APPOINTMENT DATE: ______________________________

APPOINTMENT TIME: ______________________________

DEMOGRAPHICS:

LAST NAME: ______________ FIRST NAME: ______________ M.I.: ________

DOB: _____ / _____ / _____ SS# ______________________________

EMAIL: ______________________________

ADDRESS: ______________ CITY: __________ STATE: _____ ZIP: ________

CELL PHONE: ______________ HOME PHONE: ______________

HOW DID YOU HEAR ABOUT US? ______________________________

EMERGENCY CONTACT: __________ RELATION: __________ PHONE: __________

ETHNICITY: ______________ RELIGION: ______________

INSURANCE INFORMATION:

PRIMARY: ______________ ID: ______________

RELATION TO POLICYHOLDER: ______________ POLICYHOLDER'S DOB: ________

SECONDARY: ______________ ID: ______________

RELATION TO POLICYHOLDER: ______________ POLICYHOLDER'S DOB: ________

VETERAN YES / NO ______________

IN SUBMITTING MY EMAIL, I AUTHORIZE THE NEUROPATHY TREATMENT CLINIC OF OKLAHOMA (NTCO) TO UTILIZE THE EMAIL ADDRESS LISTED ABOVE FOR CORRESPONDENCE OF MONTHLY NEWSLETTERS, WEEKLY APPOINTMENT REMINDERS, AND FUTURE MARKETING MATERIAL PROVIDED BY NTCO.

TM Flow Pre Screening

Name : D/O/B:

B/p: HR:

Weight : PlusOxi:

Height :

Medical Questionaire

please circle yes or no :

Are you undergoing external defibrillation ? Yes No

Do you have an implantable pacemaker or cardicac device or insulin pump? Yes No

Did you have a Bilateral Mastectomy Yes No

Are you missing two or more limbs? Yes No

Do you have any arterial catheters on your arm or leg or an fistula or shunt ? Yes No

Are you a Diabetic Yes No if so what is your A1C ________

Circle all that apply :

Symptoms /conditions

Weakness Heaches Dizziness Chronic pain Tingling in toes Numbness

Exercise Intolerance Claudication Impaired reflex tests Erectile Dysfuncation Alchoism

Cramping in the legs Upper limb symptoms

Diseases

Parkinson's disease Heart failure Atherosclerosis LV hypertrophy Arrythmia Hypertension

Guillain Barre Syndrome Raynaud's Syndrome Alzheimer's disease A.L.S Renal failure

Type I diabetes Type II diabetes Aids Cushing's Syndrome Chronic hepatitis Cancer

Digestive Disorders Hepatic Failure Hyperthroidism Hypothyroidsm Neropathy Retinopathy

Glaucoma Retinopathy Unipolar Depression Diabetic foot Neuropathy

Cancellation / No Show Office Policy

We ask that you Provide us with 24 Hours notice of Cancellation for any appointments.

We reserve the right to charge a $30.00 fee for all No Show appointments and or Canceled appointments without a 24 Hour Notice.

Thank you for your Understanding!

Patient's Signature: ______________________________

Date: ______________________________

OTHER PROVIDER INFORMATION:

PHARMACY LOCATION & PHONE: ___________________________

PRIMARY CARE PHYSICIAN: ____________________ PHONE: ______________

CARDIOLOGIST: ______________________________ PHONE: ______________

NEUROLOGIST: ______________________________ PHONE: ______________

SOCIAL HISTORY:

DO YOU SMOKE? YES / NO QUANTITY/DAY: __________

CONSUME ALCOHOL? YES / NO QUANTITY: __________

HAVE AN IMPLANTED DEVICE? YES / NO IF SO, TYPE: ________________

DIABETIC HISTORY:

ARE YOU A DIABETIC? YES / NO WHEN WERE YOU DIAGNOSED? __________

CURRENT A1C: ____________ CURRENT FASTING SUGARS: ____________

BLOOD SUGARS CONTROLLED? YES / NO

DOES YOUR PCP TREAT YOUR DIABETES? YES / NO

IF NOT, WHO DOES? ______________________________

NEUROPATHY HISTORY:

CHIEF COMPLAINT: ☐ PAIN ☐ NUMBNESS ☐ TINGLING ☐ SHOOTING SHOCKS ☐ PAIN WITH TOUCH ☐ BURNING ☐ ACHING

WHERE ARE THESE SYMPTOMS LOCATED? ______________________

DATE DIAGNOSED: ____________ DIAGNOSED BY: ______________

IF BY EMG/NCS, GIVE THE DATE OF STUDY: __________________

I, THE UNDERSIGNED, HAVE REVIEWED THE ABOVE AND CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGN NAME: ______________________________

DATE: ______________________________

SURGICAL HISTORY:

PROCEDURE	SURGERY YEAR	COMPLICATIONS

FAMILY HISTORY:	MOTHER	FATHER	BROTHER	SISTER
ARTHRITIS	☐	☐	☐	☐
CANCER	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐
THYROID	☐	☐	☐	☐
NEUROPATHY	☐	☐	☐	☐

ALLERGIES:

____

____

____

PATIENT HEALTH QUESTIONNAIRE (PHQ-2):

The purpose of this questionnaire is to inquire about the frequency of depressed mood and lack of pleasure over the past two weeks. Please answer the following questions with a rating of 0 , +1 , +2 , or +3.

