Jeri Yvonne
Movement Disorders Neurology

8327 Brimhall Road, Suite 703, Bakersfield, CA 93312 • Phone 661.679.3590 • Fax 661.695.6900

PATIENT INFORMATION (Section I)

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Date Of Birth: _____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____

Home Phone #: _____ **Cell Phone #:** _____

Work Phone #: _____ **Alt Phone #:** _____

Employer: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Drivers License#: _____ **State Of Issue:** _____

Marital Status:
- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Separated
- ☐ Widowed

Student:
☐ Yes ☐ No

Retired:
☐ Yes ☐ No

FINANCIAL RESPONSIBILITY (Section II)
(PERSON FINANCIALLY RESPONSIBLE FOR PATIENT NAMED ABOVE)

☐ **CHECK HERE IF "SELF" & PROCEED TO SECTION 3**

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Date Of Birth: _____ **Sex:** ☐ Male ☐ Female

Social Security Number: _____

Home Phone #: _____ **Cell Phone #:** _____

Work Phone #: _____ **Alt Phone #:** _____

Employer: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Drivers License#: _____ **State Of Issue:** _____

Relationship:
- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other (Specify) _____

EMERGENCY CONTACT (Section III)

Contact Name: _____

Relationship: _____

Contact Phone #(s): _____

FOR OFFICE USE ONLY:

Appointment Date:_____ Demos Rec'vd On:_____ ☐ Insurance Setup ☐ Patient History Entered

PHARMACY INFORMATION (Please provide complete address) (Section IV)

Name Of Pharmacy:	Address, City, Zip Code:	Pharmacy Phone:	Pharmacy Fax:

PRIMARY INSURANCE INFORMATION (Section V)
(GIVE CARD TO RECEPTIONIST UPON ARRIVAL)

Insurance Company:
Claims Address:
City: **State:** **Zip:**
Phone # for Providers/Eligibility & Benefits:
Member Number:
Group Number:

Relationship to Insured:
- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other (Specify)

Insured's Full Name:
Insured's Social Security No.:
Insured's Date Of Birth:

SECONDARY INSURANCE INFORMATION (Section VI)
(GIVE CARD TO RECEPTIONIST UPON ARRIVAL)

Insurance Company:
Claims Address:
City: **State:** **Zip:**
Phone # for Providers/Eligibility & Benefits:
Member Number:
Group Number:

Relationship to Insured:
- ☐ Spouse
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other (Specify)

Insured's Full Name:
Insured's Social Security No.:
Insured's Date Of Birth:

HOW DID YOU HEAR ABOUT US? (Section VII)

☐ Referred by Physician - Physician's Name:
Phone:
Fax:
☐ Internet Website or Search Engine – Which site did you initially find us on?
☐ Newspaper/Magazine Article Or Ad – Which publication?
☐ Insurance Plan (Check here if you found us thru your insurance plan's website or in their provider directory.)
☐ Friend or Family Member:
☐ Other – Please describe:

Save Form Print Form Reset Form

Jeri Yvonne
Movement Disorders Neurology

PATIENT NAME: _____

Treatment Authorization

(*Check and sign the applicable paragraph***)**

☐ I authorize Jeri Yvonne Movement Disorders Neurology to examine, diagnose and treat me. I authorize and give Jeri Yvonne Movement Disorders Neurology consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) for a choice analysis and study and to include diagnosis for submission for payment to the insurance carrier for the named patient.

_____ _____

SIGNATURE OF PATIENT DATE

☐ I hereby authorize Jeri Yvonne Movement Disorders Neurology to examine and treat _____.

(name of patient)

I authorize and give Jeri Yvonne Movement Disorders Neurology my consent to submit specimens (blood, urine, tissue, etc.) to the laboratory (ies) of choice for analyses and study and to include diagnosis for submission for payment to the insurance carrier for the named patient.

