

PATIENT INFORMATION

Today's Date : _____

Name _____
Last First Middle Initial

Address _____
Street Apt. #

City State Zip

Phone (with area code) : _____ Home _____ wk

Date of Birth _____ Age _____ Marital Status: S M W D

Occupation _____

Name of doctor referring you here: _____

Family doctor if different from above: _____

Reason for visit: What symptoms are you having, and when did they start?

Have you missed any days of work due to this problem? No Yes

Dates _____

Are you currently on medical leave or disability? No Yes Last day worked _____

Is the problem due an injury? No Yes Describe what happened: _____

Date of Injury _____ Did it happen at work? No Yes

Auto Accident? No Yes Have you been evaluated for this problem in the past? No Yes

If so, when and where? _____

List current medication including prescription drugs: _____

Medication Allergies:

Other Allergies:

Do you smoke? No Yes How much?

Have you ever smoked? No Yes

For how long? _____

Amount of alcohol consumed weekly?

List any medical conditions and/or hospitalizations: _____

Have you ever had the following tests/consults? If yes, where and when

CT _____

MRI _____

Angiogram _____

EMG _____

EEG _____

Myelogram _____

Holter EKG (24 hr) _____

Spinal Tap _____

Previous Neurological Consultation _____

Check any of the following that you have had:

- | | |
|---|---|
| <input type="checkbox"/> 1. Neck pain | <input type="checkbox"/> 19. Sleeping problems |
| <input type="checkbox"/> 2. Back pain | <input type="checkbox"/> 20. Snoring |
| <input type="checkbox"/> 3. Arm/Leg Pain | <input type="checkbox"/> 21. Seizures |
| <input type="checkbox"/> 4. Joint Pain | <input type="checkbox"/> 22. Blackout Spells |
| <input type="checkbox"/> 5. Numbness/Tingling | <input type="checkbox"/> 23. Memory Loss |
| <input type="checkbox"/> 6. Weakness/Paralysis | <input type="checkbox"/> 24. Anxiety |
| <input type="checkbox"/> 7. Difficulty Walking | <input type="checkbox"/> 25. Depression |
| <input type="checkbox"/> 8. Falling | <input type="checkbox"/> 26. Chest Pain |
| <input type="checkbox"/> 9. Balance/Coordination Problems | <input type="checkbox"/> 27. Palpitations |
| <input type="checkbox"/> 10. Movement Disorder or Tremor | <input type="checkbox"/> 28. Cardiac/Heart Problems |
| <input type="checkbox"/> 11. Bladder Symptoms | <input type="checkbox"/> 29. Bloating |
| <input type="checkbox"/> 12. Impotence | <input type="checkbox"/> 30. Stomach Pain/Distress |
| <input type="checkbox"/> 13. Dizziness | <input type="checkbox"/> 31. Bowel Problems |
| <input type="checkbox"/> 14. Speech Disturbance | <input type="checkbox"/> 32. Respiratory Problems. |
| <input type="checkbox"/> 15. Difficulty Swallowing | <input type="checkbox"/> 33. Skin Changes/Rash |
| <input type="checkbox"/> 16. Ringing in Ears | <input type="checkbox"/> 34. Weight Gain or Loss |
| <input type="checkbox"/> 17. Hearing Loss | <input type="checkbox"/> 35. Appetite Problems |
| <input type="checkbox"/> 18. Visual Symptoms | <input type="checkbox"/> 36. Appetite Problems |

FAMILY HISTORY: Do you or any blood relative have a history of:

Self	Relative
Stroke <input type="checkbox"/> _____	<input type="checkbox"/> _____
Heart Attack <input type="checkbox"/> _____	<input type="checkbox"/> _____
High Cholesterol <input type="checkbox"/> _____	<input type="checkbox"/> _____
High Blood Pressure <input type="checkbox"/> _____	<input type="checkbox"/> _____
Diabetes <input type="checkbox"/> _____	<input type="checkbox"/> _____
Epilepsy or Seizures <input type="checkbox"/> _____	<input type="checkbox"/> _____
Migraine or Severe Headache <input type="checkbox"/> _____	<input type="checkbox"/> _____
Bleeding Tendency <input type="checkbox"/> _____	<input type="checkbox"/> _____
Tremor/Movement Disorder <input type="checkbox"/> _____	<input type="checkbox"/> _____
Parkinson's Disease <input type="checkbox"/> _____	<input type="checkbox"/> _____
Multiple Sclerosis <input type="checkbox"/> _____	<input type="checkbox"/> _____
Mental Illness <input type="checkbox"/> _____	<input type="checkbox"/> _____
Memory Loss/Alzheimer's <input type="checkbox"/> _____	<input type="checkbox"/> _____
Arthritis <input type="checkbox"/> _____	<input type="checkbox"/> _____
Visual Loss <input type="checkbox"/> _____	<input type="checkbox"/> _____
Nervous Breakdown <input type="checkbox"/> _____	<input type="checkbox"/> _____
Suicide or Attempt <input type="checkbox"/> _____	<input type="checkbox"/> _____
Depression <input type="checkbox"/> _____	<input type="checkbox"/> _____
Osteoporosis (brittle bones) <input type="checkbox"/> _____	<input type="checkbox"/> _____
Cancer/Leukemia <input type="checkbox"/> _____	<input type="checkbox"/> _____
Sleep Disorder <input type="checkbox"/> _____	<input type="checkbox"/> _____

If living: present age & any Chronic medical condition

Age at death and cause

Father _____	_____
Mother _____	_____
Sister(s) _____	_____
Brother(s) _____	_____
Children _____	_____
Husband/Wife _____	_____

BP: _____

Pulse: _____

Ht. _____