Neuropathy Relief Clinic

@Optimal Health Clinic
28315 S Tamiami Trail, Ste 101
Bonita Springs, FL 34134
239-947-1177

Dear Prospective Patient,

Thank you for choosing our office. We are excited about helping you enjoy life again without the painful symptoms of peripheral neuropathy. To learn more about Dr Gendron and his services visit our website at www.drgendron.com. We invite you to view our patient testimonials, their results are inspiring!

Note: We do our very best to keep on schedule and we do not overbook.

For that very reason the doctor, exam room and about 1 hour is reserved just for your use. To keep you and the other patients on schedule, we recommend that you arrive at least 10 minutes before your scheduled appointment time.

Attached to this letter you will find our Neuropathy Intake Application, Walking Scale and Neuropathy Pain Scale. Please fill in as much information as possible so the doctor can get a full picture of your current physical symptoms. If you need to reschedule or cancel your appointment, as a courtesy, please call us 24 hours before your scheduled appointment time.

- Please wear shorts and a t-shirt to this appointment.
- Spouses are encouraged to attend.

Thank you again for choosing us to help you and we look forward to meeting you soon!

Sincerely,

Sue Gerber
Patient Advocate

P.S. Don't forget to bring the following items to your appointment (if available):

- Driver's License
- MRI Report and/or copy of MRI CD
- Radiology Reports
- Medication List

Application for Neuropathy Treatment

Name:_____ **Date:**_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____

Social Security #:_____-____-_____ Date of Birth:____/____/____ Age:_____

Spouse's Name:_____

Occupation (Current or Previous):_____Retired: Y N

Review of Systems

Please check all that apply

□ Foot Pain	□ Diabetes	□ Spinal Stenosis	□ Cancer	□ Pinched Nerve
□ Hand Pain	□ High Cholesterol	□ Degenerative Discs	□ Chemotherapy	□ Poor Circulation
□ Low Back Pain	□ High Blood Pressure	□ Vascular Problems	□ Arthritis in Hands	□ Joint Replacements
□ Neck Pain	□ Pacemaker/ Defibrillator	□ Leg Pain	□ Arthritis in Feet	□ Foot Surgery
□ Foot Numbness	□ Herniated Disc	□ Plantar Fasciitis	□ Implanted Cord/ Bladder Stimulator	□ Poor wound healing
□ Hand Numbness	□ Bulging Disc	□ Morton's Neuroma	□ Sciatica	□ Excessive thirst or urination

Present Health Condition

In order of importance, list the health problems you are most interested in getting corrected:

1)_____
2)_____
3)_____
4)_____
5)_____

List approximately how long you have noticed these problems:

1)_____
2)_____
3)_____
4)_____
5)_____

Is there a certain time of day any of these problems are better or worse?

_____
_____
_____

Is your balance/walking ability affected? □ Y □ N
If yes, please describe: _____
_____
_____

List the things you have used for these problems:

□Gabapentin □Neurontin □Lyrica □Cymbalta
□Physical Therapy □Pain Medications □ Alleve
□Tylenol □Ibuprofen □Motrin □Chiropractic
□Massage Therapy □Injections □Creams on Hands/Feet
□Other Medications or Treatments:_____
_____
_____

What do you think is causing your problem?: _____

_____

Names of all doctors you have seen for these problems and treatment you received: _____

_____

_____

_____

_____

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? Please check all that apply:

□ Aching Pain	□ Numbness	□ Hot sensation	□ Cramping
□ Stabbing Pain	□ Tingling	□ Throbbing Pain	□ Swelling
□ Sharp Pain	□ Pins and Needles Pain	□ Dead Feeling	□ Burning
□ Tiredness	□ Heavy Feeling	□ Cold Hands/Feet	□ Electric Shocks

Is this condition interfering with any of the following?

