JACKSONVILLE
INTEGRATIVE HEALTH

Neuropathy Intake Paperwork

Patient Information:

Full Name: _____ **Sex:** _____

Date of Birth: _____ **Occupation:** _____

Address: _____

Phone Number: _____

Email: _____

Marital Status (circle): Married Divorced Widowed Single

Emergency Contact Name: _____

Emergency Contact Phone Number: _____

Primary Care Physician: _____

- **In the case that your treatment is not covered by your insurance, are you willing to pay out-of-pocket to treat your concerns?** Yes / No

Medical Information:

- **What is your major concern that brought you in today?**

_____

_____

_____

- **How long have you had this issue, pain or discomfort?**

_____

- **How does this issue interfere with your day-to-day life?**

_____

_____

- **Would you say this issue is getting better or worse, please elaborate:**

_____

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INTEGRATIVE HEALTH

- **Please rate the severity of your symptoms out of 10 where 0 means you don't have this symptom and 10 means it is very concerning:**

Tingling: _____ Numbness: _____ Burning: _____

Pain: _____ Hypersensitivity: _____ Hot:_____

Cold: _____ Balance Concerns: _____ Affecting Sleep: _____

Cramping: _____ Other Please Describe: _____

- **How concerning is this issue for you, please circle one option:**

Minimally / Moderately / Quite Severe / Extremely

- **Are your symptoms in your hands, feet or both?** _____
- **Do you have a Pacemaker (circle):** Yes / No

Diabetes Patients:

- **Do you have Type 2 Diabetes (circle):** Yes / No / Not Sure
- **If Yes, What is your average A1C:** _____
- **If Yes, how long have you had this:** _____

Cancer Patients:

- **Do you currently have active cancer (circle):** Yes / No
- **If yes, when were you diagnosed with cancer?:**

_____

- **If yes, what type of cancer were you diagnosed with by your doctor?:**

_____

- **If yes, are you currently in remission from cancer?:**

_____

- **If yes, how long have you been in remission?:**

_____

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- **Have you ever been or are you currently on any chemotherapy?**

_____

General:

- **Have you been diagnosed with Neuropathy? (circle):** Yes / No
- **If yes, have you done any treatment? (circle):** Yes / No
- **If yes, please describe the treatment and the effects it had on your body?:**

_____

_____

- **On a scale of 1-10, what is your interest in getting help for your problem, where 0 is not interested, and 10 is very interested?**

_____

- **Do you have any compression in your upper, mid or lower spine of any kind?** Yes / No

If Yes, please explain: _____

- **Was there any injury, condition or accident that occurred prior to your issue that you feel may have contributed to the cause of this issue:**

_____

- **Any Surgeries?:** Yes / No If Yes, please specify _____

_____

- **MEDICATIONS: please list all prescription and non-prescription medications you are currently taking:**

_____

_____

_____

- **Please list any allergies you may have:**

_____

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Do you have/have you ever had:

General	Neurological	Psychiatric	Respiratory
Fatigue, tiredness	Fainting spells	Depression	Chronic obstructive disease
Weakness	Seizures	Anxiety (abnormal)	Wheezing
Chills	Paralysis	Panic attacks	Chronis cough
Fever	Dizziness	Alzheimer's	Coughing up blood
Night sweat	Tremor	Confusion (abnormal)	Asthma
Appetite change	Chronic headaches	Hospitalized for nervousness	Shortness of breath
Lived in foreign country	Poor balance	Substance abuse	TB
Unexplained weight loss	Fractured back or neck	Anorexia	Lung cancer
Unexplained weight gain	Numbness of face/arm/leg	Other: _____	Emphysema
Generalized pain	Peripheral neuropathy		Chronic bronchitis
Unable to tolerate heat	Stroke or mini-stroke		Pneumonia
Unable to tolerate cold	Other:_____		Fluid in lungs
Sedentary lifestyle			Need to sleep sitting up
Active lifestyle			Other: _____
Other: _____			

