WESTSIDE WELLNESS CENTER

Name_____ **DOB:** _____

Cell Phone_____**Email address**_____**Occupation**_____

Home Address_____City_____Zip_____

Who referred you to our office?_____

Please circle your answers

Did your symptoms begin slowly or suddenly?

What is your pain level? (0-1-2-3-4-5-6-7-8-9-10) **10 is the most painful**

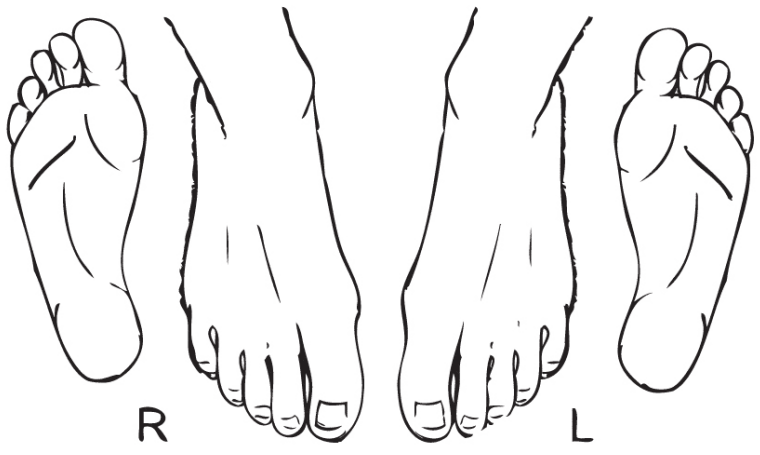
What is your burning level? (0-1-2-3-4-5-6-7-8-9-10)

What is your numbness & Tingling level? (0-1-2-3-4-5-6-7-8-9-10)

Do you have muscle cramps especially at night? (0-1-2-3-4-5-6-7-8-9-10)

Do you have balance issues or weak when walking?

Please mark all areas for pain (P) or numbness (N)



Peripheral Neuropathy Questionnaire

Name:_____ Date _____

Please take a few minutes to answer the following questions about the feeling in your legs and feet. Check **yes** or **no** based on how you usually feel. Thank you

1. Are your feet too sensitive to touch	☐ Yes ☐ No
2. Are your symptoms always worse at night?	☐ Yes ☐ No
3. Do you have auto immune disease or Rheumatoid Arthritis?	☐ Yes ☐ No
4. Do you have dairy intolerance, other Food Allergies?	☐ Yes ☐ No
5. Are you Gluten Intolerant? Have you been tested?	☐ Yes ☐ No
6. Do you have difficulty going up or down stairs?	☐ Yes ☐ No
7. Have you ever had a head injury?	☐ Yes ☐ No
8. Has your handwriting changed in recent years?	☐ Yes ☐ No
9. Do you have difficulty getting or staying asleep?	☐ Yes ☐ No
10. Do you have increased urination at night?	☐ Yes ☐ No
11. Do you have chronic lower back or neck pains?	☐ Yes ☐ No
12. Do you have Constipation or diarrhea?	☐ Yes ☐ No
13. Have you had any dental infections, root canals or extractions?	☐ Yes ☐ No
14. Do you spend more than two minutes on the toilet?	☐ Yes ☐ No
15. Are some of your family members diabetic?	☐ Yes ☐ No
16. Do you feel anxious, nervousness or hyperactive?	☐ Yes ☐ No
17. Do you have acid reflux?	☐ Yes ☐ No
18. Do you Fatty Liver Disease?	☐ Yes ☐ No
19. Do you have a pacemaker or other implant?	☐ Yes ☐ No
20. Have you had Covid-19?	☐ Yes ☐ No
21. Do you feel faint or dizzy?	☐ Yes ☐ No
22. Do you have any large joint replacements?	☐ Yes ☐ No
23. Have you already had: an EMG/Nerve test?	☐ Yes ☐ No
24. Lumbar or Cervical MRI disc herniations or spinal stenosis?	☐ Yes ☐ No
25. Do your hands go numb or swell?	☐ Yes ☐ No
26. Are you Retired [ ] Employed [ ]	
27. Is your household income 0-25,000 [ ] 25-55,000 [ ] 55,000 + [ ]	

Now that you had the chance to review all of the symptoms that have brought you here, please list all of the things in your life that have caused these health issues._____

_____

_____

_____

68 DRUGS THAT CAUSE NEUROPATHY

If you have been using any of these meds please CIRCLE them and let the doctor know.
We highlighted the most common ones for your ease of selection.

Allopurinol, Ametrine bismyslate, Amiodarone, **Amitriptyline**, Ara-C, **Aspartame**, Bortezomib, Carbamide, **Chemotherapy agents** (17) **Bortezomib, Oxaliplatin, Taxanes, Thalidomide, Vinca alkaloids,** Chloramphenicol, Chloroquine, Chlorprothixene, Clioquinol, Clofibrate, **Colchicine, Cipro**, Cyanate, Cyclosporine, Danosine, Dapsone, Dichloroacetate, Disopyramide, Disulfiram, Docetaxel, Enalapril, Ethambutol, Ethionamide, Etoposide, Glutethimide, Gold, **Hydrazaline, Imipramine (tricyclic anti-depressants),** Isoniazid, **Lisinopril,** Leflunomide, **Levaquin,** Lithium, **Metformin**, **Mercury**, Methaqualone, Metronidazole, Nitrofurantoin, Nitrous Oxide, Paclitaxel, Phenelzine, Phenytoin, **Proton Pump Inhibitors (Aciphex, Protonix, Prevacid, Prilosec),** Propafenone, Pyridoxine, **Statins,** Stavudine, Sulfasalazine, Suramin, Tacrolimus, Thalidomide, **Tumor Blockers**, **Vancomycin**, Vincristine, Vinorelbine, Zalcitabine.

Please list all medications you're currently taking or ones that you were prescribed but you were unable to tolerate or may have caused your symptoms.

_____

_____

_____

Initial Analysis / Examination

As a part of the analysis and examination process, you are consenting to the following examination procedures: Postural analysis and balance testing, range of motion, palpation, neurological testing, muscle strength testing and orthopedic testing.

No information regarding our patients is shared or distributed with any other person or organization without the patient's signed authorization. Your signature below acknowledges receipt of our privacy policy information statement.

Patient's Signature_____ Date:_____

Dr. Jason Kelberman, DC _____