River Oaks Neurology
Patient Registration Packet
This packet contains the following:

1. PATIENT DEMOGRAPHIC INFORMATION FORM
   Please fill this out as well as you can.

2. AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
   Use this if you need to request records from your doctor.
   You should give a copy of this to your doctor before your appointment with us if you can. If not, we can fax it for you.
   If your doctor referred you to us, you usually do not have to use this form.

3. NOTICE OF PRIVACY PRACTICES, AND APPOINTMENT POLICY (AND RECEIPT)
   Please sign the receipt and bring this to us. You may keep the policy.

4. PATIENT HISTORY FORM
   Please fill out as completely as you can.
   Bring these forms with you to the office yourself. Do not mail them.
   Don't worry if you are not sure about how to fill something out. We can help you.
   Call the office to arrange for extra time to complete forms. Do not come early.

We look forward to meeting you!

A note about our location:
We are on the third floor of Medical Plaza 1.
You must use the "Kingsride" elevators to reach the third floor.
Our office is just in front of the elevators, on the left.

RIVER OAKS NEUROLOGY
902 FROSTWOOD, SUITE 309
HOUSTON, TEXAS 77024
PHONE 713-960-9700 FAX 713-960-9300

PATIENT DEMOGRAPHIC INFORMATION FORM

PATIENT INFORMATION

Gender M F T Other	DOB	NATIVE COUNTRY (IF NOT USA)	Dominant Hand: ___RIGHT	___LEFT ___ Ambidextrous
Salutation	Last Name	First Name	Middle Name	Suffix
Patient Address (1)		City	State	Zip
Primary Address (2)		Occupation		
Home Phone		Employer		
Work Phone	Fax No.	Spouse / Partner / Significant Other's Name		
Cell Phone		Emergency Contact		
Email Address		Emergency Phone		

INSURANCE INFORMATION

Primary Insurance

Insurance Plan Name	Group Number	ID Number		
Ins. Co Street Address	Insured's Name	Insured's DOB		
Ins. Co. Address (Line 2)	Relationship to Patient. Self S.O. Child Other	Worker's Comp		
Ins. Co. Phone Number (1)	Ins. Co. Phone No. (2)	Ins. Co. Contact Person		
City	State	Zip	Copay $	
Deductible	Amount met:	Amount Remaining	In Network?	
Ins. Co. Notes				

Secondary Insurance

Insurance Plan Name	Group Number	ID Number		
Ins. Co Street Address	Insured's Name			
Ins. Co. Address (Line 2)	Relationship to Patient. Self S.O. Child Other	Worker's Comp		
Ins. Co. Phone No. (1)	Ins. Co. Phone No. (2)	Ins. Co. Contact Person		
City	State	Zip	Copay $	
Deductible	Amount met:	Amount Remaining	In Network?	
Ins. Co. Notes				

REFERRAL INFORMATION

Referral Source	Position	Specialty	
Referral Address	City	State	Zip
Referral Address (2)	Referral Phone	Referral Fax	
PHARMACY NAME ADDRESS AND PHONE NUMBER:			

CONSENT TO BILLING AND MEDICAL TREATMENT

PLEASE READ: For insurance agencies or third party payors to make a payment on your behalf, we must submit limited information to them. This includes information such as the patient demographics, diagnosis, and any procedure or test results. **Your signature below signifies that you consent** to our submission of such information as needed to obtain insurance certification and reimbursement. Your signature also signifies that your are requesting and consenting to routine medical office evaluation and treatment, including physical examination, administration of medications, and procedures such as venipuncture for blood tests, local or intravenous injections, electromyography, electroencephalography, and nerve conduction testing. You agree you will not proceed with taking medications that are prescribed by this office, or undergoing procedures until your physician has explained their need and risk to your satisfaction.