_____ _____

SIGNATURE OF PATIENT or REPRESENTATIVE DATE

Acknowledgement of No Show & Late Cancellation Policy

Patients who fail to show up for their scheduled appointments or fail to give 24 hours' notice when canceling or rescheduling their appointments place an extra burden on the staff of JYMDN. Furthermore, since the appointment goes unfilled, this represents either a delay to see another patient or a financial burden to JYMDN. Therefore, JYMDN has implemented the following policy:

- A **$25 charge** will be assessed for "no-showing" or failing to give 24-hour notice of the need to cancel **routine follow-up appointments**
- A **$25 charge** will be assessed for "no-showing" or failing to give 24-hour notice of the need to cancel **NEW PATIENT appointments and scheduled PROCEDURES**, including EMG, EEG and Home Sleep Testing

These charges are not billable to your insurance company and will ultimately be the responsibility of the patient. All no-show and late cancellation fees will need to be paid before your next appointment with the physician. If a patient has 3 no-show or late cancellations, they may be dismissed from the practice.

_____ _____

SIGNATURE OF PATIENT or REPRESENTATIVE DATE

Prescription Benefits and Medication History

I give consent to JYMDN to download my prescription benefits and medication history information from Surescripts pharmacy clearinghouse.

_____ _____

SIGNATURE OF PATIENT or REPRESENTATIVE DATE

8327 Brimhall Road | Suite 703 | Bakersfield, CA 93312
TEL: (661) 679-3590 | Fax: (661) 695-6900 | www.drjeriyvonneneurology.com

Jeri Yvonne
Movement Disorders Neurology

Authorization for Release of Information

I hereby authorize Jeri Yvonne Movement Disorders Neurology to release any information necessary to my insurance company (ies), including governmental health care insurer (such as Medicare and Medicaid) or other health care practitioners involved in the care of the named patient. I understand that I am giving this authorization only in the case of a subpoena or for the release of information necessary for the provision of continuity of care, to determine insurance benefits and the payment of any claims, and/or for all health plan procedures related to the evaluation of the quality and cost-efficiency of care.

SIGNATURE OF PATIENT or REPRESENTATIVE _____ DATE _____

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I acknowledge that I have received a copy of JYMDN's "Notices of Protected Health Information Practices".

SIGNATURE OF PATIENT or REPRESENTATIVE _____ DATE _____

Authorized Contacts

Many times family members will call and ask or give medically related information about the patient. So we may properly protect your privacy, please indicate yes, no, or n/a if you would like for us to share or discuss your private medical information with any of the following relatives/groups of people:

Yes	No	N/A		Name of Individual(s):
☐	☐	☐	**Spouse:**	
☐	☐	☐	**Adult Child(ren):**	
☐	☐	☐	**Parent(s):**	
☐	☐	☐	**Other(s):**	

☐ **I do not wish my information to be disclosed to any person.**
Initial and Date: _____

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Payment Policy

I understand that I am responsible for payment of professional services at the time they are rendered. I understand that I am responsible for any amount not covered by insurance including, without limitation, deductible, co-payment, co-insurance, or other amounts unpaid by my insurance, if benefits assigned. Jeri Yvonne Movement Disorders Neurology files claims for Medicare assignment and only the commercial care plans with which we are contracted. Claims will not be filed with other insurance carriers.

NAME of Insured / Responsible Party | Signature of Insured / Responsible Party | Date

Legal Irrevocable Assignment Of Benefits And Release Of Medical And Summary Plan Documents

In considering the amount of expenses to be incurred, I _____, the undersigned, have insurance and/or employee health care benefits coverage with _____(insurance co. information), and hereby irrevocably assign and convey directly to the treating physicians at Jeri Yvonne Movement Disorders Neurology (hereafter "provider") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider/practice. Said irrevocable assignment and transfer shall be for the purpose of granting the provider and practice an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider and practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider and practice all benefits and amount due for services rendered by the physician.

I understand that if the provider and practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider and practice for all charges in excess of the benefits paid. **All payments will be made to provider and practice at: Jeri Yvonne Movement Disorders Neurology, 8327 Brimihall Road, Suite 703, Bakersfield, CA 93312.**

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider and practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider and practice in any attempts by such provider and practice to pursue such claim, chosen action or right against any insurers and/or employee health care plan, including, if necessary, bring suit with such provider and practice against any insurers and/or employee health care plan in my name but at such provider and practice's expense.

This lifetime assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

NAME of Insured / Responsible Party | Signature of Insured / Responsible Party | Date

Save Form | Print Form | Reset Form

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Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. **PLEASE REVIEW THIS NOTICE CAREFULLY.**

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Jeri Yvonne Movement Disorders Neurology, 8327 Brimhall Road,
Suite 703, Bakersfield, CA 93312

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (UHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice — including, but not limited to, our doctors and nurses — may use or disclose your IIHI, in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care provider for purposes related to your treatment.

2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. **Health Care Operations.** Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your HHI to other health care providers and entities to assist in their health care operations.

4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

5. **Treatment Options**. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

8. **Disclosures Required By Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - maintaining vital records, such as births and deaths
   - reporting child abuse or neglect
   - preventing or controlling disease, injury or disability
   - notifying a person regarding potential exposure to a communicable disease
   - notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - reporting reactions to drugs or problems with products or devices
   - notifying individuals if a product or device they may be using has been recalled
   - notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of a adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices
   - In response to a warrant, summons, court order, subpoena or similar legal process
   - To identify/locate a suspect, material witness, fugitive or missing person
   - In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

5. **Research**. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an IRB or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to the individual's privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

6. **Serious Threats to Health or Safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

7. **Military**. Our practice may disclose your ITHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

8. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of State, or to conduct investigations.

9. **Inmates**. Our practice may disclose your JIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

10. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications**. You have the right to request that our practice & communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to our Privacy Officer specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to our Privacy Officer. Your request must describe in a clear and concise fashion:

    a) the information you wish restricted;
    b) whether you are requesting to limit our practice's use, disclosure or both; and
    c) to whom you want the limits to apply.

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our Privacy Officer in order to inspect and/or obtain a copy of your JIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. **Accounting of Disclosures**. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your Ill-Il for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to our Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact our Privacy Officer.

7. **Right to File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Privacy Officer, We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. **Right to Provide an Authorization for Other Uses and Disclosures**. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer.

Jeri Yvonne
Movement Disorders Neurology

NEW PATIENT INTAKE FORM
Movement Disorders

Patient Name: _____ Date: _____ Age: _____

Referring Physician: _____ Family Physician (PCP): _____

Handedness: ☐ Left ☐ Right ☐ Both

Reason for Appointment:

GENERAL QUESTIONS:

1. Do you have tremor: ☐ Yes ☐ No If No, skip to question #2.
   a. If yes, where: ☐ Right hand ☐ Left hand ☐ Right arm ☐ Left arm ☐ Right leg ☐ Left leg
      ☐ Head ☐ Face ☐ Tongue ☐ Trunk
   b. Does your tremor bother you:
      ☐ at Rest ☐ with Action (writing, eating, using a tool) ☐ Holding an arm/leg outstretched
      ☐ Other _____
   c. What makes your tremor better? ☐ Medication ☐ Certain positions ☐ Alcohol
      ☐ Other _____
2. Do you have balance difficulty? ☐ Yes ☐ No If No, skip to question #3.
   a. If yes, have you fallen? ☐ Yes ☐ No
   b. How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly
3. Do you have any sleep difficulty? ☐ Yes ☐ No If No, skip to question #4.
   a. Is the problem: (*check all that apply*)
      ☐ Falling asleep ☐ Staying asleep ☐ Vivid dreams ☐ Talking/kicking/fighting in your sleep
      ☐ Excessive daytime sleepiness ☐ A feeling of needing to move the legs and walk around
      ☐ Waking up short of breath
4. Do you have anxiety, depression, mood/personality changes? ☐ Yes ☐ No If No, skip to question #5.
   a. Please check all that apply:
      ☐ Anxiety ☐ Depression ☐ Personality change ☐ Mood change

5. Do you have any problems with your memory? ☐ Yes ☐ No If Yes, see below.

   a. Please check all that apply:
      ☐ Remembering short term events (events from past week/month)
      ☐ Remembering long term events (childhood/early adulthood memories)
      ☐ Difficulty concentrating
      ☐ Difficulty finding words
      ☐ Other _____

PAST MEDICAL HISTORY:

Check below if applicable:

☐ Diabetes ☐ Hypertension ☐ Stroke ☐ Heart Disease ☐ GERD
☐ Breathing Problems ☐ Arthritis ☐ Kidney Problems ☐ Thyroid ☐ Cholesterol
☐ Cancer Type(s): _____

Please list any other medical conditions below:

PAST SURGICAL HISTORY/HOSPITALIZATIONS:

Date (Year)	Surgery or Reason for Hospitalization

MEDICATIONS: (please include any over-the-counter medications and supplements). If you already have a list prepared, please attach a copy. You do not need to rewrite it.

MEDICINE	DOSE	# OF TIMES PER DAY

ALLERGIES:

☐ No known drug or food allergies

☐ Drug Allergy: _____

☐ Food Allergy: _____

SOCIAL HISTORY:

a. ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Significant other

b. Tobacco use ☐ None ☐ Quit Year: _____ ☐ Current Type/Frequency: _____

c. Alcohol ☐ None ☐ Current Type/Frequency: _____

d. Illicit drug use ☐ None ☐ Current Type/Frequency: _____

e. Do you exercise? ☐ Yes ☐ No If yes, frequency: _____

f. Current stressors? _____

g. Any exposures to toxins or chemicals? (occupational or personal) Example: Heavy exposure to pesticides, welding, working with heavy metals.
☐ Yes ☐ No If yes, Type: _____

h. Highest level of education completed? _____

i. Current or prior occupation. If retired, please list the year of retirement: _____

j. Do you have children? ☐ Yes ☐ No If yes, how many? _____

FAMILY HISTORY: For Aunt, Uncle, and Grandparents, please list M for Mom's side and P for Dad's side.

	None	Son	Daughter	Mother	Father	Brother	Sister	Aunt	Uncle	Gmother	Gfather
Parkinson's disease											
Memory loss											
Dystonia											
Tremor											
Symptoms like yours											
OTHER:											
OTHER:											
OTHER:											

REVIEW OF SYSTEMS:
Please check the "Yes" or "No" box to indicate if you currently have any of the following symptoms:

	YES	NO		YES	NO		YES	NO
Weight loss			Shortness of breath			Depression		
Fatigue			Constipation			Hallucinations		
Blurred vision			Diarrhea			Numbness		
Double vision			Frequent urination			Loss of sense of smell		
Nasal discharge			Urinary urgency			Loss of sense of taste		
Hoarseness			Loss of control of urine			Rashes		
Difficulty chewing			Bleeding disorders			Skin changes		
Difficulty swallowing			Bruising easily			Abnormal moles		
Chest pain			Problems with easy bruising			Intolerance to cold		
Fainting spells			Muscle pain			Excessive thirst		
Cough			Anxiety			Enlarged lymph nodes		

Please list any medications you have tried and failed. Failed may represent a side effect on the medication or no effect.

Please list any other concerns or specific questions that you would like addressed today.

Thank you for taking the time to complete this form.
This helps us to spend our visit addressing your primary concerns
and reviewing recommendations for your neurological care.

Save Form Print Form Reset Form

NEW PATIENT QUESTIONNAIRE

Name: _____ Appointment Date: _____

Birth Date: _____ Age: _____ Referred By: _____

What is the reason for the visit? _____

When did you first become aware of this problem? _____

Describe the problem: _____

Describe the duration and course of the problem *(continuous, intermittent, seconds, minutes, hours, etc.)*. _____

What is the body part most affected? _____

Have you previously received a diagnosis for this problem? ☐ Yes ☐ No

If so, what was the diagnosis? _____

Who made the diagnosis? _____

What tests have been performed to aid this problem? _____

What treatments have you received for this problem? _____

What improves your problem *(medication, rest, etc.)*? _____

What worsens your problem *(exercise, lack of sleep, stress, etc.)*? _____

How has your problem interfered with your activities of daily living, such as bathing, feeding, or clothing yourself?

What is your occupation, and how has your problem interfered with it? _____

Who in your family has a similar problem? _____

Does anyone in your family have a neurological disease? If so, specify. _____

PLEASE CHECK THE APPROPRIATE ANSWERS

GENERAL HEALTH ☐ Excellent ☐ Good ☐ Fair ☐ Poor

OTHER ILLNESSES:

☐ Cancer, Specify: _____
☐ Heart Disease _____
☐ Kidney Disease _____
☐ Liver Disease _____
☐ Lung Disease _____
☐ Chronic Infection _____
☐ Mental Disorder _____
☐ Other _____

☐ High Blood Pressure
☐ Diabetes
☐ Thyroid Disease
☐ Arthritis
☐ Glaucoma
☐ Blood Disorder
☐ High Cholesterol
☐ Ulcer

FAMILY HISTORY *(DISEASES THAT RUN IN YOUR FAMILY)*:
List any family members that have the following diseases:

_____ Stroke
_____ Heart Disease
_____ High Blood Pressure
_____ Memory Loss
_____ Other

_____ Seizures
_____ Diabetes
_____ Cancer *(What kind?)*

OPERATIONS AND HOSPITALIZATIONS *(List Dates and Diagnosis)*:

ACCIDENTS AND INJURIES *(List Dates and Types of Injuries)*:

LIST ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS YOU TAKE, ALONG WITH THE DOSES:

ALLERGIES OR UNUSUAL REACTIONS TO DYES OR MEDICATIONS:

HABITS:

	PRESENT	PAST	HOW MUCH
Tobacco	☐ Yes ☐ No	☐ Yes ☐ No	_____
Alcohol	☐ Yes ☐ No	☐ Yes ☐ No	_____
Exercise	☐ Yes ☐ No	☐ Yes ☐ No	_____
Drug Use	☐ Yes ☐ No	☐ Yes ☐ No	_____

LIST OF SYMPTOMS
PLEASE CHECK ALL THOSE WHICH APPLY

☐ Excessive weight gain _____ lb.in _____ months

☐ Excessive weight loss _____ lb.in _____ months

☐ Excessive sweating, hair change, or hot/cold insensitivity

☐ Prolonged sore throat, hoarseness, or difficulty swallowing

☐ Difficulty breathing or chronic cough

☐ Chest pain or irregular heart beat

☐ Abdominal pain, nausea, change in bowel habits or control

☐ Change in urination frequency, pain upon urinating, incontinence

☐ Change in menstrual cycle *(Women)* or Impotence *(Men)*

☐ Uncontrollable crying or laughing

☐ Change in hearing

☐ Change in sense of smell or taste

☐ Blurred vision

☐ Double vision

☐ Generalized weakness or fatigue *(all muscles)*

☐ Specific limb or muscle weakness – Specify: _____

☐ Decrease in muscle size – Specify: _____

☐ Involuntary movements – Check: ☐ Cramping ☐ Trembling ☐ Jerking ☐ Other

☐ Numbness – Specify where: _____

☐ Muscle pain or tenderness – Specify where: _____

☐ Memory loss

☐ Difficulty concentrating

☐ Depression

☐ Sleeping too much – average sleep per night: _____ hours

☐ Inability to sleep *(Insomnia)* – average sleep per night: _____ Hours

☐ Blackouts *(fainting spells)*

☐ Lightheaded – the feeling of almost passing out

☐ Vertigo – the feeling of the room or yourself spinning

☐ Seizures

☐ Headaches

☐ Neck stiffness or pain – shooting pain into arm(s)? ☐ Yes ☐ No

☐ Low back stiffness or pain – shooting pain into leg(s)? ☐ Yes ☐ No

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