Peripheral Neuropathy Intake Questionnaire (Page 1 of 2)

NW Pain Institute
Dr. Werner Marksfeld, DC
16821 SE McGillivray Blvd., Suite 204, Vancouver, WA 98683

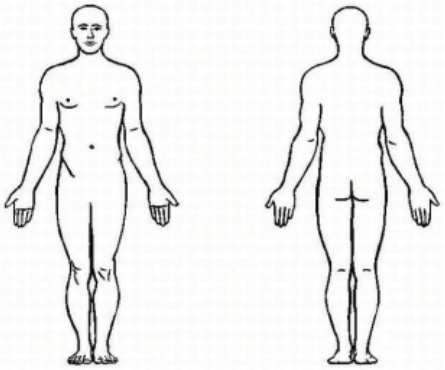
Name _____ Date _____

Thank you for choosing us, we appreciate you allowing us to be part of your health care!

Under our care, you will not receive any drugs or surgery. Your results will be attained through a strict adherence to the treatment recommendations.

We only accept cases that through examinations and testing we are confident we can help, so please fill out the following information thoroughly to give us the most complete picture of your health profile. Please feel free to ask any questions if you need assistance. We look forward to serving you.

PLEASE DARKEN THE BODY PART(S) IN WHICH YOU ARE CURRENTLY EXPERIENCING SYMPTOMS:



WHEN DID THE CONDITION BEGIN?				
IS THE CONDITION GETTING WORSE?	Y	N		
EXPLAIN WHAT HAPPENED:				
IS THIS CONDITION INTERFERING WITH YOUR (PLEASE CIRCLE):	WORK	SLEEP	DAILY ROUTINE	OTHER:
IF SO, PLEASE EXPLAIN:				

CHIEF COMPLAINTS

Where does it hurt?	ONSET When did it start?	PROVOCATIVE What makes it worse?	PALLIATIVE What makes it better?	QUALITY Numb, sharp, burning, etc?	RADIATION Does the pain go down your arm/leg?	SEVERITY 1-10 (highest)	TEMPORAL When does it hurt? Constant, On and Off?

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TELL US ABOUT YOU

NAME:		SOCIAL SECURITY #:		DATE:
DATE OF BIRTH:	AGE:	SEX: M F	MARITAL STATUS: M S D W	# OF CHILDREN:
ADDRESS:				
CITY:		STATE:	ZIP:	
HOME PH#:		CELL PH#:		
EMAIL ADDRESS:			OCCUPATION:	
COMPANY NAME:			LENGTH OF EMPLOYMENT:	
TYPE OF WORK:	OFFICE/CLERICAL	LIGHT LABOR	MODERATE LABOR	HEAVY LABOR
SPOUSES OR CAREGIVER'S NAME:				
IN CASE OF EMERGENCY CONTACT NAME:			HOME PHONE:	

TELL US ABOUT YOUR PAST HEALTH

Y	N	Severe / Frequent Headaches	Y	N	Alcohol / Drug Abuse	Y	N	Stroke
Y	N	Frequent Neck Pain	Y	N	Hepatitis	Y	N	Heart Surgery / Pacemaker
Y	N	Middle Back Pain	Y	N	HIV / Aids	Y	N	Heart Murmur
Y	N	Lower Back Pain	Y	N	Shingles	Y	N	Congenital Heart Defect
Y	N	Arm / Leg Pain	Y	N	Cancer	Y	N	Mitral Valve Prolapse
Y	N	Arthritis	Y	N	Chemotherapy	Y	N	Artificial Valves
Y	N	Artificial Limbs / Joints	Y	N	Anemia	Y	N	Rheumatic Fever
Y	N	Fainting / Seizures / Epilepsy	Y	N	Difficulty Breathing	Y	N	Diabetes / Tuberculosis
Y	N	Ulcers / Colitis	Y	N	Psychiatric Problems	Y	N	High / Low Blood Pressure
Y	N	Kidney Problems	Y	N	Heart Attack	Y	N	Fractures
Y	N	Workers Comp Injuries	Y	N	Personal Injuries	Y	N	Injuries to Head, Neck or Back
Y	N	Hospitalized	Y	N	Past Chiropractic Care	Y	N	Surgery

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: (OR SEE ATTACHED)						
PLEASE LIST ANY VITAMINS YOU ARE CURRENTLY TAKING:						
PLEASE LIST ANY SERIOUS MEDICAL CONDITIONS YOU HAVE EVER HAD:						
PRIMARY CARE PHYSICIAN:				PHONE #:		
DATE OF LAST DOCTOR VISIT:						
LIST ANY THING YOU MAY BE ALLERGIC TO:						
LIST PAST SERIOUS ACCIDENTS:						
FAMILY HEALTH HISTORY:	DIABETES	CANCER	HEART DISEASE/STROKE		OTHER	
DO YOU SMOKE?:	Y	N	HOW LONG:		PACKS PER DAY:	
ALCOHOL CONSUMPTION:	NEVER	SOCIAL	LIGHT	MODERATE	HEAVY	