(Patient, Guardian, or Medical Power of Attorney) **Signature**_____ **Date**_____

AUTHORIZATION FOR RELEASE OF MEDICAL / PSYCHOLOGICAL RECORDS

PATIENT INFORMATION

LAST NAME **FIRST NAME** **DATE OF BIRTH**

SOCIAL SECURITY NUMBER **HOME TELEPHONE** **GENDER (identity)** **M F T**

T: Transgendered

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of the following confidential medical information from my medical record:

☐ From: **J. Gavin Norris, M.D., Ph.D.**

☐ To: **River Oaks Neurology**
902 Frostwood
Suite 309
Houston, TX 77024
Office 713-960-9700
Fax 713-960-9300

☐ From: Name:

☐ To: Street:

City State ZIP

Phone

Fax

THE RELEASE OF CHEMICAL DEPENDENCY AND HIV DATA IS AUTHORIZED.

(OTHERWISE USE ALTERNATE FORM).

	TO BE RELEASED	DATES OF SERVICE		TO BE RELEASED	DATES OF SERVICE
☐	LAB WORK		☐	EMG REPORT	
☐	PROGRESS NOTES		☐	RADIOLOGY REPORTS	
☐	NEURO. EXAM		☐	ENTIRE RECORD	
☐	MEDICATION RECORDS		☐	OTHER_____	

Reason for Release of Information:

I understand that this authorization for the release of medical information is valid for one calendar year unless I inform River Oaks Neurology of my wish to discontinue this authorization. I further understand the I may revoke this authorization in writing at any time I choose. Any release of information undertaken in reliance upon this authorization prior to revocation shall not constitute a breech of my confidentiality. I am aware that I will be billed a customary fee for the copying of my records, when applicable. I understand that the information requested will be provided within 21 days of the completion of this request.

PATIENT'S SIGNATURE (OR IF LEGAL REPRESENTATIVE – STATE POWER TO ACT) DATE (EFFECTIVE DATE OF RELEASE)

AUTHORIZATION FOR THE RELEASE OF PSYCHOLOGICAL (INCLUDING NEUROPSYCHOLOGICAL) RECORDS

I authorize the release of the following confidential PSYCHOLOGICAL information from my PSYCHOLOGICAL record:

J. Gavin Norris, MD, PhD

To: **River Oaks Neurology**
902 Frostwood STE 309
Houston, TX 77024
Office 713-960-9700 Fax 713-960-9300

Doctor:

Street:

From:

City, State, ZIP

Office Phone

Office Fax

TO BE RELEASED **DATES OF SERVICE**

RELEASE OF CHEMICAL DEPENDENCY AND HIV DATA IS AUTHORIZED.

(SIGN THIS HALF TO REQUEST PSYCHIATRIC, PSYCHOLOGIC OR NEUROPSYCHOLOGIC INFORMATION, OTHERWISE LEAVE BLANK.)

Reason for Release of Information:

I understand that this authorization for the release of PSYCHOLOGICAL information is valid for one calendar year unless I inform River Oaks Neurology of my wish to discontinue this authorization. I further understand the I may revoke this authorization in writing at any time I choose. Any release of information undertaken in reliance upon this authorization prior to revocation shall not constitute a breech of my confidentiality. I am aware that I will be billed a customary fee for the copying of my records, when applicable. I understand that the information requested will be provided within 21 days of the completion of this request.

PATIENT'S SIGNATURE DATE (EFFECTIVE DATE OF RELEASE)

River Oaks Neurology, P.A.
902 Frostwood, Suite 309
Houston, Texas 77024
Phone: (713) 960-9700 Fax: (713) 960-9300

Notice of Privacy Practices and Late Arrival / No Show Policy

I, _____, acknowledge that I have received the Notice of Privacy Practices posted on the practice website, in the patient care area of the office, and, if requested, in a printed copy.

I also acknowledge that I am aware of the office policy that patients who are not present *with completed registration paperwork* within 15 minutes of their scheduled appointment time may be charged a rescheduling fee, and may be rescheduled to a later appointment, possibly on a later date. Furthermore, appointment cancellations less than 24 hours prior to an appointment may also be charged a fee to reschedule (you may leave a voice mail message if needed). We have more flexibility to reschedule patients if we know in advance that a patient will be late, so please contact the office as soon as possible if your arrival may be delayed. This policy is to assure that other patients have access to office appointments and can be seen on time. A fee schedule is available on our website.

_____

Signature

_____

Date

Please sign and date this receipt page and return it to the office staff.

