CAROLINA
PAIN & HORMONE
115 Stone Village Drive Fort Mill SC, 29708
P: 803-548-7300 F: 803-548-7301
www.yorkprimarycare.com

New Patient Neuropathy Paperwork

Name: First:_____Last: _____

Today's Date: _____ Date of Birth: _____ SS#_____

Sex: MALE [ ] FEMALE [ ] Present Weight: _____

May we contact you by email: YES [ ] NO [ ] Email Address: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Numbers: Home:_____Cell:_____Work: _____

Best number to leave a message:_____

Patient employed by:_____

Business Address:_____

Insurance Information:_____Card No._____Gr. No._____

Secondary Insurance :_____Card No._____Gr. No._____

Marital Status: MARRIED [ ] SINGLE [ ] DIVORCED [ ] WIDOW [ ]

Spouse/ Significant Others Name:_____Phone: _____

Emergency Contact Name:_____Relationship: _____

Emergency Contact Phone Number: _____

Primary Care Physician:_____Phone #:_____

What brought you to Carolina Pain & Hormone Center today?

_____

_____

_____

How did you hear about us _____

PAST MEDICAL HISTORY:

Do you have the following in your past medical history (check all that apply)?

❑ Diabetes	❑ High Blood Pressure
❑ Low Blood Pressure	❑ History of Blood Clots
❑ Close Relatives with History of Blood Clots	❑ Heart Disease or Congestive Heart Failure
❑ Heart Problems	❑ Hepatitis / Liver Disease
❑ Varicosities / Phlebitis	❑ Kidney Disease
❑ Treated for Psychiatric Problems	❑ Rheumatic Fever
❑ Jaundice / HIV	❑ Anemia
❑ Bruise Easily	❑ Blood Disease
❑ Thyroid Problems	❑ Lupus
❑ Arthritis	❑ Transient Ischemic Attack (TIA) / Stroke
❑ Asthma	❑ Lung Disease
❑ Infection	❑ Anemia
❑ Cancer	

List any drug allergies:

_____

_____

Please list all medications, Rx, OTC, vitamins or supplements that you are currently taking:

_____

_____

_____

_____

Please list any surgeries or hospitalizations: (Including plastic surgery)

_____

_____

Other medical history for yourself:

_____

_____

Other medical history for your family:

_____

_____

SOCIAL HISTORY:

Do you smoke cigarettes? YES [ ] NO [ ]

If yes, number per day?_____How many years? _____

Quit Date: _____

Do you drink alcohol? YES [ ] NO [ ]

If yes, number of drinks per day?_____How many years? _____

Do you use marijuana or recreational drugs? YES [ ] NO [ ]

If yes, number of times used per day?_____ How many years? _____

Have you ever used needles to inject drugs? YES [ ] NO [ ]

Do you exercise regularly? YES [ ] NO [ ]

What kind of exercise? _____

How would you rate your diet? GOOD [ ] FAIR [ ] POOR [ ]

Review of Systems

Name_____**Date** _____

Circle any symptoms you are experiencing: *Check Box if NONE apply:* ❑

Constitutional: Fever chills headache fatigue weight loss / gain

Eye, Ears, Nose, Mouth, Throat: blurred vision strain / pain, double vision Headaches ear pain difficulty swallowing difficulty with smell

Heart: chest pain palpitations difficulty breathing when flat swelling / edema fainting

Lungs: shortness of breath cough sputum production wheezing or asthma coughing up blood

Gastrointestinal: abdominal pain indigestion nausea vomiting change in bowel habit blood in stool loss of bowel control

Urinary system/gynecological: Pain on urination blood in urine urinary frequency urinary urgency vaginal/penile discharge

Neurological: Focal neurological deficit weakness numbness &/or tingling incoordination seizure stroke tremors

Musculoskeletal: Joint pain / spasms Joint swelling Joint stiffness weakness

Skin: rashes, loss of hair itching

Psychosocial: Depression anxiety insomnia recent stressors recent changes in lifestyle

Endocrine: excessive thirst excessive sweating low libido low energy dry skin mental fog

Blood and Lymphatic systems: Bleeding problems swollen glands

Allergic / Immunologic: allergy symptoms allergic reactions

Other:_____.

