DANVILLE
Neuropathy Center

Patient Information			
Last Name:	First Name:		Middle:
SSN#:	DOB:	Age:	Gender:
Marital Status:	Emergency Contact Name:		Emergency Contact Phone:
Address:			
City:	State:		Zip:
Home Phone: ( )	Cell Phone: ( )		Work Phone: ( )
Email Address:			

Office Use Only:		
Vital Signs:		
Temperature:	Height:	Weight:
Heart Rate:	Blood Pressure:	RR, O2:

Financial Policy: Our office will verify your insurance eligibility; however, we cannot be held responsible for the information received when verifying insurance benefits because it is not a guarantee of payment or eligibility. Upon request, we will obtain an **ESTIMATE** of coverage from your insurance company prior to the service date. While we request an accurate estimate from your insurer, your final balance may differ from the estimate provided once insurance processes the claim. As a courtesy to you, our billing service (National Billing Institute) will submit your insurance claim(s) for services rendered at this office they can be reached at: (855)-842-1633. We will send a claim to any secondary insurance if this is provided at the time of service. Please be advised that your insurance policy is a contract between you and your insurance company.

I, the undersigned, acknowledge that I understand the above, and agree to be financially responsible for any services I receive regardless of any insurance claim outcome. I further understand that the final determination of my claim status is the sole responsibility of my insurance company. By signing below, I hereby authorize Danville Neuropathy Center to release all information necessary to secure payment from my insurance carrier(s). Notice of Privacy Practice is available upon request.

_____ _____

Patient/Guarantor/Responsible Party **Date**

Danville Neuropathy Center
New Patient Intake Form

1. Chief Complaint (reason for your visit today). Please include the **location** of pain or symptoms:

Additional areas of pain or symptoms:

Are you diabetic? ___ Yes ___ No
What is you fasting blood sugar:_____
What is your most recent A1c result:_____

Pain/Symptom Description:

2. Circle description or character of your pain:

Numbness	Dull	Stabbing	Throbbing
Tingling	Burning	Aching	Pins/Needles
Sharp	Itching	Hot	Cold

Other:

---

3. How often does your pain occur?

Constant	**Intermittent (comes and goes)**	**Changes in severity but is always present**

4. Please rate your pain/symptoms(including numbness) based on a scale of 0-10, 0 being "*no pain/symptoms*" and 10 being "*the worst pain/symptoms you can imagine*":

Right now I feel:

0	1	2	3	4	5	6	7	8	9	10
No pain/symptoms										Worst pain/symptoms

The best it gets:

0	1	2	3	4	5	6	7	8	9	10
No pain/symptoms										Worst pain/symptoms

The worst it gets:

0	1	2	3	4	5	6	7	8	9	10
No pain/symptoms										Worst pain/symptoms

5. Does your pain interrupt your sleep? _____ YES _____ NO

Onset of Symptoms:

6. Approximately when did your pain begin? _____ Month _____ Day _____ Year

7. How did your pain begin? **Gradually** or **Suddenly**

8. Since your pain began, how has it changed? **Improved** or **Worsened** or **Stayed the same**

9. What time of day is your pain/symptom(s) at its worst?

Morning **Afternoon** **Evening** **Bedtime**

10. Please list factors that make your pain worse:

---

11. Please list factors that make your pain better:

---

12. Do you have any issues with your balance? ___Yes ___No
If yes, has your balance caused you to fall? ___Yes ___No

13. Do you use an assistive device? ___Yes ___No
If yes, circle the assistive device you use: cane walker walking sticks other

14. Do you exercise? ___Yes ___No

If yes, how often do you exercise?_____

Please circle the kind of exercise you do (circle all that apply):

walking	stretching	balance exercise	yoga
weight lifting	bicycling	elliptical	running
pilates	treadmill	swimming	other:_____