You may keep the following “NOTICE OF PRIVACY PRACTICES” for your records.

River Oaks Neurology, P.A.
902 Frostwood, Suite 309, Houston TX 77024
(713) 960-9700

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have a right to adequate notice of the uses and disclosures of your protected health information ("PHI") (i.e., information that discloses your identity or leads to disclosure of your identity) that may be made by this medical practice. You are also entitled to notice of your rights and the duties of this practice with respect to your personal health information.

Required by Law

Our practice has the following duties with respect to your personal health information:

1. We are required by law to maintain the privacy of your personal health information.
2. We must provide you with notice of our legal duties and privacy practices with respect to personal health information.
3. We must abide by the terms of the notice of privacy practices that is currently in effect.

How We May Use and Disclose Your Information

The following describes how our practice is permitted by law to share your personal health information with others in order to provide you with medical care. This notice does not describe every use or disclosure our practice makes; it is intended as a general overview.

Medical Treatment. We may need to share information about you in order to provide medical care to you. For example, we may share information with other physicians, nurses or healthcare professionals entering information into your medical records relating to your medical care and treatment. We may share information about you including x-rays, prescriptions and requests for lab work.

Payment. We may need to disclose information about the treatment, procedures or care our practice provided to you in order to bill and receive payment for services we provided. We may share this information with you, an insurance company or any third party responsible for payment. We may also need to disclose personal health information about you with your health plan and/or referring physician in order to obtain prior authorization for treatment, to determine whether payment for the treatment is covered by your plan or to facilitate payment of a referring physician.

Healthcare Operations. In order to help us run our practice more efficiently and provide better patient care, we may use and disclose your personal health information to Business Associates who need to use or disclose your information to provide a service for our medical practice, such as our billing company or software vendors who provide assistance with data management on our behalf. *[Provide additional examples appropriate to your practice]*.

Required by Law. We will disclose medical information related to you if required to do so by state, federal or local law.

Public Health Activities/Risks. Your medical information may be disclosed to a public health authority that is authorized by law to collect or receive such information for public health activities. Certain disclosures may be made for public health activities in the following circumstances:

1. to prevent or control disease, injury or disability;
2. to report of births or deaths;
3. to report child abuse or neglect;
4. to report reactions to medications or product defects;
5. to notify individuals of product recalls;
6. to notify a person who may have been exposed to a communicable disease or at risk of contracting or spreading a disease or condition;
7. if our practice reasonably believes a person is the victim of abuse, neglect, or domestic violence, we may disclose personal health information to the appropriate authority. We will only make this disclosure if you agree to the disclosure or we are required or authorized to do so by law without your permission. *Appointment Reminders or Treatment Alternatives*. Our practice may use and disclose medical information about you to provide you with reminders that you are due for care or you have an upcoming appointment. We may also wish to provide you with information on treatment alternatives or other health related benefits that may be of interest to you. We may contact you by phone, fax or e-mail. We will make every effort to protect your privacy when leaving a message for you and try to reveal as little confidential information as possible (e.g., when leaving a message on your answering machine that may be heard by others). Research. Under certain circumstances, our practice may use or disclose your personal health information for research purposes. Our practice cannot use or disclose information about you without your written authorization, but we may if the authorization requirement has been waived by a Review Board who has assessed the effect of the research protocol on your privacy rights and interests and certified that there are adequate controls in place to protect your information from improper use and disclosure. Our practice may also disclose information about you in preparing to conduct research (e.g., to help them find patients who may be qualified to participate in a particular study), but your information will not leave our practice. We will make all attempts to make your information non-identifiable, but we may not always be able to guarantee this. If however, the researcher will have access to information that will identify you, we will seek to obtain your permission (though we cannot guarantee this). We will always obtain your specific authorization if required by law.

To Avert Serious Threat to Health or Safety. If our practice believes, in good faith, that a use or disclosure of your medical information is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public, we may disclose your medical information.

Worker's Compensation. We may release medical information about you for work-related illness or injury for workers' compensation or other related programs.

Health Oversight Activities. Your personal health information may be disclosed to federal, state or local authorities as part of an investigation or government activity authorized by law. This may include audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary actions or other activities necessary for the oversight of the health care system, government benefit programs and compliance with government regulatory programs or civil rights laws.

