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NEUROLOGY
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PATIENT REGISTRATION/INTAKE FORM

Name_____ Date of Birth____/____/____
Address_____ Phone # (____)_____
_____ Cell # (____)_____
Email: _____ Work # (____)_____
Sex: M____ F____
If patient is a minor, Please list parent/legal guardian name(s): _____
_____
Primary Care Physician_____
Referring Physician (if different from Primary)_____

Pharmacies: (Please provide Name, Phone Number and City if address is unknown)
Primary Pharmacy_____
Address_____ Phone # (____)_____
Secondary Pharmacy_____
Address_____ Phone# (____)_____
Mail Order Pharmacy_____
Address_____ Phone # (____)_____

What are your current symptoms and/or reason(s) for today's visit?
_____
_____
_____
_____
_____

What is your marital status? Single__ Married__ Domestic Partner__ Divorced__ Widowed__

What is your race? White__ Black/African American__ Asian__
American Indian/Alaskan Native__ Hawaiian/Pacific Islander__
Other__ Prefer not to answer__

What is your ethnicity? Latino/Hispanic Origin__ Not Latino/Hispanic Origin__
Prefer not to answer__

What is your primary language? English__ Other_____

Employment Yes__ No__ Full Time__ Part Time__ Retired__ Disabled__
Self Employed__ Active Military__
If YES, Where_____

What is your Occupation _____

Handedness: Right Handed__ Left Handed__ Ambidextrous__

Do you drink Alcohol? Never__ Light__ Moderate__ Heavy__ In Recovery__

Do you use tobacco? Yes__ No__ Quit When_____

List Medical Conditions past and present:_____
_____
_____
_____

Previous Surgeries and/or Hospitalizations:_____
_____
_____
_____

Do you have any of the following?	YES	NO	DETAILS:
Visual Disturbance			
Fevers/ Weight Loss/ Chills			
Excessive Thirst or Urination			
Hearing Loss/Ringing in the ears/Dizziness			
Chest Pains/Heart fluttering/Shortness of Breath			
Coughing/Wheezing			
Nausea/Abdominal pain/Diarrhea/Vomiting			
Bleeding from the bowels			
Bladder Control Loss or Incontinence			
Pain in Joints/Back/Muscles			
Rashes/Skin Issues			
Depression/Anxiety/Stress			
Easy Bruising/Abnormal Bleeding/Unexplained Lumps			

List all Medications and Doses (or provide an updated list):

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Do you have any ALLERGIES? __Yes __No

Medication Allergies: **Reactions:**

_____ _____
_____ _____
_____ _____

Seasonal/Food Allergies: **Reactions:**

_____ _____
_____ _____

Family Medical History:

	Neurological Problems (Strokes, Epilepsy, Migraines, Alzheimer's, MS, Parkinson's, ect.)	Inherited Problems (Otosclerosis, Fragile, Muscular Dystrophy, ect.)	Other Serious Problems (Cardiac, Rheumatoid, ect.)	Unusual Conditions
Mother				
Father				
Grandparents (specify paternal or maternal)				
Brother				
Sister				
Children				

_____ _____

Signature of Patient or Responsible Party Date