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	+1	+2	+3
2. Feeling down, depressed or hopeless	0	+1	+2	+3

MEDICAL HISTORY

(Please circle all that apply)

CARDIOVASCULAR
Aneurysm
Angina
Deep
Dysrhythmia
Hypertension (HTN)
Murmur
Myocardial Infarction
Other Heart Disease

EARS
Hearing Aids

NOSE/SINUSES
Allergic Rhinitis
Sinus Infection

MOUTH/THROAT/TEETH
Dentures

RESPIRATORY
Asthma
Bronchitis
COPD
Bronchitis/Emphysema
Pleuritis
Pneumonia

EYES
Blindness
Cataracts
Glaucoma
Wear
Glasses/Contacts

HEAD
Trauma

GASTROINTESTINAL
Cirrhosis
GERD
Gallbladder disease
Heartburn
Hemorrhoids
Hepatitis
Hiatal hernia
Jaundice
Ulcer

GENITOURINARY
Hernia
Incontinence
Nephrolithiasis
Other kidney disease
STDs
UTI(s)

MUSCULOSKELETAL
Arthritis
Gout
M/S injury

ENDOCRINE
Goiter
Hyperlipidemia
Hypothyroidism
Thyroid disease
Thyroiditis
Type I DM
Type II DM

NEUROLOGICAL
Epilepsy
Seizures
Severe headaches (migraines)
Stroke
TIA

PSYCHIATRIC
Bipolar disorder
Depression
Hallucinations (delusions)
Suicidal ideation
Suicide attempts

SKIN
Dermatitis
Mole(s)
Other skin condition(s)
Psoriasis

INFECTIOUS
HIV
STDs
Tuberculosis (dz)
Tuberculosis (exposure)

HEME/ONC
Anemia
Cancer

OTHER CONTITIONS
____
____

MEDICATIONS

MEDICATION NAME	DOSAGE & MG

DO I NEED TO TEST FOR PAD?

PERIPHERAL ARTERIAL DISEASE (PAD) IS A SERIOUS CIRCULATORY PROBLEM IN WHICH THE BLOOD VESSELS THAT CARRY BLOOD TO YOUR ARMS, LEGS, BRAIN, OR KIDNEYS BECOME NARROWED OR CLOGGED. IT AFFECTS OVER 8 MILLION AMERICANS, MOST OVER THE AGE OF 50. IT MAY RESULT IN LEG DISCOMFORT WITH WALKING, POOR HEALING LEG SORES/ULCERS, DIFFICULT TO CONTROL BLOOD PRESSURE OR SYMPTOMS OF STROKE. PEOPLE WITH PAD ARE AT SIGNIFICANTLY INCREASED RISK OF STROKE AND HEART ATTACK. ANSWERS TO THESE QUESTIONS WILL DETERMINE IF YOU ARE RISK FOR PAD AND IF A VASCULAR EXAM WILL HELP US BETTER ASSES YOUR VASCULAR HEALTH STATUS.

CHECK IF ANY APPLY:

- ☐ **FOOT/CALF/BUTTOCK/HIP/THIGH DISCOMFORT WHEN YOU WALK WHICH IS RELIEVED BY REST**
- ☐ **ANY PAIN AT REST IN YOUR LOWER LEGS/FEET**
- ☐ **FOOT/TOE PAIN THAT OFTEN DISTURBS YOUR SLEEP**
- ☐ **TOES/FEET PALE, DISCOLORED OR BLUISH**
- ☐ **SKIN WOUNDS OR ULCERS ON YOUR FEET/TOES THAT ARE TOO SLOW TO HEAL**
- ☐ **DIAGNOSED WITH DIMINISHED OR ABSENT PEDAL (FOOT) PULSES**
- ☐ **SUFFERED A SEVERE INJURY TO THE LEGS/FEET**
- ☐ **HAVE AN INFECTION OF THE LEG(S)/FEET THAT MAY BE GANGRENOUS (BLACK SKIN TISSUE)**

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment, or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: ______________________________

Printed Name-Patient or Responsible Party

____

Patient Signature or Responsible Party Date

____

Relationship to patient (if other than patient)

Witness: ______________________________

Printed Name-Practice Representative

______________________ ______/_____/__________

Signature Date