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Thank you for selecting our practice. In order to better serve your needs, please arrive 30 minutes prior to your appointment time and bring the following items with you:

- **COMPLETED** New Patient paperwork
- Insurance Card
- Driver's License or other form of photo identification
- Your co-payment if required by your insurance
- A copy of recent lab results and MRI/CT images and reports

PERSONAL INFORMATION:

First Name:_____________________ MI:____________Last Name:________________________________

Preferred Name: _______________________________

Address:____

City:___________________________________State:______________Zip:___________________________

Date of Birth: _____/______/________ Sex: M / F Other______________Marital Status: ___________

Home #: (   )   -   Email Address:____

Cell #: (   )   -   Work #: (   )   -

EMERGENCY CONTACT:

Name:____________________Relationship:_________________Phone #: (   )   -

PHYSICIAN CARE TEAM:

Referring Physician:___________________________________Phone #: (   )   -

Primary Physician:____________________________________Phone #: (   )   -

INSURANCE AND GUARDIAN INFORMATION:

Primary Insurance:______________________________Policy holder name:______________________

Patient's relationship to policy holder: Self / Spouse / Child / Other

Policy #:____Group #:___________________________

Employer:___________________________SSN:_________________________DOB:_____________________

Secondary Insurance:______________________________Policy holder name:______________________

Patient's relationship to policy holder: Self / Spouse / Child / Other

Policy #:____Group #:___________________________

Patient Name ________________________________
(Please Print)

PLEASE ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE

Please list the reason for your visit and describe your symptoms:

____

____

____

____

Have you had similar problems/symptoms in the past? Yes / No

How long has this condition existed? ____

ALLERGIES

Do you have any allergies to medications? Yes / No (**If Yes, list medication and reaction**)

____

____

____

____

TOBACCO HISTORY

Do you use tobacco? Circle all that apply: Cigarettes Cigars Chew

If yes, how many per day?__________________________how many years?____________ _______________

Ever tried to quit? Yes / No Quit date: ________________

MEDICAL HISTORY

Please list any medical conditions you have had in the past (include dates):

____

____

____

____

SURGICAL HISTORY

Please list any operations you have had in the past (include dates):

____

____

____

____

Patient Name ________________________________
(Please Print)

FAMILY MEDICAL HISTORY

Do you have any family members that have ever had any of the following conditions?

	Mother	Father	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other:
Cancer									
Dementia									
Diabetes									
Fibromyalgia									
Hypertension									
Migraines									
Multiple Sclerosis									
Neuropathy									
Parkinsonism									
Psychiatric Problems									
Seizures									
Stroke									
Thyroid Disease									
Tremor									
Other:									
Other:									
Other:									

SOCIAL HISTORY

Do you consume alcoholic beverages? Yes / No

If yes, what type? ____

How many drinks per day, per week or per month?____________________________________

Do you use recreational drugs? Yes / No

If yes, what type? Circle all that apply: Marijuana Methamphetamine Cocaine Other

How much per day, week or per month?____

Rev.3/7/17 KT

Patient Name ______________________________
(Please Print)

What kind of work do you do? ____

How would you rate your current stress level? Low / Moderate / Severe

Is this the same or different from your usual stress level? Same / Different

Have you ever experienced an emotionally traumatic event in the past? Yes / No

Are you pregnant? Yes / No Are you breastfeeding? Yes / No

Are you planning on becoming pregnant in the near future? Yes / No

FALL SCREENING

Falls within last 3 months? Yes / No

Fear of falling? Yes / No

Difficulty ambulating? Yes / No

Do you use an assistive device? Circle all that apply: Cane Walker Wheel Chair Scooter

HEALTHCARE DIRECTIVE

Living Will? Yes / No Power of Attorney? Yes / No

PREVIOUS DIAGNOSTIC TESTS

If you have had any of the following tests, please write in the approximate date(s) they were performed and location of the test:

EEG (brain wave test):____

MRI/MRA (list site, for example brain, neck, etc.):____

CT/CTA head and/or neck: ____

Lumbar puncture (spinal tap):____

EMG/NCS (nerve conduction study):____

PHARMACY INFORMATION

Your preferred **LOCAL RETAIL** pharmacy (name & address):____

____

Your preferred **MAIL ORDER** pharmacy (name & address):____

____

Patient Name ______________________________
(Please Print)

MEDICATIONS

Are you taking any medications at this time? Yes / No

Please list ALL medications including over the counter and supplements. If needed, please continue medications on the back of this sheet.

Medication: ______________________________ _______MG # per day____________
Reason for taking: ____

Medication: ______________________________ _______MG # per day____________
Reason for taking: ____

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Reason for taking: ____

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Reason for taking: ____

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Reason for taking: ____

Medication: ______________________________ _______MG # per day____________
Reason for taking: ____

Medication: ______________________________ _______MG # per day____________
Reason for taking: ____

Patient Name ______________________________
(Please Print)

REVIEW OF SYSTEMS

Are you right or left hand dominant? Right / Left

Do you have any problems with the following? If yes, please circle all that apply:

Constitutional:
- Fever
- Chills
- Weight Loss
- Weight Gain
- Fatigue
- Weakness

Eyes:
- Blurred Vision
- Double Vision
- Eye Pain
- Eye Redness
- Droopy Eyelids

Gastrointestinal:
- Nausea
- Vomiting
- Abdominal Pain
- Blood in Stools
- Bowel Incontinence

Musculoskeletal:
- Muscle Pain
- Neck Pain
- Back Pain
- Joint Pain
- Limb Pain

Skin:
- Rash
- Itching
- Skin Wounds

Cardiovascular:
- Chest Pain
- Palpitations
- Leg Swelling

Urinary:
- Urgency
- Frequency
- Pain w/ Urination
- Blood in Urine
- Bladder Incontinence

Endocrine/Blood:
- Bruise/Bleed Easily
- Excessive Thirst
- Deepening of Voice
- Seasonal Allergies
- Food Allergies

Ears, Nose, Throat:
- Hearing Loss
- Tinnitus
- Ear Pain
- Congestion
- Sore Throat
- Swollen Glands

Respiratory:
- Cough
- Shortness of Breath
- Wheezing

Psychiatric/ Behavioral:
- Depression
- Suicidal Ideas
- Nervous/Anxiety
- Hallucinations
- Personality Changes
- Emotional Problems
- Insomnia
- Memory Loss

Neurological:
- Dizziness
- Tingling
- Numbness
- Tremor
- Sensory Change
- Speech Change
- Focal Weakness
- Seizures
- Loss of Consciousness