Neuropathy History

Name:_____Date:_____

Chief Complaints: Pain – Numbness – Tingling – Pain with touch – Shooting Shocks – Other symptoms:_____.

Where: Toes - Feet (tops / bottoms) - Ankles – Calves – Thighs

When: Constantly – Day Time – Night Time – Other Times_____.

What causes the symptoms to Increase? Walking – Standing – Shoes on or off – Bed Covers – Rest – Others_____.

What causes the symptoms to Decrease? Resting – Lying Down – Shoes on or off – Movement/Walking – Medications:_____Others:_____.

How would you describe the pain, burning, numbness, tingling or aching?:
(0 = least severe / 10 = extremely severe)

0 1 2 3 4 5 6 7 8 9 10

How long have you had Neuropathy?_____.

How was the diagnosis of Neuropathy made? Neurologist:_____.

Nerve Conduction Test (EMG/NCS) Yes / No –Date_____.

Are you a Diabetic? Yes / No. If so how long?_____.

Most Recent A1C_____Date of A1C_____.Blood Sugar today_____.

Have you had Cancer? Yes / No. If so have you had chemotherapy or radiation? Yes / No

Do you drink alcohol? Yes / No. If so, how many drinks per week?_____.

Do you smoke? Yes / No. If so, how many packs per day?_____For how long?_____.

If previous smoker, when did you quit?_____.

Does the Neuropathy interrupt your sleep of disturb your balance? Yes / No

Do you now or have you in the past taken: Neurontin – Gabapentin – Lyrica – Cymbalta: Yes / No

Have you ever been exposed to heavy metals, Agent Orange or any other chemicals? Yes / No

Have you ever been diagnosed with a vitamin or mineral deficiency? Yes / No

Have you ever been diagnosed with an auto immune disorder? Yes / No

Have you ever been diagnosed with a thyroid problem? Yes / No

Neuropathy Function Index

Name:_____ Date:_____

Circle only one number for each line item that best describes how your neuropathy symptoms have interfered with your:

0 = does not interfere (no pain) 10 = completely interferes (severe pain)

a.	**Walking Ability**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
b.	**Sitting**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
c.	**Standing**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
d.	**Normal Daily Activities**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
e.	**Mood**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
f.	**Normal Work**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
g.	**Sleep**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
h.	**Relationship with spouse or family**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
i.	**Social Activities with Others**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
j.	**Enjoyment of Life**	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