□ Sleep □ Work □ Daily Activities □ Housework □ Recreational Activities □ Walking □ Standing □ Shopping

Social History

Do you smoke? □ Yes □ No If yes, how many packs/daily:_____

Do you drink? □ Yes □ No If yes, how many drinks/week:_____

Do you exercise regularly? Yes No If yes, describe what type and how often:_____

_____

Current Pain Levels

How would you rate your pain in the last week:

No Pain — Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

If you had to accept some level of pain after completion of treatment, what would be an acceptable level?

No Pain — Worst Pain Possible

0 1 2 3 4 5 6 7 8 9 10

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 of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request:

Name:_____ Signature:_____ Date:_____

Please give name, address, and office phone of your primary care physician/family doctor?:

Name: _____

When were you last seen there:_____

May we send them updates on your treatment/condition: □Yes □No

List ALL Allergies (or Sensitivities) to Medicines, Foods, and other items:

Item you react to:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list the prescription drugs you are currently taking, or attach list:

Name:	Dose (MG or IU)	Times Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all Nutritional Supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Date of Above List: _____

Optimal Health Clinic
Advanced Non-Surgical Treatment Technology for Chronic Pain
947.1177

Walking Scale Questionnaire

These questions ask about limitations to your walking due to pain during the past 2 weeks. For each statement please circle the one number that best describes your degree of limitation. Please check you have circled one number for each question. Please hand this to the doctor at the start of your consultation.

In the past 2 weeks please describe your pain level	**Not at all**	**A little**	**Moderately**	**Quite a Bit**	**Extremely**
Limited your ability to walk?	1	2	3	4	5
Limited your ability run?	1	2	3	4	5
Limited your ability to climb up or down stairs	1	2	3	4	5
While standing?	1	2	3	4	5
Limited your balance when standing or walking?	1	2	3	4	5
Limited how far you are able to walk?	1	2	3	4	5
Increased the effort needed for you to walk?	1	2	3	4	5
Made it necessary for you to use support when walking indoors (e.g. holding onto furniture, using a cane, etc)?	1	2	3	4	5
Made it necessary for you to use support when walking outdoors (e.g. holding onto furniture, using a cane, etc)?	1	2	3	4	5
Slowed down your walking?	1	2	3	4	5
Affected how smoothly you walk?	1	2	3	4	5
Made you concentrate on your walking?	1	2	3	4	5

Thank you for completing this questionnaire.

Walking Scale Disability Score: <NORMAL, 13-27, MILD 28-45, MEDIUM 46-62, >63 SEVERE DISABILITY

Date_____ Score_____
Date_____ Score_____

Neuropathic Pain Scale

Date: __/__/____ Name: _____ No.: _____

Instructions: There are several different aspects of pain which we are interested in measuring: pain **sharpness, heat/cold, dullness, intensity**, overall **unpleasantness**, and **surface vs. deep** pain.

The distinction between these aspects of pain might be clearer if you think of taste. For example, people might agree on how sweet a piece of pie might be (the **intensity** of the sweetness) but some might enjoy it more if it were sweeter while others might prefer it to be less sweet. Similarly, people can judge the loudness of music and agree on what is more quiet and what is louder, but disagree on how it makes them feel. Some prefer quiet music and some prefer it more loud. In short, the **intensity** of a sensation is not the same as how it makes you feel. A sound might be unpleasant and still be quiet (think of someone grating their fingernails along a chalkboard). A sound can be quiet and "dull" or loud and "dull".

Pain is the same. Many people are able to tell the difference between many aspects of their pain: for example, **how much** it hurts, and **how unpleasant** or annoying it is. Although often the intensity of pain has a strong influence on how unpleasant the experience of pain is, some people are able to experience more pain that others before they feel very bad about it.

There are scales for measuring different aspects of pain. For one patient, a pain might feel extremely hot, but not at all dull, while another patient may not experience any heat, but feel like their pain is very dull. We expect you to rate very high on some of these scales, and very low on others.