Cardiac	Vascular	Gastrointestinal	Genitourinary
Angina (chest pain)	Leg pain walking over 1 block	Diarrhea	Hesitancy/urgency to urinate
Rapid heartbeat	Leg pain walking less than 1 block	Constipation	Need to urinate often at night
Past heart attacks	Leg pain while at rest	Stool changes	Loss of bladder control
Heart murmur	Blood clots in legs	Bowel habits changes	Difficulty urinating
Congestive heart failure	Deep	Hemorrhoids	Renal failure
High blood pressure	Superficial	Indigestion	Impotence
Aortic aneurysm	Cold feet/hands	Ulcers	Current dialysis
Pacemaker	Amputation	Irritable bowel	Renal transplant
Defibrillator	Peripheral vascular disease	Colon polyps	Prostate enlargement
Other heart problems	Ulcers of legs	Cramps/pains	Cancer of bladder/kidneys
	Varicose veins	Cancer of the stomach /bowel	Other: _____
	Aneurysm of arteries	Diverticulitis	
	Other: _____	Other: _____	

Blood & Lymph System	Eyes, Ears, Nose & Throat	Musculoskeletal	Skin
Anemia	Pain	Arthritis	
Blood disease	Hearing loss	Spinal Compression/Stenosis	Rashes
Transfusions	Polyps	Disc Herniation/bulge	Tumors
Leukemia	Vertigo	Joint swelling	Sensitivity to sunlight
Bone marrow test	Ringing in ears (tinnitus)	Joint stiffness	Malignant melanomas
Long term Courmadin use	Sinus infections	Muscle aches	Squamous cell carcinoma
Blood clotting problems	Deafness	Muscle weakness	Basal cell carcinoma
Hemophilia	Other: _____	Leg cramps	Easy bruising
Active hemoglobin		Other: _____	Fungal infections
High/low blood pressure			Non-healing sores
HIV/AIDS			Excessive rough or dry skin
Other: _____			Other: _____

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JACKSONVILLE
INTEGRATIVE HEALTH

TERMS AND CONDITIONS 1."Affiliates" means one or more of the Clinics, other associated Clinics, their staff, employees, associates, affiliates, shareholders, owners, directors, independent contractors, consultants, vendors, as well as Stratton Regen LLC and any of its group companies, and their staff, employees, associates, affiliates, shareholders, owners, directors, independent contractors, consultants, and vendors.

2."Clinic" means the Clinic at which you had/are having/are going to have a consultation and/or examination on the day of signing these terms and conditions.

3."Loved One" means any family member/s/friend/s/person/people that accompany you to the Clinic.

4."Using Facilities" or "Use of our Facilities" or any derivative thereof with capitalized first letters, refers to the time you and/or your Loved One spend at the Clinic, anything and everything that is said or done by representatives of the Clinic and/or its Affiliates during that time, as well as any communication of any nature whatsoever with the Clinic and its Affiliates before, during, and after your time at the Clinic.

5.The Clinic is not obliged to accept any patient into treatment.

6. Right of admission is reserved.

7. If you would like a copy of these terms and conditions, you can obtain one from the front desk receptionist.

8. Any clause, part of a clause, provision, representation, or warranty of this Agreement which is prohibited or which is held to be void/unenforceable by a competent court shall be void/unenforceable only to the extent of such prohibition or unenforceability, without invalidating the remaining provisions hereof and/or the remainder of that clause.

9. In order for the medical provider to give accurate and appropriate medical advice and/or treatment, which may be conveyed to the patient by the Clinic and/or its Affiliates on behalf of and as per the instructions of the medical provider, any and all of your relevant medical information must be stated in your paperwork and given to the medical examiner doing your examination and/or the receptionist. The Clinic and its Affiliates will not be held liable for any damages/loss/costs/any other consequences resulting from any incomplete, inaccurate or misleading information provided by you.

10. The Use of our Facilities in any way whatsoever by yourself and your Loved One is entirely at your own risk.

11.The Clinic and its Affiliates will not be held liable for any costs and/or expenses and/or loss and/or damages and/or injury and/or death caused by any negligence or gross negligence.

