LIGHTHOUSE
MEDICAL CENTER

FILL OUT THE APPLICATION ENTIRELY & LEGIBLY. WE NEED INFORMATION FOR INSURANCE

NAME:		**SSN #**		**DATE**
DOB	**AGE**	**SEX M F**	**MARITAL STATUS M S D W**	**NO. OF CHILDREN**
ADDRESS				
CITY		**STATE**		**ZIP**
PHONE		**EMAIL**		
SPOUSE NAME		**PHONE**		
YOUR OCCUPATION				**RETIRED Y N**
CURRENT OR PREVIOUS WORK :	**CLERICAL Y N**	**LIGHT LABOR Y N**	**MODERATE LABOR Y N**	**HEAVY LABOR Y N**
EMERGENCY CONTACT			**PHONE**	

TELL US ABOUT YOUR HEALTH AND SYMPTOMS (CURRENT OR HAVE BEEN DIAGNOSED)

PLEASE CHECK ALL THAT APPLY ⇨

___ LOWER BACK PAIN
___ LEG OR FOOT PAIN/NUMBNESS
___ SPINAL FRACTURES
___ SPINAL ARTHRITIS
___ SPINAL STENOSIS
___ SCIATICA
___SHINGLES
___NECK PAIN
___HAND PAIN
___HERNIATED DISC
___ HAND NUMBNESS
___PLANTAR FASCIITIS
___DIABETES
___HIGH COLESTEROL
___HIGH/LOW BLOOD PRESSURE
___CHEMOTHERAPY (CURRENTLY OR PREVIOUSLY ON)
___ CANCER (CURRENTLY OR PREVIOUSLY DIAGNOSED)

___ HEART PROBLEMS
___HEART ATTACK
___DEGENERATIVE DISC
___VASCULAR LEG PROBLEMS
___VASCULAR SURGERY
___STROKE
___ARTHRITIS IN HANDS/FEET
___BULGING DISC
___MORTON'S NEUROMA
___NEUROPATHY
___KNEE SURGERY
___FOOT SURGERY
___HIP SURGERY
___JOINT REPLACEMENT
___IMPLANTED CORD/BLADDER STIMULATOR
___EXCESSIVE THIRST OR URINATION
___KIDNEY ISSUES OR DIALYSIS

___POOR WOUND HEALING
___PINCHED NERVE
___POOR CIRCULATION
___GOUT
___LEG FRACTURES
___BLOOD DISEASE
___ BLEEDING DISORDER

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PLEASE LIST ANY MEDICATION AND/OR VITAMINS CURRENTLY TAKING	
1.	10.
2.	11.
3.	12.
4.	13.
5,	14.
6.	15.
7.	16.
8.	17.
9.	18.

PLEASE LIST BELOW ANY SERIOUS MEDICAL CONDITIONS YOU HAVE HAD

_____

NAME OF YOUR PRIMARY CARE PHYSICIAN _____

MAY WE CONTACT THEM WITH UPDATES REGARDING YOUR TREATMENT? ☐ YES ☐ NO

PLEASE LIST BELOW ANY BACK, KNEE OR LEG SURGERIES YOU'VE HAD:

_____

HAVE YOU HAD AN EMG PERFORMED ON YOUR LEGS/FEET? ☐ **YES** ☐ **NO**

DO YOU EXERCISE REGULARLY? ☐ **YES** ☐ **NO**

ARE YOUR SYMPTOMS WORSE AT NIGHT? ☐ **YES** ☐ **NO** **AROUND WHAT TIME?** _____

DO YOU SMOKE? ☐ **YES** ☐ **NO IF YES, HOW MANY CIGARETTES DAILY?** _____

DO YOU DRINK? ☐ **YES** ☐ **NO IF YES, HOW MANY DRINKS PER WEEK?** _____

DO YOU EXERCISE REGULARLY? ☐ **YES** ☐ **NO IF YES, PLEASE DESCRIBE TYPE AND HOW OFTEN:**

_____

_____

_____

LIST ALL ALLERGIES/SENSITIVITIES TO MEDICATIONS, FOOD AND OTHER ITEMS:

ITEMS YOU REACT TO:	**REACTION:**
_____	_____
_____	_____
_____	_____

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PRESENT HEALTH CONDITIONS FOR NEUROPATHY PATIENTS

IN ORDER OF IMPORTANCE, LIST THE HEALTH POBLEMS YOU ARE MOST INTERESTED IN GETTING CORRECTED:

1._____

2._____

3._____

4._____

LIST APPROXIMATELY HOW LONG YOU HAVE NOTICED THESE PROBLEMS:

1._____

2._____

3._____

4._____

IS THERE A CERTAIN TIME OF THE DAY ANY OF THESE PROBLEMS ARE BETTER OR WORSE?

_____

_____

_____

IS YOUR BALANCE OR WALKING ABILITY AFFECTED? IF YES, PLEASE DESCRIBE:

_____

_____

_____

WHAT DO YOU THINK IS CAUSING YOUR PROBLEM?

_____

_____

_____

CIRCLE THE THINGS YOU HAVE USED FOR THESE PROBLEMS:

GABAPENTIN NEURONTIN LYRICA CYMBALTA PHYSICAL THERAPY PAIN MEDICATIONS ALEVE

TYLENOL INUPROFEN MOTRIN CHIROPRACTIC MASSAGE THERAPY INJECTIONS CREAMS

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PRESENT HEALTH CONDITIONS FOR NEUROPATHY PATIENTS

HAVE YOUR SYMPTOMS: ☐ **IMPROVED** ☐ **WORSENED** ☐ **STAYED THE SAME**

LIST ANYTHING THAT MAKES YOUR CONDITION WORSE:

_____

_____

_____

LIST ANYTHING THAT MAKES YOUR CONDITION BETTER:

_____

_____

_____

HOW WOULD YOU DESCRIBE THE SYMPTOMS?

___ACHING PAIN	___NUMBNESS	___HOT SENSATION	___COLD HANDS/FEET
___STABBING PAIN	___TINGLING	___THROBBING PAIN	___CRAMPING
___SHARP PAIN	___BURNING	___PINS & NEEDLES	___SWELLING
___TIREDNESS	___HEAVY FEELING	___DEAD FEELING	___ELECTRIC SHOCKS

IS THIS CONDITION INTERFERING WITH ANY OF THE FOLLOWING?

____SLEEP	____WALKING	___DAILY ACTIVITIES
____WORK	____STANDING	___RECREATIONAL ACTIVITIES

PATIENT'S QUALITY OF LIFE SURVEY—NEUROPATHY

PLEASE TAKE SEVERAL MINUTES TO ANWSER THESE QUESTIONS SO WE CAN HELP YOU GET BETTER (CIRCLE AS MANY THAT APPLY)

