The Livingston Clinic
**Dr. Stuart Meyers, D.C.**

5889 Whitmore Lake Rd, Suite 3 ~ Brighton, MI 48116
810-227-7799 ~ www.LivChiro.com

**Name:** _____

# Neuropathy Care Application

Date: _____
Nickname: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F
Address: _____
City: _____ State: _____ Zip: _____
Mobile Phone #: _____ Alternate Phone #: _____
Email Address: _____
Occupation (Current or Previous): _____ Retired: ☐ Yes ☐ No
Employer: _____
Current or Previous Work Type:
Clerical – Y / N Light Labor – Y / N Moderate Labor – Y / N Heavy Labor – Y / N
Spouse/Partner/Parent/Other Trusted Adult: _____ _____
(Name) (Phone)
Marital Status: ☐ S ☐ M ☐ D ☐ W Number of Children: _____
In Case of Emergency: Contact Name: _____ Phone #: _____
How did you hear about our office? _____

**What is your main health concern / condition today?** _____

**My symptoms:** *(Check all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| ☐ Foot Pain | ☐ Foot Numbness | ☐ Foot Surgery | ☐ Leg Pain | ☐ Hand Pain | ☐ Hand Numbness |
| ☐ Plantar Fasciitis | ☐ Poor Circulation | ☐ Balance Issues | ☐ Falls | ☐ Neck Pain | ☐ Sciatica |
| ☐ Joint Replacement | ☐ Poor Healing | ☐ Arthritis | ☐ Bulging Discs | ☐ Diabetes: Type I or Type II | |

**How would you describe your symptoms?** *(Check all that apply)*

| | | | | | |
|---|---|---|---|---|---|
| ☐ Sharp Pain | ☐ Stabbing Pain | ☐ Aching | ☐ Throbbing | ☐ Numbness | ☐ Tiredness |
| ☐ Heavy Feeling | ☐ Dead Feeling | ☐ Swelling | ☐ Tingling | ☐ Pins/Needles | ☐ Cramping |
| ☐ Burning | ☐ Electric Shocks | ☐ Cold | ☐ Stiff | ☐ Other: _____ | |

**When did this begin?** _____ **What makes it worse?** _____

**What makes it better?** _____

**Describe the physical appearance of your feet/legs.** *(Check all that apply)*

| | | | | |
|---|---|---|---|---|
| ☐ Discolored | ☐ Dry / Flaky | ☐ No Hair Growth | ☐ Discolored Nails | ☐ Loss of Nails |
| ☐ Cyanotic (Blue) | ☐ Petechiae (Red Spots) | ☐ Blisters / Sores | ☐ Fungal | ☐ Other: _____ |

**Is this condition interfering with any of the following?** *(Check all that apply)*

☐ Daily Activities ☐ Relationships ☐ Hobbies ☐ Exercise ☐ Standing ☐ Walking ☐ Lifting ☐ Sleep ☐ Work

**Does your neuropathy cause any other problems?** _____

**Frequency of your neuropathy symptoms:**

☐ Constant (76–100%) ☐ Frequent (51–75%) ☐ Occasional (25–50%) ☐ Intermittent (24% or less)

**On a scale of 0 – 10, How serious and committed are you about fixing your condition?**

Not Serious 1 2 3 4 5 6 7 8 9 10 Totally Committed

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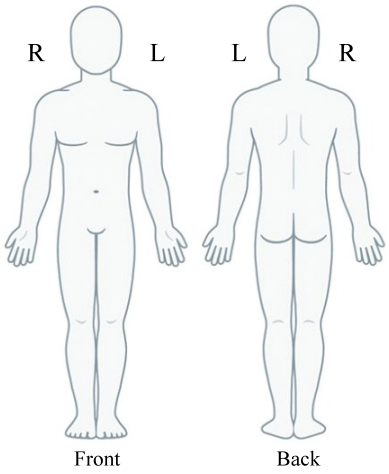
**Please indicate on this drawing the area(s) where you are currently experiencing symptoms:**




**What have you used / tried to relieve your neuropathy symptoms?** *(Check all that apply)*

☐ Gabapentin ☐ Amitriptyline ☐ Nuerontin ☐ Cymbalta ☐ Lyrica ☐ Opioids ☐ Injections
☐ Aleve (Naproxen) ☐ Tylenol (Acetaminohen) ☐ Advil / Motrin (Ibuprofen) ☐ CBD / Hemp Products
☐ Creams ☐ Chiropractic ☐ Physical Therapy ☐ Massage ☐ Other: _____

**Please list any / all prescription medications or vitamins / supplements you are currently taking**
(continue on back if you need more room or you may attach a list):

| Name of Prescription Medication / Vitamin / Supplement | Why Do You Take It? |
|---|---|
| | |
| | |
| | |
| | |

**Are you currently taking a blood thinner (Coumadin, Lovenox, Heparin, etc)?** ☐ Yes ☐ No

**Are you currently taking a statin (Atorvastatin, Lipitor, Crestor, etc)?** ☐ Yes ☐ No

**Do you drink alcohol?** ☐ Yes ☐ No If yes, how many drinks per week? _____

**Do you smoke cigarettes?** ☐ Yes ☐ No If yes, how many cigarettes daily? _____

**Do you exercise regularly?** ☐ Yes ☐ No If yes, please describe type & how often? _____

**Did this start or progress after COVID or receiving a COVID vaccine?** ☐ Yes ☐ No

Name of your Primary Care Physician: _____ Phone: _____

May we contact them with updates regarding your treatment? ☐ Yes ☐ No

I hereby authorize release of any medical information necessary to evaluate my case to the above named physician. TLC will not enter into any dispute with your insurance company. If there is a discrepancy, it is the patient's responsibility to contact their insurance provider. We invite you to discuss with us any questions regarding our services and/or fees. The best healthcare services are based on mutual understanding and respect. I understand the above information guarantee this form was completed correctly and to the best of my knowledge. I understand it is my responsibility to notify the staff of any changes in my medical status or insurance.