Law Enforcement. We may disclose your personal health information to law enforcement individuals if we are required to do so by law. We may also disclose medical information about you in compliance with a court order, warrant or subpoena or summons issued by the court. We will make best efforts to contact you about these types of requests so that you can obtain an order restricting or prohibiting disclosure of the information requested. We may also use such information to defend ourselves in actions or threatened actions that may be brought against our practice.

Coroners, Medical Examiners and Funeral Directors. We may release personal health information to a coroner or medical examiner for the purposes of identification, determining cause of death or other duties as authorized by law. We may also release medical information to funeral directors as necessary to carry out their duties with respect to the deceased.

Organ, Eye, Tissue Donation. If you are an organ donor, we may disclose your personal health information to organ procurement organizations, or other entities that facilitate tissue donation or transplantation.

Inmates. If you are an inmate of a correctional institution or within the custody of law enforcement officials, we may disclose medical information about you to allow the institution to provide you with medical care, to protect the health and safety of yourself and others, or for the safety and security of the correctional institution.

Other uses and disclosures will be made only with your written authorization and you may revoke your authorization at any time.

Uses and Disclosures Where We Will Obtain your Written Authorization

Psychotherapy Notes. We may only disclose your psychotherapy notes for limited purposes such as carrying out treatment. For other purposes we will obtain your written consent.

Marketing. For most marketing purposes we will obtain your written consent; exceptions include if the product or service is directly treatment related, discussed face-to-face or given as a promotional gift of nominal value.

Uses and Disclosures That You Can Agree or Object To

Others Involved in your Healthcare. Unless you object, we may we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies. We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall allow you to object to future disclosures as soon as reasonably practicable after the delivery of treatment.

Patient Rights

You have the following rights with respect to your personal health information:

Right to Receive Personal Health Information Confidentially. You have the right to receive confidential communications of your personal health information by alternate means or at alternate locations. For example, if you would like for us only to communicate with you at home, and never at your workplace or to send information to you on your workplace e-mail, you may request this of our practice. You must make this request in writing but do not need to disclose the reason for your request. We will attempt to accommodate all **reasonable** requests. Please be specific as to how or where you wish us to communicate with you.

Right to Inspect and Copy. You have the right to inspect and copy your medical record that has been created to treat you and is used to make decisions about your care. This includes medical and billing records. Records related to your care may also be disclosed to an authorized person such as a parent or guardian upon proper proof of a legitimate legal relationship. You must submit your request in writing to inspect and copy your records. If you would like to copy your records, our practice may charge you fees for the cost of copying records, mail or other minimal costs associated with your request.

Right to Amend. If you think there is information in your record that may be inaccurate or incomplete, you have the right to request an amendment or clarification of information in your record. Your request to make an amendment to your record must include the following and may be refused if the following elements are not met:

1. Submit your request in writing
2. Describe what you would like the amendment to say and your reasoning for why the change should be made
3. The amendment must be dated, signed by you and notarized

Please note that we will not change information created by third parties, if the information is not part of the medical information kept by our practice or we believe the information you provided to us is inaccurate or incomplete. We reserve the right to deny your request if we have reason to believe the information is accurate.

Right to Restrict Uses and Disclosures. You have the right to request restrictions on how our practice makes certain uses and disclosures of your personal health information for treatment, payment or healthcare operations. You may restrict how much information we may provide to family members regarding your treatment or payment for your care. You may also restrict certain types of marketing materials related to your care or treatment. **We are not required to agree to your request or we may not be able to comply with your request, but we will do all that we can to accommodate your request. If we agree to your request, we must comply. However, if the information is required to provide emergency treatment to you, we will not comply.** Your request must be in writing and include the following:

1. What information you would like to limit
2. Whether you want to limit our use, or disclosure or both
3. To whom you want the limits to apply (e.g., disclosures to parents, children, spouse, etc.)