We want you to use the measures that follow to tell us exactly what you experience.

Check the boxes that best describes your pain.

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1. Please check the box in the scale below to tell us how **intense** your pain is.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No pain — The most **intense** pain sensation imaginable

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2. Please use the scale below to tell us how **sharp** your pain feels. Words used to describe "sharp" feelings include "like a knife", "like a spike", "jabbing", or "like jolts".

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not sharp — The most **sharp** pain sensation imaginable ("like a knife")

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3. Please use the scale below to tell us how **hot** your pain feels. Words used to describe very hot pain include "burning" and "on fire".

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not hot — The most **hot** sensation imaginable ("on fire")

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4. Please use the scale below to tell us how **dull** your pain feels. Words used to describe very dull pain include "like a toothache", "dull pain", and "like a bruise".

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not dull — The most **dull** sensation imaginable

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5. Please use the scale below to tell us how **cold** your pain feels. Words used to describe very cold pain include "like ice", and "freezing".

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not cold — The most **cold** sensation imaginable ("freezing")

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6. Please use the scale below to tell us how **sensitive** your skin is to light touch or clothing. Words used to describe sensitive skin include "like sunburned skin", and "raw skin".

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not sensitive — The most **sensitive** sensation imaginable ("raw skin")

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7. Please use the scale below to tell us how **itchy** your pain feels. Words used to describe itchy pain include "like poison oak", and "like a mosquito bite".

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not itchy — The most **itchy** sensation imaginable ("like poison oak")

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8. Which of the following best describes the **time** quality of your pain? Please check only one answer.

I feel a background pain all of the time and occasional flare-ups (break-through pain) some of the time.

Describe the background pain: _____

Describe the flare-up (break-through) pain: _____

I feel a single type of pain all the time. Describe this pain. _____

I feel a single type of pain only sometimes. Describe this pain. _____

Describe this occasional pain: _____

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9. Now that you have told us the different physical aspects of your pain, the different types of sensations, we want you to tell us overall how **unpleasant** your pain is to you. Words used to describe very unpleasant pain include "miserable" and "intolerable". Remember pain can have a low intensity, but still feel extremely unpleasant, and some kinds of pain can have a high intensity but be very tolerable. With this scale, please tell us how **unpleasant** your pain feels.

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Not unpleasant

The most **unpleasant** sensation imaginable ("intolerable")

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10. Lastly, we want you to give us an estimate of the severity of your deep versus surface pain. We want you to rate each location of pain separately. We realize that it can be difficult to make these estimates, and most likely it will be a "best guess", but please give us your best estimate.

HOW INTENSE IS YOUR *DEEP* PAIN?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No **deep** pain

The most **intense deep** pain sensation imaginable

HOW INTENSE IS YOUR *SURFACE* PAIN?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

No **surface** pain

The most **intense surface** pain sensation imaginable

Optimal Health Clinic Therapy

We are an integrated medical center. We provide a number of services depending on your needs. The Doctor will assess you and prescribe a treatment protocol specific to your needs.

Live O2

Used for cellular oxygen delivery. Restores proper oxygenation to the cells.

PEMF

Pulse electromagnetic field therapy. A cellular exercise which helps tissue and bone repair.

Bemer

Increases circulation. 8 minutes will increase circulation for up to 12 hours. Helps with optimal regulation of the circulatory system.

Knee on Trac

Decompression of the knee. Takes pressure off nerves and increases mobility while decreasing pain.

Cervical traction

Decompression of the neck. Takes pressure off nerves which helps with pain management.

Back on Trac

Spinal decompression which helps with mobility by taking pressure off nerves. Helps with pain management.

Hakomed

Bioelectric nerve stimulation good for pain management and nerve repair.

We also offer

Laser

Improves blood flow and lowers inflammation.

Pressure wave

High energy sound wave therapy which eliminates pain, promotes bone and tissue healing.