Northwest **Neurological** PLLC

Patient Name:

____

Date of Birth: _________________________________

Handedness: RIGHT or LEFT (circle)

PCP Name: ____________________________________

Most bothersome symptoms you wish to address:

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____

Goals for your care:

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____

Other significant or active medical problems:

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____

Recent hospitalizations or ER visits:

(year, name of hospital, reason)

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____

Description and year of brain or spine surgeries:

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____

Please write medication name, dose, and when you take medication (or attach a list). If you complete this list you do not need to bring in your medications

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Previous Treatments tried for your symptoms (benefits or side effects):

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Physical, Occupational, and/or Speech Therapy:

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Allergies (to what and what happens):

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List Recent or most significant other surgeries or procedures:

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____

Brain or Spine MRI or Head CT in last 4 years?

(list type of scan and facility where it was done):

____

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____

EMG/Nerve testing (location, year, doctor, arms or legs)

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____

EEG (brain wave recording)? When and Where?

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____

Spinal Tap? When and Where?

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____

Smoking: Yes / No

If "Yes," how many years? ______________________

Alcohol: Yes / No

If "Yes," how many drinks per day? _______________

Single / Married (circle)

Living Situation (circle):

Home: Alone or Home with Family

Assisted Living Name:

____

Nursing Home Name:

____

Types (or prior types) of work: ____________________

____

Highest Education level:

____

Health problems in family members:

Mother: ____

____

Father: ____

____

Siblings: _______________________________________

____

How many siblings: ______________________________

Children's health problems: ______________________

____

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Circle Symptoms:

- Sleep, appetite, weight changes
- Vision changes or pain
- Ear problems, speech, or swallowing problems
- Chest pain or palpitations
- Constipation or diarrhea
- Bladder frequency, urgency or incontinence
- Muscle aches or pains
- Skin problems
- Anxiety or depression

Please write below symptoms that best describe your problem(s). Include location and severity of symptoms (mild/moderate/severe):

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____

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____