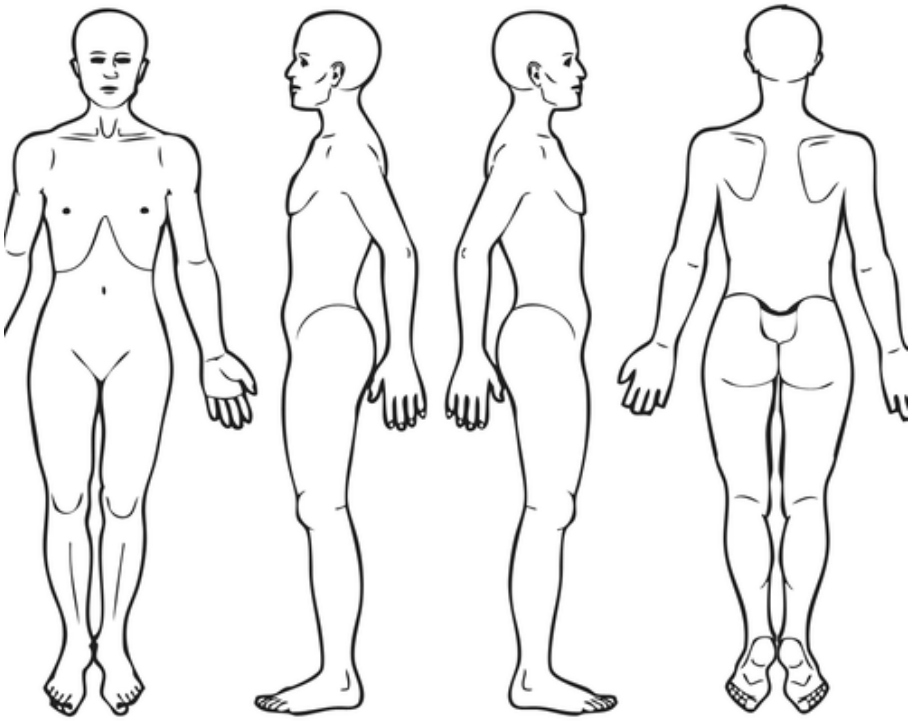
15. Regarding the issue you are addressing today, circle all of the following treatments you have tried:

Physical therapy	Chiropractic care	acupuncture	Hot packs	Cold packs	Platelet-rich plasma injection
Massage	Occupational therapy	Home TENS unit	Stem cell	Epidural	Other:_____

16. The above treatments (please circle):

Helped a lot Helped temporarily Made things worse There was not change

17. Please mark the areas in which you are experiencing pain:



Interventional Pain Treatment History:

18. Epidural Steroid Injection (circle all areas that apply): Cervical / Thoracic / Lumbar

- ☐ Joint Injection-joint(s) that were injected:_____

Medial Branch Blocks/Facet Injections (circle all areas that apply): Cervical / Thoracic / Lumbar

- ☐ Nerve Blocks - area(s)/nerve(s):_____
- ☐ Radio-Frequency Nerve Ablation (circle all areas that apply): Cervical / Thoracic / Lumbar
- ☐ Spinal Cord Stimulator - Trial Only/Permanent Implant:_____
- ☐ Trigger Point Injections, where?_____
- ☐ Other - _____

19. Which of the above procedures have helped with your pain?

_____

_____

Past Medical History:

20. Check the box(es) for the following conditions/diseases that you have been treated for in the past:

Head:

- ☐ Trauma

Eyes:

- ☐ Blindness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Wears glasses
- ☐ Wears contacts

Nose/Sinuses:

- ☐ Allergic rhinitis
- ☐ Nosebleeds
- ☐ Sinus infections

Ears:

- ☐ Hearing aids
- ☐ Hard of hearing

Mouth/Throat/Teeth

- ☐ Dentures

Cardiovascular:

- ☐ Aneurysm
- ☐ Angina
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Atrial fibrillation (AFib)
- ☐ High blood pressure (HTN)
- ☐ Murmur
- ☐ Myocardial Infarction (heart attack)
- ☐ Other heart disease
- ☐ Peripheral vascular disease (PVD)
- ☐ History of Stent/Pacemaker/ Defibrillator
- ☐ Elevated cholesterol

Respiratory:

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Lymphedema
- ☐ Pleuritis
- ☐ Pneumonia

Skin:

- ☐ Dermatitis
- ☐ Mole(s)
- ☐ Other skin condition(s)

Please specify:

_____

- ☐ Parkinson's disease
- ☐ Psoriasis
- ☐ Rash/Sores

Gastrointestinal:

- ☐ Cirrhosis
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gall bladder disease
- ☐ Gastrointestinal bleeding
- ☐ GERD
- ☐ Heartburn
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hiatal hernia
- ☐ IBS
- ☐ Crohn's disease
- ☐ Jaundice
- ☐ Ulcer

Genitourinary:

- ☐ Hernia
- ☐ Incontinence
- ☐ Kidney stones
- ☐ Other kidney disease
- ☐ UTI's
- ☐ Benign prosthetic hyperplasia (BPH)

Musculoskeletal

- ☐ Arthritis
  - ☐ Osteoarthritis
  - ☐ Rheumatoid
- ☐ Bursitis
- ☐ Carpal Tunnel Syndrome
- ☐ Gout
- ☐ Musculoskeletal Injury

Please specify:

_____

- ☐ Peripheral Neuropathy

Heme/Onc:

- ☐ Anemia
- ☐ Cancer:

Please specify type:

_____

Infectious:

- ☐ HIV
- ☐ STDs
- ☐ Tuberculosis (dx)
- ☐ Tuberculosis (exposure)

Neurological:

- ☐ Epilepsy
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Stroke
- ☐ TIA

Psychiatric:

- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Fatigue
- ☐ Suicidal ideation
- ☐ Suicide attempts

Endocrine:

- ☐ Goiter
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Thyroid disease
- ☐ Type I Diabetes
- ☐ Type II Diabetes
- ☐ Loss of Hair
- ☐ Heat/Cold intolerance

Other:

- ☐ B12 Deficiency
- ☐ Balance disorder
- ☐ Fibromyalgia
- ☐ Foot drop
- ☐ Obesity
- ☐ Restless leg syndrome
- ☐ Rheumatic fever
- ☐ Sarcoidosis
- ☐ Sjorgren's syndrome
- ☐ Sleep apnea
- ☐ Vertigo
- ☐ Auto-immune disorder:

Please specify:

_____

Past Surgical History:

21. Please list any surgical procedures you have had done in the past including date:

_____ date:_____

_____ date:_____

_____ date:_____

_____ date:_____

_____ date:_____

Diagnostic Studies:

22. Related to your current symptoms, mark all of the following tests that you have had:

MRI of the:_____ Date completed: _____

X-ray of the:_____ Date completed: _____

CT scan:_____ Date completed: _____

EMG/NCS of the:_____ Date completed: _____

Other:_____ Date completed: _____

*You are required to bring reports of any diagnostic studies you have completed to your consultation appointment.

Current Medications:

23. Please list all medications you are currently taking including vitamins. Attach additional pages if required:

Medication Name:

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

24. Please list all past pain medications that you have been on at any point for your current pain complaints?

Medication Name:

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

_____ dose:_____ frequency:_____

Allergies:

25. Do you have any drug/medication allergies? ___Yes ___No
If yes, please list all medications you are allergic to:

Medication Name:	Allergic Reaction:
_____	_____
_____	_____
_____	_____

26. Topical Allergies (please mark all that apply): ___ Latex ___ Iodine ___ Tape ___ IV Contrast

Family History:

27.

Father	Living or Deceased (Please circle)	Age:	Medical Problems: _____ _____
Mother	Living or Deceased (Please circle)	Age:	Medical Problems: _____ _____
Sisters	Living or Deceased (Please circle)	Age:	Medical Problems: _____ _____
Brothers	Living or Deceased (Please circle)	Age:	Medical Problems: _____ _____

☐ No family history, I am adopted

Social History:

28. Occupation:_____ When was the last time you worked?_____

29. Who is in your current household? _____

30. Are there any stair is your current home? _____ If so, how many?_____

31. Toxin exposure: Heavy metal(s):_____ Chemotherapy:_____

Other toxin exposure:_____

32. **Alcohol use:**

☐ Never ☐ Socially ☐ Daily ☐ History of alcoholism ☐Current alcoholism

33. **Tobacco Use:**

☐ Never ☐ Current
Packs per day:_____
How many years: _____

☐Former
Packs per day:_____
How many years: _____
Quit date:_____

34. **Illegal Drug Use:**

☐ No illegal drug use ☐ Currently using illegal drugs ☐ Formerly used illegal drugs

35. **Cardiovascular:**

☐ Eat healthy meals ☐ Regularly exercise ☐ Take daily aspirin

Review of Systems:

36. Mark the following symptoms that you currently suffer from:

Constitutional:

☐ Fevers ☐ Chills ☐ Sweats ☐ Weakness ☐ Fatigue

☐ Malaise ☐ Unexplained weight gain ☐ Low sex drive ☐ Difficulty sleeping ☐ Decreased activity

Eyes:

☐ Blurriness ☐ Double vision ☐ Visual Disturbance ☐ Pain

Ears/Nose/Throat/Neck:

☐ Hearing problems ☐ Ear pain ☐ Sinus problems ☐ Sore throat ☐ Nosebleeds

Respiratory:

☐ Shortness of breath ☐ Cough ☐ Sputum production ☐ Wheezing

Cardiovascular:

☐ Chest pain ☐ Palpitations ☐ Swelling in feet ☐ Shortness of breath during sleep

☐ Bleeding disorder ☐ Blood clots ☐ Fainting

Gastrointestinal:

☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

☐ Heartburn ☐ Abdominal pain

Genitourinary/Nephrology:

☐ Painful urination ☐ Blood in urine ☐ Change in urine stream ☐ Unusual discharge

☐ Flank pain ☐ Urinary incontinence

Musculoskeletal:

☐ Back pain ☐ Neck pain ☐ Joint pain ☐ Muscle pain ☐ Muscle cramp

☐ Muscle spasm ☐ Gait disturbances ☐ Joint stiffness ☐ Joint swelling ☐ Trauma

Integumentary:

☐ Rash ☐ Itching ☐ Lesions ☐ Bruising

Neurological:

☐ Abnormal balance ☐ Confusion ☐ Numbness ☐ Tingling ☐ Dizziness ☐ Headaches

☐ Loss of coordination ☐ Memory loss ☐ Seizures ☐ Tinnitus ☐ Tremors ☐ Vertigo

Psychiatric:

☐ Feeling anxious ☐ Depressed mood ☐ Suicidal thoughts ☐ Hallucinations

☐ Stress problems ☐ Suicidal planning ☐ Thoughts of harming others

Clinic Directions

Danville Neuropathy Center
Abundant Life Health & Wellness
919 San Ramon Valley Blvd., Ste. #255
Danville, CA 94526