NEUROPATHY INDEX SCORE:_____% *(Provider Use Only)*

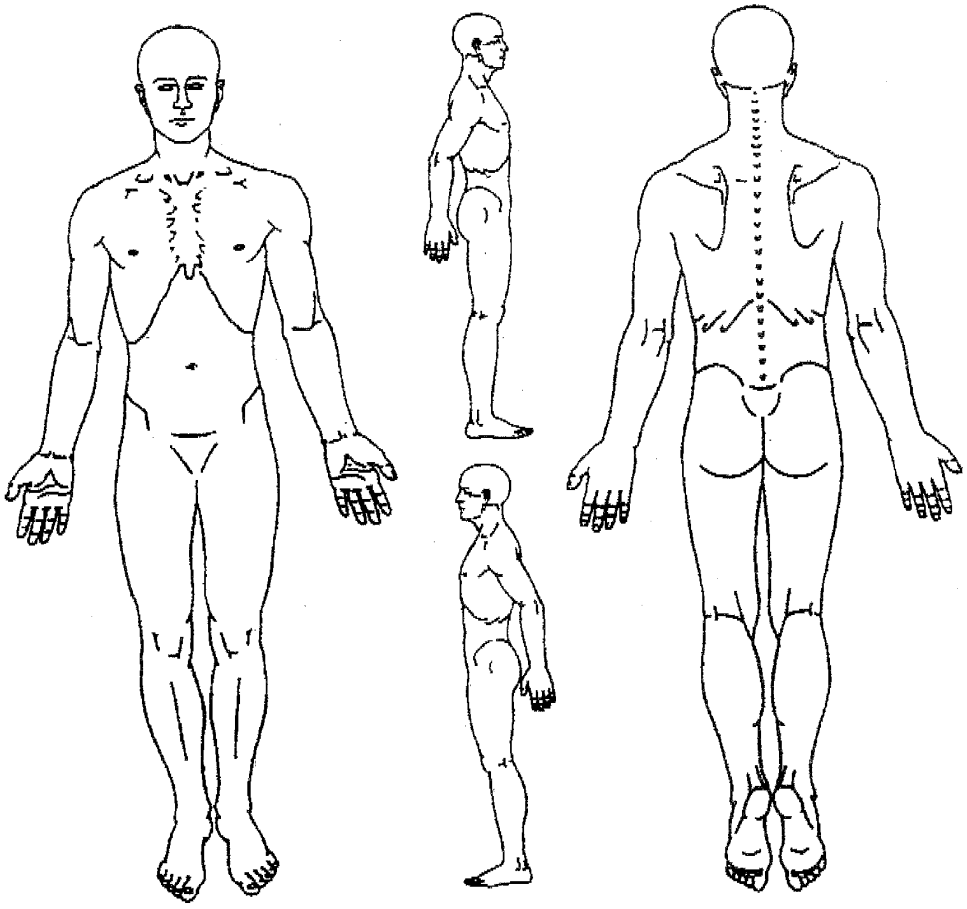
Neurological Pain Questionnaire

Name:_____ Date:_____

1. Mark the areas of pain.
2. Code the areas of pain

A = Ache	P = Pins & Needles	B = Burning
S = Stabbing	N = Numbness	O = Other

3. Please make notes about the time your pain is most severe, actions that increase, or decrease it. Anything that will help the doctor understand your pain.
4. Connect the notes with an arrow to the area involved.



Privacy Notice:

As of August 14, 2002 the government ruled that healthcare practices must be in compliance with HIPAA, a privacy ruling.

To my patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created by the Health Insurance Portability and Accountability Act of 1996. Our commitment is to your privacy.

This practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. I realize that these laws are complicated, but I must provide you with the following important information.

Use and Disclosure of your Health Information in Certain Special Circumstances:

1. To public health authorities and health oversight agencies that are authorized by the law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health or safety of the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of the US or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutes or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and/ or other similar programs.

Your Rights Regarding Your Health Information:

1. Communications. You can request that this practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care options. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care of payment; however, if we do agree, we are bound by our agreement except when it requires otherwise by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You may submit your request in writing.
4. You may ask to have your health information amended if you believe it is incorrect, incomplete, and as long as the information is kept by you or for this practice. To request an amendment, your request must be made in writing. You must provide a reason supporting your request for the amendment.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with the board of Medical Examiners, or the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. If you have questions regarding this notice or health information privacy policies, please contact a Carolina Pain & Hormone Center representative.

Informed Consent

I,_____, acknowledge that I have been presented with a copy of the Carolina Pain & Hormone Center Notice of Privacy Practices and am aware that all clinic personnel may have access to private information in order to serve patients.

I consent to the provider's use of protected health information as described in the notice for treatment, payment, or health care operations. I understand that I must provide a signed authorization before any disclosures may be made.

Signature:_____Date: _____

We may call to remind you of your appointment or to notify you of test results. I agree, if I have an answering machine, to allow doctor or staff members of Carolina Pain & Hormone Center to identify themselves, as well as myself, and to notify me of my appointment or to tell me that my test results are back. We will not leave the test results on your answering machine.

Signature:_____Date: _____

I request that my protected health care information be disclosed to the following: (If they are not listed below we will not disclose any information to the party requesting it, unless as listed in the Privacy Notice)

_____

_____

_____

_____

_____

Signature:_____Date: _____