1. HOW HAVE YOU TAKEN CARE OF YOUR HEALTH IN THE PAST?

A. MEDICATIONS B. ROUTINE MEDICAL C. NUTRITION/DIET D. VITAMINS

E. EMERGENCY ROOM F. EXERCISE G. HOLISTIC CARE H. CHIROPRACTIC

I. OTHER (PLEASE SPECIFY): _____

2. HOW DID THE PREVIOUS METHOD(S) WORK OUT FOR YOU?

A. BAD RESULTS B. SOME RESULTS C. GREAT RESULTS D. NOHING CHANGED

E. DID NOT GET WORSE F. DID NOT WORK VERY LONG G. STILL TRYING H. CONFUSED

3. HOW HAVE OTHERS BEEN AFFECTED BY YOUR HEALTH CONDITION?

A. NO ONE IS AFFECTED B. HAVEN'T NOTICED ANY PROBLEM

C. THEY TELL ME TO DO SOMETHING D. PEOPLE AVOID ME

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PATIENT'S QUALITY OF LIFE SURVEY—NEUROPATHY

4. WHAT ARE YOU AFRAID THIS MIGHT BE (OR BEGINNING) TO AFFECT (OR WILL AFFECT) ?

A. JOB B. KIDS C. FUTURE ABILITY D. MARRIAGE E. SELF-ESTEEM

F. SLEEP G. TIME H. FINANCES I. FREEDOM

5. ARE THERE HEALTH CONDITIONS YOU ARE AFRAID THIS MIGHT TURN INTO?

A. NEED SURGERY B. CHRONIC FATIGUE C. DEPRESSION D. FIBROMYALGIA

E. ARTHRITIS F. DIABETES G. CANCER H. HEART DISEASE

I. FAMILY HEALTH PROBLEMS

6. HOW HAS YOUR HEALTH CONDITION AFFECTED YOU JOB, RELATIONSHIPS, FINANCES, FAMILY OR OTHER ACTIVITIES?

PLEASE GIVE EXAMPLES: _____

_____

_____

_____

7. WHAT HAS THAT COST YOU? (TIME, MONEY, HAPPINESS, FREEDOM, SLEEP, PROMOTION ETC…)

GIVE 3 EXAMPLES: _____

_____

_____

_____

8. WHAT ARE YOU MOST CONCERNED WITH REGARDING YOUR PROBLEM? _____

_____

_____

_____

9. WHERE DO YOU PICTURE YOURSELF BEING IN THE NEXT 1 TO 3 YEARS IF THIS PROBLEM IS NOT TAKEN CARE OF?

PLEASE BE SPECIFIC: _____

_____

_____

_____

10. WHAT WOULD YOU BE DIFFERENT/BETTER WITHOUT THIS PROBLEM? PLEASE BE SPECIFIC: _____

_____

_____

_____

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PATIENT'S QUALITY OF LIFE SURVEY—NEUROPATHY (CONTINUED)

11. WHAT DO YOU DESIRE MOST TO GET FROM WORKING WITH US? _____

_____

_____

_____

12. WHAT WOULD THAT MEAN TO YOU? _____

_____

_____

_____

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PREVIOUS HEALTH HISTORY

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND PERTINENT PERSONAL INFORMATION. THE DOCTOR RESERVES THE RIGHT TO DISCUSS THIS INFORMATION WITH MEDICAL AND ALLIED HEALTH PROFESSIONALS PER THE INFORMED CONSENT. COPIES BY YOUR VERBAL REQUEST.

NAME: _____ SIGNATURE: _____

PLEASE GIVE THE NAME, ADDRESS AND OFFICE PHONE NUMBER OF YOUR PRIMARY CARE PHYSICIAN.

NAME: _____ PHONE: _____

ADDRESS: _____

WHEN WERE YOU LAST SEEN THERE? _____

MAY WE SEND THEM UPDATES ON YOUR TREATMENT/CONDITION? ☐ YES ☐ NO

STATEMENT

A. I HEREB AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO EVALUATE MY CASE OR PROCESS ANY FUTURE CLAIMS.

B. I AUTHORIZE PAYMENT OF ANY MEDICAL BENEFITS FROM TIRD PARTIES FOR ANY FUTURE CHARGES SUBMITTED TO BE PAID DIRECTLY TO THIS OFFICE. WE INVITE YOU TO DISCUSS WITH US ANY QUESTIONS REGARDING OUR SERVICES AND OR FEES. THE BEST HEALTH SERVICES ARE BASED ON A FRIENDLY, MUTUAL UNDERSTANDING BETWEEN THE PROVIDER AND PATIENT.

C. I UNDERSTAND THE ABOVE INFORMATION AND GUARANTEE THIS FORM WAS COMPLETED CORRECTLY TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL OR INSURANCE STATUS .

SIGNATURE: _____ DATE: _____