Broward Neuropathy & Wellness Center
Dr. Andrew Cherry
FREE NEUROPATHY CONSULTATION

Date:_____

Full Name:	Driver License Expiration Date: ***
Cell Phone:	Email:
Birthdate:	***Social Security #:
Address:	City/State/Zip:
Occupation:	Retired? Yes No ***Monthly Income $
Spouse Name:	How did you hear about us?

Check all your symptoms

- ☐ Numbness/Tingling
- ☐ Burning
- ☐ Cramping
- ☐ Freezing
- ☐ Electric Shock Like Pain
- ☐ Balance Problems

Rate your level of pain (Circle a number)

1 2 3 4 5 6 7 8 9 10 (worst possible)

Which body parts are involved? (Circle each)

Foot / Feet Hand / Hands Upper Leg / Lower Leg Upper Arm / Lower Arm

How long have you had these symptoms?_____

Are you symptoms (circle what applies) daily constant frequent intermittent occasional

Are you getting Worse Staying the Same Getting Better? (circle what applies)

How would you describe your symptoms: *(circle what applies)*

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

Is this condition interfering with any of the following: *(circle each)*

Sleep Recreational Activities Work Walking Standing Daily Activities

Circle the things you have tried for these problems:

Gabapentin Neurontin Lyrica Cymbalta Physical Therapy Pain Meds Injections Chiropractic Massage Therapy Creams Nutrition

Circle the types of doctors you have seen for these problems

Neurologist Foot Doctor Hand Doctor Orthopedic Family Doctor Other:_____

Have any previous methods worked for you? (Circle what applies)

Bad results Some results Great results Nothing changed Didn't work very long Still trying

How are these conditions affecting your: (circle what applies)

Job Kids Future ability Marriage Self Esteem Sleep Time Finances Freedom

Describe how these problems have affected your life. Give 3 examples (circle or write)

Time money happiness freedom sleep promotion other:_____

What are you most concerned with regarding these problems:_____

_____

If your condition does not improve, what worries you most about the future?:

_____

How would life be better for you without this problem? Please be specific:

_____

List what conditions you are taking medicine for:

_____

_____

List any surgeries you have had and dates: _____

_____

Are you a diabetic? Yes or No

Has your balance been getting worse? Yes or No

Are your symptoms (like pain, tingling, numbness, cramps, electric shocks) worse at night? Yes or No

Can you feel the pedals in your car as well as you used to? Yes or No

Do you feel like your feet are wet or you are walking on cardboard? Yes or No

Can you walk barefoot? Yes or No

This program requires consistency, participation at home, and personal responsibility. How comfortable are you with that?

☐ Very comfortable ☐ Somewhat comfortable ☐ Unsure ☐ Not comfortable

On a scale of 1–10, how committed are you to doing what it takes if you are a candidate?

Commitment Level (circle one): 1 2 3 4 5 6 7 8 9 10

If this type of care is not covered by insurance and requires an out-of-pocket investment. Which best describes your mindset?

☐ I understand and am prepared to invest in my health ☐ I have concerns but am open to discussing options ☐ I am not sure I am ready for that level of commitment

Are you here primarily to gather information, or are you open to moving forward with care if it makes sense?

☐ Information only ☐ Open to care ☐ Unsure

What would help you feel confident in your decision either way?

_____

Neuropathy Care Support & Decision Questionnaire

Neuropathy treatment often involves important health decisions. In many cases, insurance provides limited or no coverage for certain treatments. Because of this, patients sometimes choose to involve a spouse, family member, or trusted person when reviewing their results and discussing care options.

The following questions help us understand who supports you so we can better assist you during your care.

1. Support System

Who knows that you are here today seeking help for your nerve condition?

☐ Spouse / Partner
☐ Adult Child
☐ Other Family Member
☐ Friend
☐ Caregiver
☐ No one yet

Name(s): _____

Relationship to you: _____

2. Impact on Others

Does your neuropathy condition affect anyone else in your life?

For example: limiting activities together, needing help with mobility, transportation, or daily tasks.

☐ Yes
☐ No

If yes, please explain briefly:

_____

3. Health Care Decision Support

When making important healthcare decisions, do you usually discuss them with someone you trust?

☐ Yes
☐ No
☐ Sometimes

If yes:

Name: _____

Relationship: _____

4. Financial Decision Support

Because insurance may not fully cover neuropathy treatment, some patients choose to involve a spouse, family member, or trusted individual when discussing treatment options and financial decisions.

Is there someone who helps you make financial decisions related to healthcare?

☐ Yes
☐ No

If yes:

Name: _____

Relationship: _____

5. Emergency Contact

Who should we contact in case of a medical emergency?

Name: _____

Relationship: _____

6. Participation in Your Care

If treatment is recommended and insurance coverage is limited, we encourage patients to bring someone they trust to their **Examination visit** so they can better understand the doctor's recommendations and help support the decision-making process.

Who would you feel comfortable bringing with you to review your results and treatment options?

Name: _____

Relationship: _____

What improvement would make the **biggest difference in your life** if your nerve condition improved?

☐ Less pain or burning
☐ Improved balance or walking
☐ Sleep better
☐ Stay independent
☐ Avoid medications
☐ Other: _____