Right to an Accounting of Uses and Disclosures. You have the right to receive an accounting of the disclosures of your personal health information that our practice makes for purposes other than treatment, payment or healthcare operations. All requests must be submitted in writing. All requests must state a time period **not longer than six (6) years back.** You must state whether you would like the accounting in electronic or paper form. One request in a twelve-month period will be provided to you at no charge. We may charge you a fee for all additional requests within a twelve-month period. We will notify you as to the cost of fulfilling your additional request and allow you the opportunity to modify it before fees are due.

All requests should be submitted to the reception desk for appropriate processing.

Right to Copy of Notice. You have the right to obtain a copy of our notice of privacy practices upon request at any time. Please call us at (713) 960-9700 for a copy or ask for a copy at the reception desk.

Changes to this Notice. Our practice is required to abide by the terms of this notice, which is currently in effect. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all personal health information we already have about you and may obtain in the future. If we change our notice, we will post notice of this change thirty (30) days prior to making the change effective. The notice will be posted in our office lobby and on our practice website. All revised notices will be promptly posted and made available to you in our waiting room. You may also request a current Notice when you visit our office. Changes to our notice will only be effective on the date that is reflected at the bottom of the last page on the revised Notice.

Practice Contact. If you would like more information about this notice, please contact our office manager at (713) 960-9700. If you have any complaints regarding our privacy practices, please address your complaint to us in writing and follow the designated complaint process below.

Complaints. If you believe your privacy rights may have been violated or you become aware of a privacy concern you would like to report to our practice, please follow this complaint process: Send a written letter to the practice contact named above, including the following information:

   a. Name and Address
   b. Social Security Number or Patient Identification Number
   c. Detailed description of the circumstances surrounding your complaint including dates, times and any relevant information to help us understand your complaint.
   d. Contact information
   e. Signature and Date

2. Please allow fourteen (14) business days for an answer from our practice regarding your complaint.
3. If you are not satisfied with our response to your complaint, you may notify the Secretary of the Department of Health and Human Services.

Please note, all concerns or complaints regarding your personal health information are important to our practice. There will be no retaliation against you for filing a complaint with our office.

Additional Privacy Protections. Our practice is committed to protecting your privacy and for the proper use and disclosures of your personal health information. For particularly sensitive conditions, even though the law allows us to disclose the information for various reasons, patients may request in writing that certain information be handled with additional discretion. Our privacy officer and medical staff must evaluate each request individually to determine if and how the information in question can be additionally protected. Any arrangements made for special handling and protection of patient information must be agreed to in writing by both the privacy officer and medical staff, as well as the patient or patient's guardian.

Electronic Notice. We are also required to prominently post our Notice of Privacy Practices on our medical practice Website. You can find this notice at our internet address, **www.RiverOaksNeurology.com**. Revised 01/17/2011

River Oaks Neurology
902 Frostwood, Suite 309
Houston, Texas 77024

PATIENT HISTORY FORM

TODAY'S DATE:

_____/_____/_____

CHIEF COMPLAINT AND HISTORY OF PRESENT ILLNESS

Name	The reason for your visit (i.e. headache, memory loss, tremor, pain, numbness):

Do you believe your symptoms are due to a car wreck or work accident? **Yes_____ No_____**

Can you tell us some details about the reason for your visit today? For example, what are your symptoms, when did they start, and does anything make it better or worse?

(use the back of this page if needed)

PREVIOUS MEDICAL HISTORY

Have you ever had:	YES	NO	If yes, please describe below. Have you seen a neurologist before? Yes____ No____
Cancer	○	○	
High or Low Blood Pressure	○	○	
Anemia / Blood Problem / Transfusion	○	○	
Heart Problems	○	○	
Lung / Breathing Problems	○	○	
Kidney, Bladder, or Liver Disease	○	○	
Diabetes	○	○	
Thyroid Disease	○	○	
Stomach Disease or Ulcers	○	○	
Asthma, Hay Fever	○	○	
Dementia / Alzheimer's	○	○	
Strokes	○	○	
Parkinson's Disease or Tremors	○	○	
Seizures / Epilepsy	○	○	
Brain or Spinal Cord Tumor	○	○	
Neuropathy / Radiculopathy	○	○	
Muscle Disease	○	○	
Migraines	○	○	
Loss of Consciousness	○	○	
Learning Disability or Autism	○	○	
Back Problems	○	○	
Head Injury	○	○	
Other Neurologic Disease	○	○	
Eye Trouble (Sight, Cataract, Glaucoma)	○	○	
Ear, Nose, or Throat Trouble	○	○	
Arthritis or Joint / Muscle Injury	○	○	
Skin disease, cysts, or benign tumor	○	○	
Tuberculosis	○	○	
Measles, Mumps, or Chicken Pox	○	○	
AIDS, HIV, Syphilis, or other STD	○	○	
Scarlet Fever	○	○	
Handicap, Disability, Birth Defect	○	○	
Hereditary Disorders	○	○	