FROM 580
1. Take the 680 transfer towards Sacramento

2. Exit Sycamore Valley Rd.

3. Turn Left on Sycamore Valley Rd.

4. Turn Left on San Ramon Valley Blvd.

5. Victorian Medical Center is on the right hand side

FROM WALNUT CREEK
1. Head South on 680 towards San Jose

2. Exit Sycamore Valley Rd WEST (Stay to the right)

3. Turn left on San Ramon Valley Blvd.

4. Victorian Medical Center is on the right side

FROM RICHMOND AREA OR PARTS OF OAKLAND
1. Take I-80 West

2. Take I-580 East via Exit 8B towards I-880 Downtown

Oakland/Alameda/Hayward/Stockton/San Jose

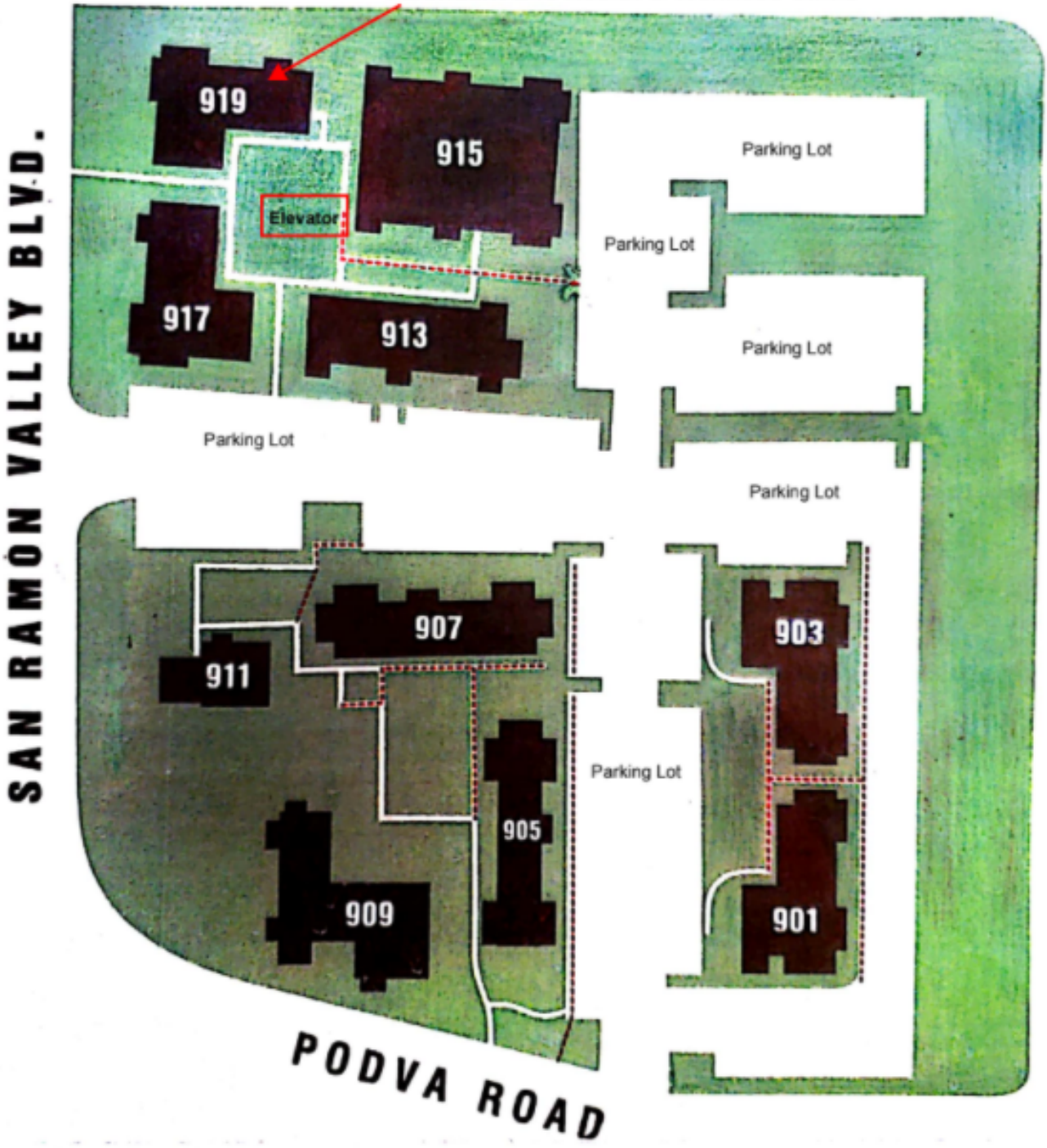
3. Merge to CA-24 East toward Walnut Creek (Keep left toward Walnut Creek)

4. Merge to I-680 toward San Jose/Dublin

We are located on the second floor of building 919. There are multiple stairs and an elevator access points.

If you need directions from any other areas please call our office at (925) 718-8759.

Danville Neuropathy Center



---------- Wheelchair accessible

Elevators available in center of courtyard

Danville Neuropathy Center and Abundant Life Health & Wellness participate in an Organized Health Care Arrangement (OHCA). This allows us to share health information to carry out treatment, payment and joint health care operations relating to the OHCA, including integrated information system management, health information exchange, financial and billing services, insurance, quality improvement, and risk management activities. The Notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

This page is intended as a summary of the Notice.
Please review the remainder of the Notice for more details.

Your Rights

You have the right to:

- Request a copy of your paper or electronic medical record
- Request a correction to your paper or electronic medical record
- Request confidential communications
- Ask us to limit the information we share
- Get a list of certain disclosures we have made of your information
- Get a copy of this privacy notice
- Choose someone to act for you, in accordance with certain legal requirements
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Assist in a disaster relief effort

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and certain other health information we have about you. We will provide a copy or a summary of

your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct information about you in your medical record that you think is incorrect or incomplete by writing to the Privacy Officer at the end of this notice.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times and with whom we've shared your health information for six years prior to the date you ask. We are not required to include disclosures for treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this Privacy Notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting the Privacy Officer where the violation occurred:
    - Joshua Filippini – Josh@abundantlifehealthandwellness.com

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will try to accommodate your requests where we can.

In these cases, you have both the right and choice to tell us whether to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Certain marketing purposes

In the case of marketing & fundraising:

- We may contact you for marketing and fund raising efforts, but you can tell us not to contact you again.

Health Information Exchange:

- We may also participate in certain health information exchanges that share health information electronically with other healthcare providers, as permitted by California and federal law.

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information to treat you and share it with other professionals who are treating you. Example: A staff member treating you asks another staff member about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena if certain requirements are met.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office.

Other Instructions for Notice
In addition to the Federal rules regarding privacy, we will follow California State laws regarding health care privacy. We will obtain appropriate consents before we share information concerning your genetic information, HIV status, substance abuse and certain mental health information. We also will obtain your consent for other uses and disclosures of your health information when required by California law to do so.