**Signature** _____ **Date** _____

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# Functional Goals Survey

*Please answer these questions the best you can so we can help you get better.*
*Please be as honest and complete as possible.*

**Date:** _____

What is the ***main reason*** you have come to see us today? _____

How many doctors have you seen for your neuropathy? _____

What medications/supplements/therapies/treatments did they prescribe/recommend for you?

_____

_____

Has what you've done to date for your neuropathy helped?

☐ Yes, a lot ☐ Yes, some ☐ No, not at all ☐ Indifferent

What are 3 - 5 activities you can no longer do or are struggling to do because of your neuropathy? Please be specific.

1. _____
2. _____
3. _____
4. _____
5. _____

What is your honest vision of your life in the next few years if this problem continues to progress?

_____

_____

What would be different and/or better without this problem? Please be specific.

_____

_____

_____

What is your biggest fear in regards to the progression of this condition?

_____

_____

_____

What would be and/or mean success to you in our office?

_____

_____

_____

_____

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# CONSENT FOR TREATMENT AND AUTHORIZATION TO PERFORM X-RAYS

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy, including exercise, traction, use of vibration platforms, laser and LED Infra red light, hyperbaric oxygen, Shockwave, and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Stuart Meyers, D.C. and/or other doctors of chiropractic and staff who now or in the future work at The Livingston Clinic.

I have had an opportunity to discuss with Dr. Meyers and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations, sprains, and possibly other unforseen complications. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then know, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to treatment and x-rays. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To the best of my knowledge I am ***NOT*** pregnant and Dr. Meyers and his staff has my permission to x-ray me for diagnostic interpretation.

By signing this authorization, I am also agreeing to have texts and/or emails sent to the number or email I have provided, from The Livingston Clinic and its employees.

I understand that there is no implied cure or guarantee of improvement by my agreeing to the Doctor's recommendations. I further understand that my failure to comply fully with these recommendations will limit my results from the treatment received. I also acknowledge that I am responsible for services and/or products that are rendered.

_____ _____

**Patient's Signature or of person acting on patient's behalf (Relationship)** **Date**

_____ _____

**Witness's Signature** **Date**

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**Name:** _____

# PRIVACY PRACTICES

## Health Insurance Portability and Accountability Act (HIPAA)

I understand that The Livingston Clinic's "Patient Privacy and Information Security Policy" in its full form is available to me upon request and that I have a right to review the "Patient Privacy and Information Security Policy" prior to signing this document.

The "Patient Privacy and Information Security Policy" describes the types of uses and disclosures of my protected health information and the policies and procedures of confidentiality that will occur in my treatment, payment of my bills or in the performance of healthcare operations of The Livingston Clinic. This "Patient Privacy and Information Security Policy" also describes my rights and The Livingston Clinic's duties with respect to my protected health information and patient confidentiality.

The Livingston Clinic reserves the right to change the privacy practices that are described in the Patient Privacy and Information Security Policy". I may obtain a copy of the revised notice by calling the office and requesting a copy be sent to me by mail or by asking for one at the time of my next appointment.

I give permission for the doctor(s) and/or staff to discuss my

□ Care / Condition / Treatment □ Financial Statements with the following persons.

| **Name** | **Relationship** |
|---|---|
| _____ | _____ |
| _____ | _____ |

I understand the above permissions will remain in effect until such time as they are revoked in writing. A new authorization, when completed, will replace any older authorizations.

_____ _____

**Patient's Signature** **Date**
(or Signature of person acting on patient's behalf (relationship)

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# OFFICE FINANCIAL POLICY

We welcome you and your family to our office. We take pride in providing quality chiropractic care for families. Please take time to review our Office Financial Policy, as these guidelines have been designed to better serve your individual needs.

## PAYMENT POLICY

**Payment is due the day service is provided.**

- While we work with all insurance companies, our office may not be "in network" with your insurance. There may be out-of-network coverage through your policy. Our staff will be happy to check with your insurance company to determine coverage status. However, even in network coverage is not a guarantee of coverage.

- Please communicate with the receptionist whether you will be filing claims to an insurance company and present your current insurance card to the receptionist for her to make a copy. If at any time you change insurance companies, please notify the receptionist immediately to update your records. All insurance claims are filed weekly on Thursday or Friday.

- We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to directly assist your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services and will be your responsibility.

- If the patient is referred to another specialist or discontinues care for any reason other than discharge by the doctor, payment in full is due; regardless of any claims submitted.

## MY FINANCIAL RESPONSIBILITY

I understand that I am personally **financially responsible** for all services not covered by Insurance or by Medicare. I am also responsible for all applicable annual deductibles or copayments.

## CANCELLATION POLICY

If for any reason you cannot make your pre-scheduled appointment time we do ask for a 24-hour notice. If we do not hear from you to cancel your appointment at all or at least one hour before your pre-scheduled appointment more than three times an administrative fee of $25.00 will be charged to your account*. No further treatments will be administered until this fee is paid.

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I have read and understand the Financial Office Policy and agree to abide by these terms.

**X** _____ _____

**Patient's Signature or person acting on patient's behalf (Relationship)** **Date**