Surgery? ○ None ○ Tonsillectomy ○ Appendectomy ○ Hysterectomy ○ Other_____

Anything Else Not Mentioned?

GENERAL REVIEW OF SYSTEMS			Name and Date:_____
HAVE YOU RECENTLY HAD?	**YES**	**NO**	**DETAILS**
Changes in your weight?	○	○	
Generalized Weakness or Fatigue?	○	○	
Fever and/or Chills?	○	○	
Night sweats?	○	○	
Unexplained Skin Sores?	○	○	
Itching or Rashes?	○	○	
Lumps Under the Skin or Breast?	○	○	
Fingernail / Toenail Changes?	○	○	
Unusual or Changed Moles?	○	○	
Ear Ache / Ear Discharge?	○	○	
Frequent Colds / Flu?	○	○	
Frequent Nasal or Sinus Congestion or Seasonal Allergies?	○	○	
Seasonal Allergies?	○	○	
Frequent Bloody Nose?	○	○	
Sore Throat or Hoarseness of Voice?	○	○	
Swollen Glands in the Neck?	○	○	
Shortness of Breath?	○	○	
Excessive Snoring?	○	○	
Wheezing?	○	○	
Chronic or Acute Cough?	○	○	
Cough producing Sputum or Blood?	○	○	
Pneumonia?	○	○	
Chest Pain?	○	○	
Heart Palpitations / Racing Pulse?	○	○	
Fluid Retention?	○	○	
Varicose Veins?	○	○	
Blood Clotting Problems?	○	○	
Bruising?	○	○	
Jaundice?	○	○	
Changes in your Appetite?	○	○	
Nausea or Vomiting?	○	○	
Heartburn, Indigestion, or Reflux?	○	○	
Diarrhea?	○	○	
Constipation?	○	○	
Rectal Bleeding?	○	○	
Hepatitis / Jaundice?	○	○	
Genital Pain or Discharge?	○	○	
Urination difficulty or incontinence	○	○	
Corrective Lenses (glasses or contacts)?	○	○	
Dentures?	○	○	
Itching or Watery Eyes?	○	○	
Joint Pain or Swelling?	○	○	
Joint Weakness/Stiffness/Instability?	○	○	
Other ?			

NEUROLOGICAL REVIEW OF SYSTEMS			Name and Date:_____
HAVE YOU HAD?	**YES**	**NO**	**DETAILS**
Fainting / Loss of Consciousness?	○	○	
Unusual / Frequent Headaches?	○	○	
Problems with Balance or Coordination?	○	○	
Unusual Shaking, Jerking, or Tremor?	○	○	
Difficulty Walking, or Slow Walking?	○	○	
Difficulty Staying Awake?	○	○	
Changes in Taste or Smell?	○	○	
Vision Loss or Changes?	○	○	
Double Vision?	○	○	
Eye Pain?	○	○	
Facial Pain or Numbness?	○	○	
Slurred Speech, Facial / Eye Drooping?	○	○	
Hearing Loss / Ringing in your Ears?	○	○	
Dizziness or Vertigo?	○	○	
Difficulty Swallowing, Choking?	○	○	
Voice Too Soft or Loud?	○	○	
Trouble Lifting or Turning your Head?	○	○	
Back Pain? Where?	○	○	
Severe or Unusual Pain? Where?	○	○	
Unusual numbness? Where?	○	○	
Weakness in any part of your body?	○	○	
Changes in Sexual Responsiveness?	○	○	
Burning or Numb Feet?	○	○	
Muscle Cramping?	○	○	
Muscle Twitching or Shrinking?	○	○	
Dry mouth?	○	○	
Excessive Sweating?	○	○	
Auditory or Visual Hallucinations, “Hearing Things” or “Seeing Things”	○	○	
Problems Understanding what Others Say to You?	○	○	
Problems Expressing Yourself?	○	○	
Finding the Right Word to Complete a Thought?	○	○	
Changes in Handwriting?	○	○	
Problems Understanding what You Read?	○	○	
Problems Doing Math Calculations?	○	○	
Problems with Concentration or Attention?	○	○	
Problems with Memory?	○	○	
Problems with Getting Lost or Confused in a Familiar Place?	○	○	
Problems with Depression / Sadness?	○	○	
Problems with Anxiety?	○	○	
Changes in Your Personality?	○	○	
More Irritability?	○	○	
Excessive Sleepiness?	○	○	
Insomnia? Other problems with sleep?	○	○	

