THE NEUROLOGICAL INSTITUTE, P.A.

7000 Shannon Willow Rd. Charlotte, NC 28226 (P) 704-372-3714 (F) 704-333-4601

DOCUMENTS NEEDED AT THE TIME OF APPOINTMENT

Date: ___________________________

Dear ____________________________________,

You have been scheduled for an appointment with _______________________________. This appointment is on:

_____________________/_______________________ @ ____________________am / pm
Day **Date** **Time**

____
Office Location

<u>Please arrive 30 minutes prior to your appointment to allow for any additional paperwork.</u>

Please remember that this time has been reserved for your visit with the doctor. We customarily charge for missed appointments unless given a minimum of twenty four hours notice. Enclosed you will find forms to be completed. Please fill them out and then **<u>bring them with you at the time of your appointment. (Do not mail of fax these forms)</u>**

Medical records from your previous treating physician will be helpful to our physicians. Please make arrangements to have them mailed or faxed to us prior to your appointment.

Also, attached is our payment policy. Read this information carefully. If you have any questions, please call us before your appointment. Our Business Office will be glad to assist you.

We are looking forward to having you as one of our patients.

Thank you,

The Doctors and Staff of The Neurological Institute

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PAYMENT POLICY

Patient's Name:____

Date of Birth: ________________________________Chart # ______________________

If the treatment you are seeking is due to a work related injury/problem please check the **Yes** box. If the treatment is not for a work related injury/problem check the **No** box.

☐ **Yes (work related accident)** ☐ **No (not a work related accident)**

<u>OFFICE VISITS FOR NEW AND ESTABLISHED PATIENTS:</u>

Payment in full is expected at the time service is rendered, unless the patient is covered by a managed care policy in which we participate. In this case the patient or the responsible party is only required to pay the deductible if not met and/or co-payment/ coinsurance dictated by the insurance plan at the time of service.

<u>HOSPITAL AND OTHER OUT-OF-OFFICE CHARGES</u>

We file all primary and secondary insurance for these charges. Should the patient require follow-up at our office, our office payment policy will take effect and the patient or responsible party will be subject to its' restrictions.

ADDITIONAL CHARGES

No show or Late Cancellation charges will be applied to the patients account anytime a patient does not show or give at least 24 hours cancellation notice prior to a scheduled appointment. This charge is $35.00. Due to the possibility of equipment failure, leaving a message on our recorder will not necessarily guarantee early cancellation of an appointment. There will be charges incurred for copying medical records, completing forms and generating forms of medical necessity. There is a $25.00 fee for returned checks.

PLEASE NOTE:

We file Tertiary if contracted with insurance as a courtesy to our patients. All other insurance must be filled by the insured. If insurance does not pay within thirty days after billing, the patient or responsible party is liable for any and all charges not paid by the insurance, including denials for charges determined to be above reasonable and customary. All charges are due in full after this thirty day period. Liablity cases are between the patient and his/her attorney, thus payment in full is still expected prior to the time of service as stated above. Payment is not required on approved or contested Worker's Compensation visits. If your account is turned over to a collection agency payment in full will be required before scheduling an appointment.

I certify that I have read and understand the payment policy above and will comply with its precepts. I also hereby guarantee payment in full of any balance due for services rendered upon discharge.

Signature of Patient or Responsible Party: ______________________________________

Date: ___________________________________

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NOTICE TO PATIENTS REGARDIGN MEDICAL RECORDS/FORMS

Patient's Name:____

Date of Birth: ________________________________**Chart #** ______________________

Following HIPAA guidelines, any patient's records will be destroyed if the patient has not been seen in our practice in over 10 years. You may request a copy of your own records to keep if you would like.

- Please mail or drop off any forms to be completed at least 5 business days before you need them returned.
- Please be prepared to pay when you drop off the form/forms for completion, or you may enclose a check for the correct amount when mailing the forms to; The Neurological Institute.

CHARGES ARE AS FOLLOWS:

• DISABILITY FORMS	$25.00
• FL-2 FORMS	$35.00
• HOUSING FORMS	$25.00
• MISCELLANEOUS FORMS	$20.00 (per page)
• DETAILED FORMS*	$50.00 (per page)
• DMV FORMS	$25.00

*(Extensive Chart Review with Detailed Answers)

FORMS WILL NOT BE COMPLETED AND SIGNED UNTIL PAYMENT IS MADE

Thank you for your cooperation,

The Doctors and Staff of The Neurological Institute

Signature of patient/Responsible Party: ____

Date: _____________________________________

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RELEASE OF VERBAL INFORMATION

Patient's Name: ____

Date of Birth: ________________________________Chart # ______________________

The Neurological Institute is not permitted by law, to give medical information or updates about your condition to anyone unless authorized by you, the patient.

If you wish relatives and/or friends, who ask about your condition, to have the right to be verbally informed about your condition when they ask The Neurological Institute Staff please list the names of these people below. Relatives and friends might include your spouse, son or daughter, grandchild, niece, nephew, neighbor or friend.

I, ____, as a patient of The Neurological Institute, authorize the release of verbal medical information regarding my treatment and care and updates of my condition to the following individuals.

Name:____ Relationship: __________________

Name:____ Relationship: __________________

Name:____ Relationship: __________________

Name:____ Relationship: __________________

Signature of patient/Responsible Party: ____

Date: ______________________________________

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name:____

Date of Birth:____________

I, __________________________________, hereby authorize The Neurological Institute and/or its agents:
(Check one)

_____ To release information regarding my medical care and/or treatment to:
____
____
____
Or

_____ To request information regarding my medical care and/or treatment from:
____
____
____

I understand that I may revoke this consent at any time, except to the extent that action has already been taken.

____ __________
Patient Signature (parent, guardian, caretaker) **Date**

[if other than patient signature, relationship: _______________________________________]

____ __________
Witness Signature Date

<u>MAIL FORM:</u>
Medical Records
The Neurological Institute
7000 Shannon Willow Rd.
Charlotte, NC 28226

<u>FAX FORM:</u> 704-333-4601, Attention: Medical Records

NOTICE OF PRIVACY POLICIES FOR THE NEUROLOGICAL INSTITUTE PA Revision # 2

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

Introduction

At , The Neurological Institute PA, we are committed to treating and using protected health information (**PHI**) about you responsibly. This Notice describes the personal information we collect, and how and when we use or disclose that information. This Notice is effective April 14, 2003 and applies to all protected health information as defined by federal regulations.

Understanding your Health Record/Information

Each time you visit The Neurological Institute PA, a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer (for example, your insurance company or companies) can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation
- A source of data for planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we receive.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, understand whom, what, when, where, and why others may access your health information, and make sure more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of The Neurological Institute PA, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.526,
- Authorize another person to receive your PHI,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

The Neurological Institute PA is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures in the authorization.

For More Information or to Report a Problem

If you have any questions and would like additional information, you may contact the practice's Compliance Officer, Linda G Reep, at (704) 372-3714 Ext 303.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Compliance Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Compliance Officer or the Office for Civil Rights. The address for the OCR is:

Office for Civil Rights
US Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington DC 20201

NOTICE OF PRIVACY POLICIES FOR THE NEUROLOGICAL INSTITUTE PA
Revision # 2

Examples of Disclosures for Treatment, Payment and Health Operations

We may use your health information for treatment or to assist your other health care providers in connection with your treatment.
For example: Information obtained by a nurse, physician, or other member of your health care team (including the referring doctor and his/her staff) will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in your treatment. We may use or disclose health information when contacting pharmacies to order medication prescriptions and/or prescription refills.

We may use your health information for payment.

For example: A bill may be sent to you or a third party payer (i.e. your insurance company or companies). The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We may use or disclose health information if we need to contact you directly (if necessary) to collect an outstanding debt that is the responsibility of the patient.

We may use your health information for regular health operations or to support our business functions.

For example: We may use PHI in your health record to assess and/or improve the quality of care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contracts with business associates. Examples include any outside laboratories used for tests ordered by our physicians, our computer support company (Agastha), any Home Health Care agencies as needed as a supplier of Durable Medical Equipment for your treatment, our transcription services, our Collection Agencies used for overdue accounts, and the company that we use for disposal of private records. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we have asked them to do and bill you or your third party payer, if applicable, for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Signing in: Unless you notify us that you object, we will use your name at a front desk sign in sheet to document your presence in the office. Your name will be used to call the patient back to an exam room, or to the front desk for further information and/or direction.

Notification to family members or others involved in your care: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location and general condition. Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We may use or disclose information when providing appointment reminders via phone and/or mail (e.g., when contacting you at the number(s) you have provided to us and leaving a message as a reminder.)

Research: We may disclose information to researchers when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Marketing: We may use your PHI to contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose your PHI to comply with workers' compensation laws and other similar laws that provide benefits for work-related injuries or illnesses.

Public Health and Safety, Health Oversight Activities: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We may also disclose your PHI to a health oversight agency for activities authorized by law such as audits, investigations, inspections, licensure, or disciplinary actions.

As required by Law and Law Enforcement: We may disclose your PHI when we are required to do so by state or federal law. We may disclose health information for law enforcement purposes or as required in response to a valid subpoena. We may disclose your PHI to a government agency that is authorized by law to receive reports of abuse, neglect, or domestic violence.

OUR POLICIES FOR PROTECTING YOUR PROTECTED HEALTH INFORMATION:

We protect the PHI that we maintain about you by using physical, electronic, and administrative safeguards that meet or exceed applicable law. When our business activities require us to provide PHI to third parties, they must agree to follow appropriate standards of security and confidentiality regarding the PHI provided. Access to your PHI is restricted to appropriate business purposes.

We have developed privacy policies to protect your PHI. All employees receive training on these policies and they must sign a privacy acknowledgment form, binding them to abide by our policies and procedures.

In addition to these safeguards, we have developed a number of other protections such as;

- Using confidentiality provisions in our contracts with third parties to restrict the use and disclosure of, and to protect the privacy of PHI,
- Restricting access to PHI by physical security measures in certain areas of our business operations, and
- Using only non-identifiable information for research purposes whenever possible.

Acknowledgement of Receipt of Notice of Privacy Policies

I, ______________________________, understand that as part of my health care, THE NEUROLOGICAL INSTITUTE, PA originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge receipt of the *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this acknowledgement,
- The right to access, inspect, and obtain copies of my Protected Health Information (PHI),
- The right to ask this provider to correct, amend, or delete my PHI,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations,
- The right to request an accounting of disclosures,
- The right to confidential communications with this provider at a different location.

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (as described in the Privacy Policies Notice) and I consent to such disclosure for these permitted uses, including disclosures via fax.

I understand that THE NEUROLOGICAL INSTITUTE is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this provider may refuse to treat me as permitted by Section 164.506 of the Code of Federal regulations.

I further understand that THE NEUROLOGICAL INSTITUTE reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should THE NEUROLOGICAL INSTITUTE change their policies, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

____
Patient's Signature (or signature of responsible party, if patient is a minor)

____
Date

==
FOR OFFICE USE ONLY:

Patient Account #: ______________________

PATIENT INFORMATION FORM

When registering, please show proof of insurance and identity.

PATIENT INFORMATION

Name____
Address____
City_______________________State_________Zip_______
Phone_________________________Marital Status_______
Date of Birth__________________Age_______Sex______
Driver's License_____________________State__________
Soc. Sec #___________________________Student Y / N
Email: ____

PRIMARY CARE PHYSICIAN (PCP)

Name____
Phone____

PATIENT'S EMPLOYER

Employer Name_____________________________________
Address____
City_______________________State_______Zip________
Phone_________________________________Ext________
Title/Occupation____________________________________

PATIENT'S SPOUSE/GUARDIAN/RESPONSIBLE PARTY

Spouse/Guardian___________________________________
Relationship_________________Phone______________
Soc. Sec#_____________________DOB______________
Driver's License#____________________State_________
Address____
City_____________________State______Zip__________

SPOUSE/GUARDIAN/RESPONSIBLE PARTY EMPLOYE

Name____
Address____
City_____________________State______Zip___________
Phone_____________________________Ext___________

INSURANCE INFORMATION

Policy Holders Name________________________________
Policy Holders Soc. Sec #____________________________
DOB: ____
Ins. Carrier____
Effective Date_____________________________________
PPO Network_____________________Group #_________
Group Name_______________________________________
Policy#____
Insurance Phone #__________________________________
Claims Address____________________________________
City_________________________State______Zip_______
Relationship to Insured______________________________

OTHER INSURANCE (If Applicable)

Policy Holders Name_______________________________
Policy Holders Soc. Sec #____________________________
DOB: ____
Ins. Carrier____
Effective Date______________________________________
PPO Network_____________________Group #_________
Group Name____
Policy#____
Insurance Phone #___________________________________
Claims Address_____________________________________
City__________________________State______Zip_______
Relationship to Insured______________________________

EMERGENCY CONTACT (NOT LIVING WITH YOU)

Name____
Address____
City___________________________State_____Zip_______
Hm Phone_________________Bus Phone_____________

I understand that if my insurance requires an authorization and / or referral, it is my responsibility to obtain this before my visit.
If you do not have authorization and / or referral on the day of your appointment, you will be expected to pay all charges.

If your visit will be covered by **Workman's Compensation**, we must have an authorization prior to visit.

I certify the above information is correct to the best of my knowledge. I hereby guarantee payment in full of any amounts due for goods and services rendered and authorize assignment of benefits and/or release of information and /or appeal any claims on my behalf to my insurance company or representatives.

Signature ____
(Responsible Party)

Date_____________________________

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READ AND SIGN THE FOLLOWING AUTHORIZATION FOR CONSENT:

Consent to Treatment:

I understand that no guarantees have been made to me regarding either the treatment or results of any procedures provided by the doctor.
I am aware that I may stop with this treatment at any time. I recognize that I will be responsible for paying for the services I have already received.
I acknowledge that I have been given the opportunity to ask questions and have received clarification about these and other portions of this form, and about the treatment that I am seeking.
I understand that if payment for services I receive is not made, the doctor may stop my treatment, and may employ the services of a collection agency to seek payment.

Consent to Obtain Medication History:

I am aware that my signature allows The Neurological Institute to obtain my medication history from Community Pharmacies and Pharmacy Benefit Managers (PMB).

This data is to assist The Neurological Institute in making the necessary clinical decisions for my care and treatment.

Signature of Patient or Responsible Party: ____

Date: ____________________________________

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NEW PATIENT QUESTIONNAIRE

Date: ________________ Person filling out questionnaire, if not patient (relationship to patient):

☐ Spouse ☐ Parent ☐ Child ☐ Sibling ☐ Other: __________________________

Identifying Data

Name: ____ Date of Birth: ________________

Age: _________ Sex: ☐ Male ☐ Female Hand you write with: ☐ Right hand ☐ Left hand

Race: ☐ Caucasian ☐ African American ☐ Native American ☐ Hispanic ☐ Asian/Pacific Islander

☐ Other: _______________________________

Nationality, if not US Citizen: _____________________ Language spoken fluently, if not English: _____________

Referring doctor: _____________________________ Primary medical doctor: _____________________________

Pharmacy (name, location & phone): ____

Chief Complaint

Please briefly state your main problem (reason for visit): ____

____

History of Present Illness

With regard to the above problem, please provide the following information:

LOCATION (on body): ____

____

QUALITY (description): ____

____

SEVERITY: (10-very severe) ☐ 10 ☐ 9 ☐ 8 ☐ 7 ☐ 6 ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

DURATION: ☐ few seconds ☐ 30 seconds ☐ 1 minute ☐ few minutes
☐ 30 minutes ☐ 1 hour ☐ few hours ☐ 1 day
☐ few days ☐ 1 week ☐ few weeks ☐ 1 month
☐ few months ☐ constant

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TIMING: When did the problem begin? ____

How did it begin? ☐ suddenly ☐ gradually

How often does it occur?

☐ constant ☐ every few seconds ☐ every few minutes ☐ once per hour ☐ few times per hour
☐ once per hour ☐ every few hours ☐ few times per day ☐ once per day ☐ few times per week
☐ once per week ☐ few times per month ☐ once per month ☐ every few month ☐ few times a year

CONTEXT (S) in which problem occurs: ____

____

MODIFYING FACTORS:

Things that make the problem worse: ____

Things that make the problem better: ____

ASSOCIATED SYMPTOMS:

Please list any other symptom (s) that occur with your main symptom: ___________________________

____

MISCELLANEOUS INFORMATION:

If the problem is a result of an injury, please provide the date of the injury and describe how it occurred:

____

____

____

If you have missed work because of the problem, how much work have you missed? ___________________

If you have seen any other physicians about this problem, please list their name and specialty: _______________

____

Please check any test(s) you have had because of the problem and list date performed:

☐ Blood test __________ ☐ MRI __________ ☐ CT __________ ☐ EEG __________ ☐ EMG/NCS _________

☐ Lumbar puncture (spinal tap) __________

Is there anything else that we need to know about the problem? ______________________________

____

____

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Past Medical History

Please check any of the following medical illnesses you have had:

- ☐ Abdominal aortic aneurysm
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Anemia
- ☐ Anxiety/Panic attacks
- ☐ Asthma
- ☐ Astigmatism (wear glasses)
- ☐ Atrial fibrillation
- ☐ Attention deficit disorder
- ☐ Benign positional vertigo (BPPV)
- ☐ Bipolar disorder
- ☐ Bladder infection
- ☐ Bleeding tendency
- ☐ Blindness
- ☐ Blood clot-heart
- ☐ Blood clot-leg
- ☐ Blood clot-lung
- ☐ Brain aneurysm
- ☐ Brain tumor
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiac arrest
- ☐ Carpal tunnel syndrome
- ☐ Cataracts
- ☐ Chiari malformation
- ☐ Cirrhosis
- ☐ Closed head injury
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Crohn's disease
- ☐ Deafness
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulosis
- ☐ Drug addiction
- ☐ Ear infection
- ☐ Emphysema
- ☐ Encephalitis
- ☐ Enlarged prostate (BPH)
- ☐ Epilepsy or seizure
- ☐ Essential tremor
- ☐ Gall stones
- ☐ Gastritis
- ☐ Gastro esophageal reflux
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart arrhythmia
- ☐ Heart attack
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herniated disc
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hydrocephalus
- ☐ Irritable bowel syndrome
- ☐ Kidney failure
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Lou Gehrig's disease (ALS)
- ☐ Leukemia
- ☐ Lupus
- ☐ Lymphoma
- ☐ Malabsorption
- ☐ Meningitis
- ☐ Mental retardation
- ☐ Migraine
- ☐ Mirtal valve prolapsed
- ☐ Multiple myeloma
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Narcolepsy
- ☐ Nasal allergies
- ☐ Neurofibromatosis
- ☐ Neuropathy
- ☐ Obstructive sleep apnea
- ☐ Optic neuritis
- ☐ Osteoarthritis
- ☐ Pancreatitis
- ☐ Parkinson's disease
- ☐ Peripheral vascular disease
- ☐ Platelet disorder
- ☐ Pneumonia
- ☐ Polymyositis
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Pseudotumor cerebri
- ☐ Psoriasis
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Scoliosis
- ☐ Sinus infection
- ☐ Skull fracture
- ☐ Spina bifida
- ☐ Spinal stenosis
- ☐ Stomach ulcer
- ☐ Strabismus

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- ☐ Stoke/TIA
- ☐ Subarachnoid hemorrhage
- ☐ Subdural hematoma
- ☐ Syringomyelia
- ☐ Thyroid disease
- ☐ Transverse myelitis
- ☐ Ulcerative colitis
- ☐ Valvular heart disease
- ☐ Vascular malformation

Please list any other medical illnesses you have had not mentioned above: ___________________________________

____

Past Surgical History

Please check any of the following procedures you have had:

- ☐ Abdominal aortic aneurysm repair
- ☐ Abdominal hernia repair
- ☐ Amputation
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Bladder surgery
- ☐ Brain aneurysm clip or coil
- ☐ Brain hematoma removed
- ☐ Brain tumor removed
- ☐ Brain vascular malformation removed
- ☐ Breast or breast lump removed
- ☐ Carotid endarterectomy
- ☐ Bypass or stent of leg artery
- ☐ Carpal tunnel release
- ☐ Cataract surgery
- ☐ Cerebrospinal fluid shunt
- ☐ Colorectal surgery
- ☐ Coronary bypass (CABG)
- ☐ Coronary stent
- ☐ Beep brain stimulator
- ☐ Epilepsy surgery
- ☐ Gall bladder removed
- ☐ Gastric bypass
- ☐ Greenfield filter
- ☐ Heart valve replacement
- ☐ Hiatal hernia repair
- ☐ Hip replacement
- ☐ Hysterectomy
- ☐ Inguinal hernia repair
- ☐ Kidney removed
- ☐ Kidney transplant
- ☐ Knee replacement
- ☐ Lithotripsy
- ☐ Liver transplant
- ☐ Lung removed
- ☐ Lung transplant
- ☐ Nasal surgery
- ☐ Neck surgery
- ☐ Ovary removed
- ☐ Pacemaker
- ☐ Posterior fossa decompression
- ☐ Prostate removed
- ☐ Retinal photocoagulation
- ☐ Sinus surgery
- ☐ Small bowel surgery
- ☐ Spleen removed
- ☐ Strabismus surgery
- ☐ Thyroid surgery
- ☐ Transurethral prostate resection (TURP)
- ☐ Tonsils removed
- ☐ Vagus nerve stimulator

Please list any other procedures you have had not mentioned above: ____

____

Current Medications

Medication	Dose	Frequency

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Allergies

Please list all medication allergies: ____

____

Social History

MARITAL STATUS

Currently, I am: ☐ Single, never married ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Who do you live with? ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Sibling ☐ Other

Occupation

Do you work? ☐ Yes ☐ No If not, why? ____

How much do you work? ☐ Full-time ☐ Part-time

Job title(s): ____

EDUCATION

Are you currently enrolled in school: ☐ Yes ☐ No

If yes, where? ____

Major, if any? ____

Highest level of education obtained: ____

Degree(s) earned, if any: ____

ALCOHOL/DRUGS

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? ____________________

If you quit drinking, how long age did you quit? ____________________

How much and how long did you drink? ____________________

Do you use illicit drugs? ☐ Yes ☐ No

If yes, please list: ____

TOBACCO

Do you smoke? ☐ Yes ☐ No If yes, how much? ____________________

If you quit smoking, how long ago did you quit? ____________________

How much and how long did you smoke? ____________________

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Family History

Please check the members of you family that have/had the following medical illnesses:

	Father	Mother	Brother	Sister	Other (please list)
Alcoholism	☐	☐	☐	☐	☐ ________
Alzheimer's disease	☐	☐	☐	☐	☐ ________
Anemia	☐	☐	☐	☐	☐ ________
Anxiety/Panic attacks	☐	☐	☐	☐	☐ ________
Attention deficit disorder	☐	☐	☐	☐	☐ ________
Asthma	☐	☐	☐	☐	☐ ________
Bipolar disorder	☐	☐	☐	☐	☐ ________
Bleeding tendency	☐	☐	☐	☐	☐ ________
Blindness	☐	☐	☐	☐	☐ ________
Blood clot-leg	☐	☐	☐	☐	☐ ________
Blood clot-lung	☐	☐	☐	☐	☐ ________
Brain aneurysm	☐	☐	☐	☐	☐ ________
Cancer	☐	☐	☐	☐	☐ ________
Congestive heart failure	☐	☐	☐	☐	☐ ________
Coronary artery disease	☐	☐	☐	☐	☐ ________
Crohn's disease	☐	☐	☐	☐	☐ ________
Deafness	☐	☐	☐	☐	☐ ________
Dementia	☐	☐	☐	☐	☐ ________
Depression	☐	☐	☐	☐	☐ ________
Diabetes	☐	☐	☐	☐	☐ ________
Drug addiction	☐	☐	☐	☐	☐ ________
Epilepsy or seizure	☐	☐	☐	☐	☐ ________
Essential tremor	☐	☐	☐	☐	☐ ________
Gout	☐	☐	☐	☐	☐ ________
Heart attack	☐	☐	☐	☐	☐ ________
High blood pressure	☐	☐	☐	☐	☐ ________
High cholesterol	☐	☐	☐	☐	☐ ________
Kidney failure	☐	☐	☐	☐	☐ ________
Kidney stones	☐	☐	☐	☐	☐ ________
Leukemia	☐	☐	☐	☐	☐ ________
Lou Gehrig's disease (ALS)	☐	☐	☐	☐	☐ ________
Lupus	☐	☐	☐	☐	☐ ________
Lymphoma	☐	☐	☐	☐	☐ ________

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	Father	Mother	Brother	Sister	Other (please list)
Mental retardation	☐	☐	☐	☐	☐ ____________
Migraine	☐	☐	☐	☐	☐ ____________
Multiple sclerosis	☐	☐	☐	☐	☐ ____________
Muscular dystrophy	☐	☐	☐	☐	☐ ____________
Narcolepsy	☐	☐	☐	☐	☐ ____________
Neuropathy	☐	☐	☐	☐	☐ ____________
Parkinson’s disease	☐	☐	☐	☐	☐ ____________
Peripheral vascular disease	☐	☐	☐	☐	☐ ____________
Psoriasis	☐	☐	☐	☐	☐ ____________
Rheumatoid arthritis	☐	☐	☐	☐	☐ ____________
Schizophrenia	☐	☐	☐	☐	☐ ____________
Stroke of TIA	☐	☐	☐	☐	☐ ____________
Thyroid disease	☐	☐	☐	☐	☐ ____________
Ulcerative colitis	☐	☐	☐	☐	☐ ____________

Please list any other medical illnesses in your family (and the family members that have/had them) not mentioned above:

____

____

____

Review of Systems

Please review the following lists of symptoms and check any of those that you have experienced ***recently.***

CONSTITUTIONAL

- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue
- ☐ Weakness of entire body
- ☐ Fever
- ☐ Chills
- ☐ Sweats

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Heart murmurs
- ☐ Chest pain
- ☐ Feel heart beating in chest
- ☐ Fast or slow heart beat
- ☐ Irregular heart beat
- ☐ Swelling in legs or feet

EYES

- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Pain
- ☐ Redness
- ☐ Dryness
- ☐ Feels like something is in eye

RESPIRATORY

- ☐ Cough
- ☐ Coughing up phlegm
- ☐ Coughing up blood
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Difficulty breathing at night
- ☐ Snoring

EARS, NOSE, MOUTH, THROAT

- ☐ Ear pain
- ☐ Loss of hearing
- ☐ Ringing in ears
- ☐ Nosebleeds
- ☐ Loss of smell
- ☐ Swollen or bleeding gums
- ☐ Sore tongue
- ☐ Loss of taste
- ☐ Sores in mouth
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Swollen glands in neck

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GASTROINTESTINAL
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Decreased appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Blood in stool or black stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Indigestion or gas
- ☐ Jaundice

GENITOURINARY
- ☐ Frequent urination
- ☐ Urination more than twice during the night
- ☐ Pain or burning with urination
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Loss of bladder control

MUSCULOSKELETAL
- ☐ Muscle pain
- ☐ Muscle spasm
- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Neck pain
- ☐ Back pain
- ☐ Difficulty walking

INTEGUMENTARY (SKIN)
- ☐ Sensitivity to sun
- ☐ Rash
- ☐ Hives
- ☐ Itching
- ☐ Dryness
- ☐ Tightness
- ☐ Discoloration
- ☐ Sores
- ☐ Lumps
- ☐ Hair loss
- ☐ Changes in nails

NEUROLOGICAL
- ☐ Headaches
- ☐ Dizziness
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Weakness in extremity
- ☐ Pain in extremity
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor
- ☐ Memory loss
- ☐ Difficulty speaking

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety or nervousness
- ☐ Stress
- ☐ Insomnia
- ☐ Excessive daytime sleepiness
- ☐ Euphoria or elation
- ☐ Hallucinations

ENDOCRINE
- ☐ Heat or cold intolerance
- ☐ Increased appetite
- ☐ Increased thirst

HEMATOLOGIC/LYMPHATIC
- ☐ Easy bruising
- ☐ Excessive bleeding
- ☐ Swollen lymph nodes

ALLERGIC/IMMUNOLOGIC
- ☐ Sneezing
- ☐ Runny nose
- ☐ Nasal or sinus congestion
- ☐ Watery eyes

Signature: ____ Date: ___________________________

Thank you for filling out this questionnaire. Your cooperation is greatly appreciated. This information will help us provide the best possible healthcare for you or your loved one.

Sincerely,

The Neurological Institute