12.Notwithstanding any other clause herein, in no event will the Clinic and/or its Affiliates' total cumulative liability to you exceed $5,000.00 (five thousand dollars).

13.At any point while at the Clinic and/or while interacting with the Clinic and/or its Affiliates, you may be recorded and your information may be collected, collated, processed, stored, shared, and recorded, for the purposes of training, quality control, business operations, marketing, communicating with you, record-keeping, and/or where legally required, and your information may likewise be shared with the Clinic, its Affiliates, and other clinics and third parties for the same purposes. Data will also be stored and shared off-shore. We have strict confidentiality policies in place.

14. You may not record the whole/any part of your experience Using our Facilities. Notwithstanding this, the totality of any such recordings and/or copies thereof will be considered the exclusive property of the Clinic and Stratton Regen LLC, must be kept in the strictest confidence by you and not shared in any way whatsoever, and shall not be considered as evidence admissible in court or before any tribunal unless consented to by Stratton Regen LLC in writing. Any such recordings and/or copies thereof must be returned or destroyed upon demand/request by Stratton Regen LLC. You will be held liable for any damages suffered by the Clinic and/or its Affiliates as a result of such recordings.

JACKSONVILLE
INTEGRATIVE HEALTH

15.You may not use information and/or knowledge of any kind obtained at/from the Clinic to directly or indirectly open/amend/improve any aspect of another medical practice or facility/holistic medicine practice or facility/regenerative medicine practice or facility.

16.The information, processes, systems, documentation, results, and treatment programs used by the Clinic and/or its Associates are the intellectual property of the Clinic and/or its Affiliates.

17.All intellectual property rights, including all rights, title and interest (statutory and common law) in copyright or any other right, of whatsoever nature, existing now and in the future, remain the absolute property of the Clinic and/or its Affiliates.

18.The Case Manager is not a trained medical professional and is there for the sole purpose of explaining your results to you as communicated to them by the Clinic's qualified medical practitioner, and explaining the medical practitioner's recommended care plan to you. They are simply a case manager, as the title suggests. Any advice offered by the Case Manager should accordingly not be considered to be expert medical advice, and nothing that they say should be considered to constitute a guarantee with regards to results, relief, or success of a specific treatment or care plan. Your care plan will be further approved and finalized by the provider before treatment begins, and the liability to ensure that that happens rests solely on the Clinic. If the provider for any reason determines that the care plan is not appropriate under the circumstances, it will be amended/canceled accordingly. The Case Manager is not an employee of the Clinic, they are independent contractors that are contracted through the clinics Affiliates for the purpose of effectively communicating the provider's instructions with regards to the appropriate treatment indicated for that patient by the provider. These Case Managers are separate entities to Stratton Regen LLC, and accordingly, you will not hold Stratton Regen LLC responsible for any act or omission of the Case Managers, including but not limited to negligence, wrongdoing and/or misinformation by the Case Managers.

19.While Using the Facilities, and for a period of five (5) years thereafter, you shall not encourage or solicit the Clinic or any of its Affiliates to leave or terminate its/their relationship with the Clinic and/or its other Affiliates for any reason.

20. The governing law hereof is that of the state in which the clinic you are attending is currently operating in.

21.The full direct and indirect costs of any dispute arising therefrom shall be for your sole account, and on the highest scale which could be awarded by a competent court in that jurisdiction.

22.The Affiliates' rights herein are absolutely extended to any and all third parties who/which are not necessarily a party hereto and not necessarily expressly mentioned herein, but who/which fall into the categories in the definition of "Affiliates".

23.The rights afforded to The Clinic herein are absolutely extended to its Affiliates, notwithstanding the fact that they are not a party to this agreement.

24.If you do not agree to these terms, you must not continue to make Use of our Facilities or proceed with your appointment. Continuing with the appointment will constitute your full consent to, and understanding of, the terms and conditions herein.

I, the undersigned, understand and agree to the terms and conditions contained herein, and confirm that the information I have entered herein is complete and correct.

Patient Name: _____

Signature: _____Date_____

Clinic Representative: _____Date_____