Neuropathy Care Program

Exam Fee:_______

SCHEDULING INTAKE FORM

Date: ____________________________ PCP: ___________________________________ Veteran: YES NO

First Name: ____________________________ Last Name:___________________________

DOB: _________________________
Phone:__________________________

Address: ____
Appt Date:____
Appt Time:____

How did they hear about us ____
____
____

Their Story:____
____
____
____

_______ Idiopathic neuropathy In EMR: Yes ____ No ____
_______ Diabetic neuropathy Packet sent: Yes ____ No ____
_______ Muscle weakness
_______ Difficulty walking
_______ Gait abnormality
_______ Chemo Induced
_______ Hereditary
_______ Spinal Surgery
_______ Alcohol
_______ Other – see story above

EMR Patient ID:____