FAMILY HISTORY (BLOOD RELATIVES ONLY, NOT PATIENT)			**Name and Date:**_____
Has anyone **ELSE** in your family had:	YES	NO	DETAILS:
Cancer?	○	○	
High Blood Pressure?	○	○	
Anemia / Blood Problems?	○	○	
Heart Problems?	○	○	
Lung or Breathing Problems?	○	○	
Kidney, Bladder, or Liver Problems?	○	○	
Diabetes?	○	○	
Thyroid Disease?	○	○	
Dementia / Alzheimer's?	○	○	
Strokes?	○	○	
Parkinson's or Tremor?	○	○	
Seizure or Epilepsy?	○	○	
Brain or Spinal Cord Tumors?	○	○	
Neuropathy?	○	○	
Muscle Problems?	○	○	
Migraines?	○	○	
Walking or Coordination Problems?	○	○	
Schizophrenia?	○	○	
Depression?	○	○	
Hereditary Disorders?	○	○	
Tuberculosis?	○	○	
Substance Abuse / Alcoholism?	○	○	
Other Conditions?	○	○	

SOCIAL HISTORY

How far did you go in School?	YEARS IN HIGH SCHOOL _____		YEARS IN COLLEGE? _____		HIGHEST DEGREE ? _____	
What is or was your Occupation?	_____		Are you currently employed? _____		Date last employed?_____	
Did you Serve in the Military?	Which branch?_____		Rank?_____		Military Occupation? _____	
What is your Current Marital Status?	Single ○	Married ○	Domestic partnership ○	Divorced ○	Separated ○	Widowed ○
Do you have any children?	YES ○	NO ○	How many?_____	Ages?_____		
Do you use Tobacco?	YES ○	NO ○	How much?_____	Date quit?_____		
Do you use Alcohol?	YES ○	NO ○	If so, how much?_____			
Have you ever used any illicit drugs?	YES ○	NO ○	Which drugs?_____	When?_____		

FUNCTIONAL ABILITIES

How much help do you need:	None	Some	Significant	Total	DETAILS
Bathing, grooming, toileting, and dressing?	○	○	○	○	
Getting Dressed?	○	○	○	○	
Eating and Drinking?	○	○	○	○	
Meal Preparation?	○	○	○	○	
Walking, Rising, Standing, and Sitting?	○	○	○	○	
Driving?	○	○	○	○	
Using the Telephone?	○	○	○	○	
Handling Money / Check-writing?	○	○	○	○	
Grocery Shopping?	○	○	○	○	
Doing Laundry?	○	○	○	○	
Working?	○	○	○	○	
Doing Leisure Activities?	○	○	○	○	

ALLERGY AND MEDICATIONS	**Name and Date:**_____

Please list all medication allergies and the reaction they caused:

Drug (or Food Allergy)	Reaction

Please list all your current medications:

Medication	Dose	Frequency	Prescribing Doctor	Reason for taking:	Notes
Medications you are currently taking.					

ANY ADDITIONAL NOTES YOU WOULD LIKE TO ADD, SUCH AS SEXUALITY, FAITH, CONCERNS FOR YOUR SAFETY, STRESS, HOBBIES: