NEUROPATHY CENTER OF BOULDER COUNTY
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Application for Treatment

Patient Information

Name: _____ Social Security #:_____
Last Name, First Name, Middle Initial

Address: _____
Street Address, City, State, Zip

Sex: *M* *F* Birth Date:_____Marital Status: *Single* *Married* *Widowed* *Separated*

Race: *Asian* *African American* *Caucasian* *Hispanic* *Other* *Declined*

Height: _____Weight:_____E-mail:_____

Occupation:_____Employer:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

In case of emergency, who should be notified? Name: _____Relationship: _____

Phone:_____

Primary Care Physician

Physician Name: _____

City:_____ State: _____ Phone: _____

Chief Complaint

Major Complaints (be specific):_____
Has your primary complaint been diagnosed? _____
If yes, what was the diagnosis and when were you diagnosed?_____

_____

Do you have a defibrillator? (we cannot treat you if you have a defibrillator) *Yes* *No*

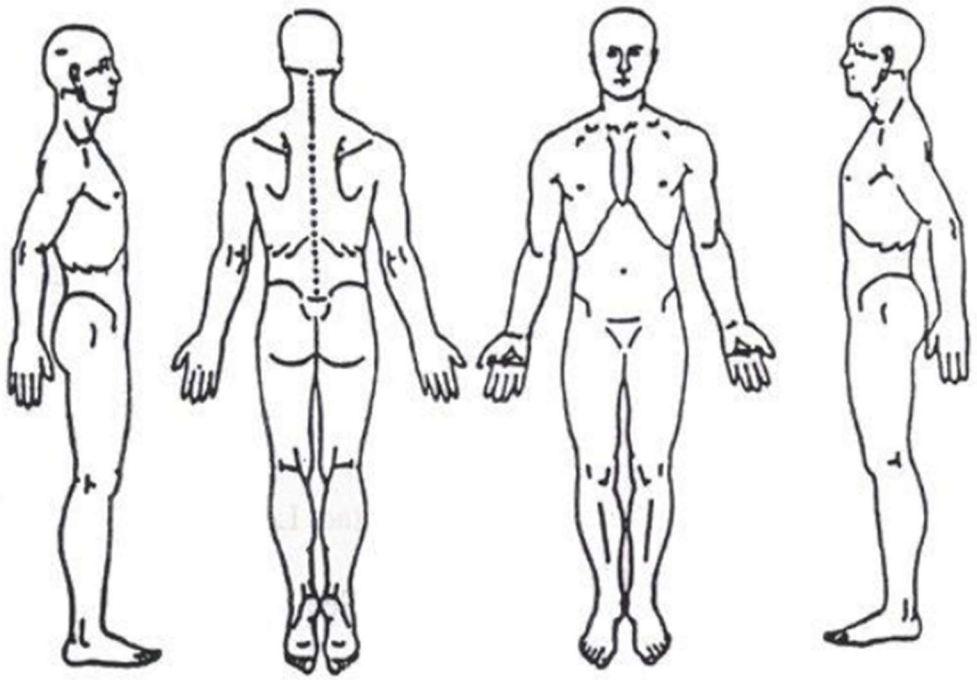
Do you have any allergies that you know of to Marcaine, Lidocaine, or Novocaine? *Yes* *No*

Do you have problems with balance? *Yes* *No*

What relieves your symptoms or causes them to return: _____

Does the pain radiate? *Yes* *No* Where:_____

Where is your pain?



Please use these symbols on the pain diagram to accurately describe your condition.

P: Pain N: Numbness T: Tingling B: Burning C: Cramping or Tightness

Health History

How often do you drink alcohol? _____

How often do you smoke cigarettes? _____

Medications (include all over-the-counter and supplements)

Year	Type
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgeries and Hospitalizations

Year	Hospitalizations
_____	_____
_____	_____
_____	_____
_____	_____

Allergies and Reactions

Allergy	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____

Patient Medical History: Past and Current (Please circle *Past, Current*, both or none for each item)

Eye/Ear/Nose/Mouth/Throat
Past *Current* Blurred vision
Past *Current* Hearing loss

Cardiovascular/Pulmonary
Past *Current* High blood pressure
Past *Current* Low blood pressure
Past *Current* Heart Disease

Psychiatric
Past *Current* Insomnia
Past *Current* Memory Loss
Past *Current* Anxiety
Past *Current* Depression

Respiratory
Past *Current* Shortness of Breath
Past *Current* Wheezing

Endocrine
Past *Current* Excessive Thirst
Past *Current* Diabetes Type 2
Past *Current* Thyroid disease

Musculoskeletal
Past *Current* Back or joint pain
Past *Current* Muscle pain or cramping
Past *Current* Difficulty walking
Past *Current* Cold extremities

Integumentary
Past *Current* Varicose veins

Neurological
Past *Current* Numbness/Tingling
Past *Current* Paralysis
Past *Current* Head Injury
Past *Current* Stroke

Hematological/Lymphatic/Other
Past *Current* Easy Bleeding or bruising
Past *Current* Hepatitis
Past *Current* Cancer
Past *Current* Shingles
Past *Current* HIV/AIDS

Recent MRIs: _____
_____

The information provided on this form is true to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my medical status.

The Health Insurance Portability and Accountability Act of 1966 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, be kept confidential. I understand that this office complies with HIPPA and that a copy of this policy is available to me at my request and on NCBC's website. I authorize the Neuropathy Center of Boulder County or my insurance company(ies) to release any information required to process my claims.

Patient Name:_____
Signature:_____ Date: _____

(Patient, Parent or Legal Guardian)

For Provider Use Only

Date of Consult:_____