NEUROLOGICAL INTAKE ASSESSMENT FORM

Date: _____

Name: _____

Age:_____ Sex: M F Marital Status: _____

Name of Spouse: _____

Name(s) and Age(s) of children:_____

_____

_____

Education:_____

Occupation:_____ Spouse's Occupation _____

What problem have you come in for today?_____

_____

When did this problem start? _____

Please state everything that you would like to tell the doctor about this problem:_____

_____

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(turn page over)

Have you had a CAT scan in the past? Y or N If so, when?_____Results? _____

Have you had a MRI in the past? Y or N If so when? _____ Results? _____

Have you had Blood tests in the past year?_____ Were they Normal? _____

Which doctors have you seen for this problem, if any? _____

_____

_____

Which family doctor or other doctor's do you see? _____

_____

_____

Do you Smoke Cigarettes? _____

Do you drink Alcohol? Never_____ Occasionally_____ Daily _____

Have you had any type of problems with Addictive Drugs in the past?_____

Do you tend to be Anxious or Nervous?_____

Is the Anxiety Mild_____, Moderate_____ or Severe _____?

Do you have trouble Sleeping_____, Going to Sleep_____, or Staying Asleep _____?

Do you tend to be Depressed? Y or N When was your last episode?_____

Is it Mild_____, Moderate_____, or Severe _____

Other past Medical History:

Operations? _____

Neck Pain? _____

Ulcers or Stomach problems? _____

Asthma?_____

Any other Medical Problems?_____

_____

Side effects or Allergies to any medications? _____

_____

_____

What Medications are you currently taking? _____

_____

_____

_____