CONFIDENTIAL PATIENT DATA

IF YOU NEED ANY ASSISTANCE COMPLETING THIS FORM, PLEASE ASK THE FRONT DESK

Today's date:

PATIENT INFORMATION

Patient's name: (Last, First, Middle Initial)	S.S. #:	Date of Birth:	Sex: ❑M ❑F

Mailing address:	Home Phone:	Primary Phone: ❑Home ❑Work ❑Cell

Mailing address Line 2:	Cell Phone:

City:	State:	Zip Code:	Email:

Occupation:	Employer:
Work Phone:	May we contact you at work? ❑Yes ❑No

Work Activities: ❑Sit ❑Stand ❑Walk ❑Light Labor ❑Heavy Labor

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Decline to answer	Spouse's Name:
Children: ❑Yes ❑No If yes, how many?	Spouse's Date of Birth:

Would you like to receive appointment reminders? Choose ONE:
❑Email ❑Text Message ❑Phone Call ❑None

Preferred Language: ❑English ❑Spanish ❑Other _________________	Ethnicity: ❑Hispanic or Latino ❑Non-Hispanic or non-Latino ❑Declined to Answer

Please check ALL races that apply: ❑White ❑Black or African American
❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian/Pacific Islander ❑Decline to Answer

Have you ever consulted a chiropractor before? ❑No ❑Yes; whom?	Whom may we thank for referring you?

Alcohol Use: ❑None ❑Light ❑Moderate ❑Heavy	**Drug Use:** ❑None ❑Light ❑Moderate ❑Heavy	**Exercise:** ❑None ❑Daily ❑Weekly ❑Monthly ❑Rarely

Smoking Status: ❑Current everyday ❑Current some days ❑Former ❑Never
Start Year _____ Quit Date _______

Typical eating habits:
❑Skip breakfast ❑Two meals a day ❑Three meals a day ❑Snacking between meals

Medications:	**Supplements:**	**Allergies:**

INSURANCE INFORMATION	
Primary Insurance:	Insured ID:

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________ and assign directly to Dr. _____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

____
Responsible Party Signature

___________________ _______________
Relationship Date

Primary Care Physician	
Name (First and Last):	
Phone Number:	
Date of Last Appointment:	

ARE YOU INTERESTED IN ANY OF THE FOLLOWING SERVICES WE OFFER?		
Service	**YES**	**NO**
Chiropractic Care		
Nutritional Therapy		
Massage Therapy		
Rehabilitation/Exercise Therapy		

Release of Medical Information and Emergency Contact:

Please list ALL persons we may share your medical/health information with or contact if we cannot reach you. An *emergency contact* is the first person medical personnel will get in touch with in the case of an emergency.

Name (First and Last)	Phone Number
1. **Emergency Contact*	
2.	
3.	

I verify the above and previous information listed regarding my health history is current and accurate.

X____Date:______/_______/_______

FOR OFFICE USE ONLY		
HEIGHT:	WEIGHT:	BP:

HEALTH HISTORY

In general, how would you rate your overall health? ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check the box beside any condition that you've had or currently have.

☐Acne	☐Cancer	☐Heart burn	☐Loss of Smell or Taste	☐Prostate Issues
☐Alcoholism	☐Carpal Tunnel	☐High Blood Pressure	☐Liver Disease	☐Prosthesis
☐Allergies	☐Chicken Pox	☐High Cholesterol	☐Migraine	☐Psoriasis
☐Anemia	☐Constipation	☐Glaucoma	☐Menopause	☐Rheumatism
☐Angina	☐Diabetes	☐Goiter	☐Mono	☐Rheumatic Fever
☐Anorexia or Bulimia	☐Dementia	☐Hair Loss	☐Multiple Sclerosis	☐Ringing in Ears
☐Anxiety	☐Depression	☐Headache	☐Mental Disease	☐Scoliosis
☐Appendicitis	☐Diarrhea	☐Hernia	☐Mumps	☐Shortness of Breath
☐Asthma	☐Earache	☐Herniated Disc	☐Neck/Back Pain	☐Shoulder Problems
☐Arthritis	☐Eczema	☐Hip Disorder	☐Numbness	☐Sleep apnea
☐Alzheimer's	☐Emphysema	☐Hypoglycemia	☐Osteoporosis	☐STD
☐AIDS	☐Excessive Bruising	☐Impotency	☐Pacemaker	☐Sudden Weight Loss/Gain
☐Bed Wetting	☐Fainting	☐Infertility	☐ PCOS	☐Suicide Attempt
☐Bleeding Disorder	☐Fibromyalgia	☐Irregular Heart	☐Pinched Nerve	☐Thyroid Disorder
☐Blurred Vision	☐Frequent Infections	☐Kidney Disease	☐ "Pins and Needles"	☐Tonsillitis
☐Breast Lump	☐Food Sensitivities	☐Kidney Stones	☐Poor Posture	☐TMJ Issues
☐Broken Bone	☐Foot/Ankle Problems	☐Knee Injury	☐Poor Circulation	☐OTHER:__________ ______________
☐Bronchitis	☐Hearing Loss	☐Low Blood Pressure	☐Pneumonia	
☐Blood Clots	☐Heart Disease		☐Polio	

PATIENT HISTORY

Please describe your past surgeries:

☐Spine:____

☐Other: ____ ☐None

Please describe your past accidents:

1. Accident:______________________(Date):______________☐Job ☐Auto ☐Other
2. Accident:______________________(Date):______________☐Job ☐Auto ☐Other
3. Accident:______________________(Date):______________☐Job ☐Auto ☐Other

FAMILY HISTORY

☐Arthritis	☐Cancer	☐Headache	☐Liver Disease	☐Migraine	☐Thyroid Disorder
☐Asthma	☐Diabetes	☐Heart Disease	☐Low Blood Pressure	☐Osteoporosis	☐TMJ Issues
☐Alzheimer's	☐Dementia	☐High Blood Pressure	☐Lung Disease	☐Rheumatism	☐OTHER:
☐Autoimmune disease	☐Depression	☐High Cholesterol	☐Mental Disease	☐Scoliosis	
☐Blood Clots	☐Fibromyalgia	☐Kidney Disease	☐Multiple Sclerosis	☐Stroke	

I verify the above and previous information listed regarding my health history is current and accurate.

X____Date:______/_______/_______

Saks Wellness Center, A NEUROGENX Preferred Provider

PATIENT INTAKE FORM

PATIENT INFORMATION

Patient:____ Gender: Male/Female

Last Name First Name Middle Initial

Phone:____________________ **Email:** __________________________

PATIENT HEALTH HISTORY

Do you have a pacemaker? ○ **Yes** ○ **No**

Are you a diabetic? ○ **Yes** ○ **No**

Have you taken chemotheraphy? ○ **Yes** ○ **No**

Are you taking a statin drug? ○ **Yes** ○ **No**

Do you have back problems? ○ **Yes** ○ **No**

Please check the box if you are currently being treated for:

○ Neuropathy ○ Diabetes ○ Cancer ○ Low Back

What was your diagnosis?

Diabetic Neuropathy: ○ Peripheral ○ Proximal ○ Autonomic ○ Focal

Other Neuropathy: ○ Cranial ○ Idiopathic ○ Femoral ○ Compression Mononeuropathy ○ Other

Who diagnosed you?

Type: ○ Pain ○ Neurologist ○ Podiatrist ○ Other Name ____________________

Previous Injuries or Surgeries

○ Back ○ Neck ○ Hips ○ Knees ○ Other

____

Medications

1. ________________
2. ________________
3. ________________
4. ________________
5. ________________
6. ________________

Notes

____

____

____

Chief Complaint

Pain? ○ Sharp ○ Dull ○ Achy ○ Stabbing ○ Numbing ○ Tingling ○ Burning

Where? ○ Back ○ Neck ○ Face ○ Hands ○ Thighs ○ Feet

What activities make it worse? ○ Sitting ○ Walking ○ Standing ○ Other

____

____

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1447 S. Otsego Avenue, Gaylord, MI 49735 | Office: 989-732-7000 | Fax: 989-488-1436
swcgaylord@gmail.com | www.sakswellnesscenter.com | www.neurogenx.com/saks

PATIENT HEALTH HISTORY (CONTINUED)

Chief Complaint (Continued) ○ Feet ○ Hands ○ Other

○ Cold when not cold ○ Feel heavy ○ Cramping ○ Poor sleep
○ Feel constricted like wearing tight shoes/gloves ○ Restless legs at night ○ Pins and needles sensation
○ Muscle weakness ○ Problems with coordination or reflexes

When did your symptoms begin? ____________________

Since then has your condition ○ Gotten better ○ Gotten worse ○ Stayed the same

Is it worse in the morning or as day progresses? ____________________

Do your symptoms vary depending on the weather? ____________________

Treatments that make it feel better?
○ Heat ○ Ice ○ Elevation ○ Massage ○ Acupuncture ○ Physical Therapy ○ Other ____________________

Summary Questions

How has this affected your lifestyle, and quality of life?
○ Walking ○ Golf ○ Gardening ○ Shopping ○ Other ____________________

If you can't find a solution to this problem what do you think will happen to you, as your Neuropathy progressively gets worse?
○ Cane ○ Walker ○ Wheelchair ○ Other ____________________

What is the main result you would like to see happen with this treatment? ____________________

____

CONSULTATION PATIENT NOTES

New Patient Questionnaire

How did you hear about the Neurogenx Nerve Center?
○ Internet ○ Facebook ○ Friends ○ Physician's Office ○ Radio ○ TV

What is the main problem/symptom that prompted you to request a consultation?
○ Pain ○ Weakness ○ Balance ○ Mobility ○ Numbness ○ Burning ○ Tingling ○ Other

How serious do you think your problem is?
○ Minimal (Annoying, but causing no limitations)
○ Slight (Tolerable, but causing a little limitation)
○ Moderate (Sometimes tolerable, but definitely causing limitations)
○ Severe (Causes significant limitations)
○ Extreme (Causing near constant limitations more than 80% of the time)

Doctor's Notes: **Follow up eval:** ○ Neuropathy hands ○ Neuropathy feet ○ Chiropractic

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swcgaylord@gmail.com | www.sakswellnesscenter.com | www.neurogenx.com/saks

Saks Wellness Center PC

NAME:______________________________

D.O.B:____________ DATE:___________

Write your WORST symptom or area of irritation on this page

Please fill out the form below to describe your current symptoms.

SYMPTOM 1

Symptom:

Area of irritation:_________________________ **Doctor's notes:**_____________________________

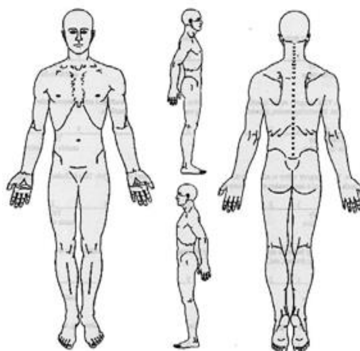
Pain rating (1-10, with 10 being worst imaginable):
❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10

Main impaired activity made more difficult by above symptom:

Pain Quality:	Pain Frequency:	Pain Radiates Into:	Pain Cause:	Pain Duration:
❑Aching	❑Constant	❑Arm	❑A Fall	When did symptom first occur? __________________
❑Burning	❑Frequent	❑Leg	❑Auto Accident	
❑Cramping	❑Intermittent	❑Shoulder	❑Lifting Injury	
❑Numbness	❑Occasional	❑Buttock	❑Unknown	
❑Sharp		***And***	❑Gradual Onset	**Doctor's Notes:** __________________
❑Shooting		❑Right Side		
❑Stiffness		❑Left Side		
❑Tingling		❑Both Sides		

Pain Pattern:	Pain Aggravated By:		Pain Relieved By:	Prior Intervention:
❑Worse in Morning	❑Bending	❑Twisting	❑Stretching	❑OTC Medicines
❑Worse in Afternoon	❑Coughing/Sneezing	❑Lying down	❑Rest	❑Prescription medicine
❑Worse in Evening	❑Getting up from chair	❑Standing	❑Lying Down	❑Massage
❑Worse when Sleeping	❑Walking	❑Sitting	❑Standing	❑ Surgery
	❑Lifting		❑Ice	❑Chiropractic Care
			❑Knees Bent	

Please Mark Applicable Areas for this Condition:



SYMPTOM 2				
Symptom: Area of irritation:__________________________			**Doctor's notes:**______________________________	
Pain rating (1-10, with 10 being worst imaginable): ❑1 ❑2 ❑3 ❑4 ❑5 ❑6 ❑7 ❑8 ❑9 ❑10				
Main impaired activity made more difficult by above symptom:				
Pain Quality: ❑Aching ❑Burning ❑Cramping ❑Numbness ❑Sharp ❑Shooting ❑Stiffness ❑Tingling	**Pain Frequency:** ❑Constant ❑Frequent ❑Intermittent ❑Occasional	**Pain Radiates Into:** ❑Arm ❑Leg ❑Shoulder ❑Buttock ***And*** ❑Right Side ❑Left Side ❑Both Sides	**Pain Cause:** ❑A Fall ❑Auto Accident ❑Lifting Injury ❑Unknown ❑Gradual Onset	**Pain Duration:** When did symptom first occur? _________________ **Doctor's Notes:** _________________
Pain Pattern: ❑Worse in Morning ❑Worse in Afternoon ❑Worse in Evening ❑Worse when Sleeping	**Pain Aggravated By:** ❑Bending ❑Coughing/Sneezing ❑Getting up from chair ❑Walking ❑Lifting	❑Twisting ❑Lying down ❑Standing ❑Sitting	**Pain Relieved By:** ❑Stretching ❑Rest ❑Lying Down ❑Standing ❑Ice ❑Knees Bent	**Prior Intervention:** ❑OTC Medicines ❑Prescription medicine ❑Massage ❑ Surgery ❑Chiropractic Care

Please Mark Applicable Areas for this Condition: