Thinners   Tranquilizers   Insulin   Other(s) ________________________

Do you have or ever had any of the following diseases or conditions? Please circle all that apply.

Heart Attack   Stroke   Congenital Heart Disease   Alcohol/Drug abuse   HIV+/AIDS

Freq. Neck Pain   HIGH/LOW Blood Pressure   Severe Freq. Headaches   Pace Maker

Fainting/Epilepsy   Diabetes/Tuberculosis   Lower back pain   Heart Surgery

Mitral Valve Prolapse   Venereal Disease   Shingles   Emphysema/Glaucoma

Psychiatric Problems   Kidney Problems   Sinus Problems   Difficulty Breathing

Artificial Bones   Heart Murmur   Artificial Valves   Hepatitis   Cancer   Anemia

Rheumatic Fever   Ulcers/Colitis   Asthma   Chemotherapy   Arthritis

List any other serious medical condition(s) you have or ever had: ____________________

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List anything that you may be allergic to: ____

____

List previous surgeries/treatments with dates: ____________________________________

____

____

List **any** serious accidents with dates: ____

Do you take supplements or Vitamins? _____if so, what? ___________________________

____

Family health history: ____

____

List any **past** treatments used to try and treat the pain, numbness, or tingling: ________

____

Were any of those treatments helpful? ____

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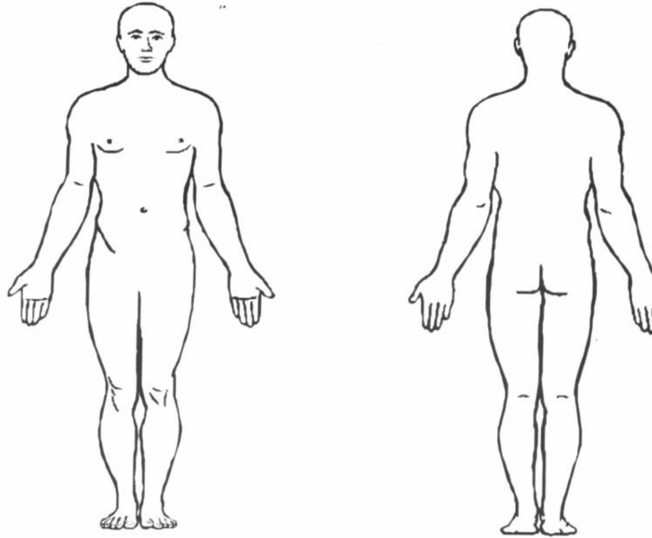
How often do you have your pain, numbness or tingling?

____Constantly (100% of the time) ____Nearly constantly (60-95% of the time)

____Intermittently (30-60% of the time) ____Occasionally (less than 30%)



Mark the areas that you're are experiencing your pain, numbness, or tingling. Indicate your pain or numbness type by marking with a letter or letters.

a) Deep (inside)
b) Superficial (on the skin)
c) Constant (all the time)
d) Intermittent (start and stops)
e) Aching
f) Burning
g) Shooting

Patient signature: _________________________________ Date: ______________

Office use only:

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