ADVANCED NEUROLOGY

Neurology New Patient Intake

Patient Name: _____ **DOB:** _____

Reason for Visit: _____

Location of Pain: _____

Date of Onset: _____

Circle all that apply

Quality: aching burning gnawing stabbing throbbing sharp dull
superficial deep occasional frequent constant worsening
improving no change Other: _____

Pain Severity: Current pain level _____ / 10

Context/Inciting Incident: fall or accident injury MVA Other: _____

Alleviating Factors: Sleep Ice Heat Medication Darkness PT/OT Diet Change
Rehabilitation

Aggravating factors: sitting standing lying down walking lifting carrying
twisting pushing/pulling gripping grasping squeezing throwing
weightbearing exercise cold weather damp weather Other: _____

Prior EMG / Sleep Study / EEG? None If yes, date/facility:

For Migraines: a few minutes or less a few hours 1-3 days more than a week

_____ headaches days/month Usually begins in: morning afternoon evening night

Medications previously tried: _____

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Allergies (Please list all medication/drug allergies with the reaction):

Name of Medication:	Reaction:

Current Medication (Please list all the medications you are currently taking):

Name of Medication	Dose	Directions	What is it for?	Who prescribes it?

What medications have you tried for your pain? _____

Preferred Pharmacy: Advanced Rx Other: _____

***Advanced Rx pick up or mail next day available (Shipping and Handling included). ***

Have you had any imaging? (Please list dates, type of imaging, body part and facility)

Date	Type of Imaging	Body Part	Imaging Facility

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Please Provider Your Past Medical Conditions/Diagnosis

Condition/Diagnosis	Details	Treating Physician

Please Provider Your Past Surgical History

Date of Surgery	Type of Surgery	Hospital	Performed By

Hospitalization other than surgery (include dates):_____

Social History

Any tobacco use? ☐ Yes | ☐ No | ☐ Prior Use

If yes, packs per day _____ for _____ years. If prior user, year quit? _____

Any alcohol use? ☐ Yes | ☐ No

If yes, drinks per day _____ for _____ years.

Any recreational drug use? ☐ Yes | ■ No Drugs Used_____

Family Medical History:

Has your mother ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your father ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Have any of your siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Have any of your children ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your mother's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your mother's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your father's parents ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Has your father's siblings ever had: ☐ Diabetes | ☐ Hypertension | ☐ Cancer| ☐ Other_____
Any other family history and relation to you:_____

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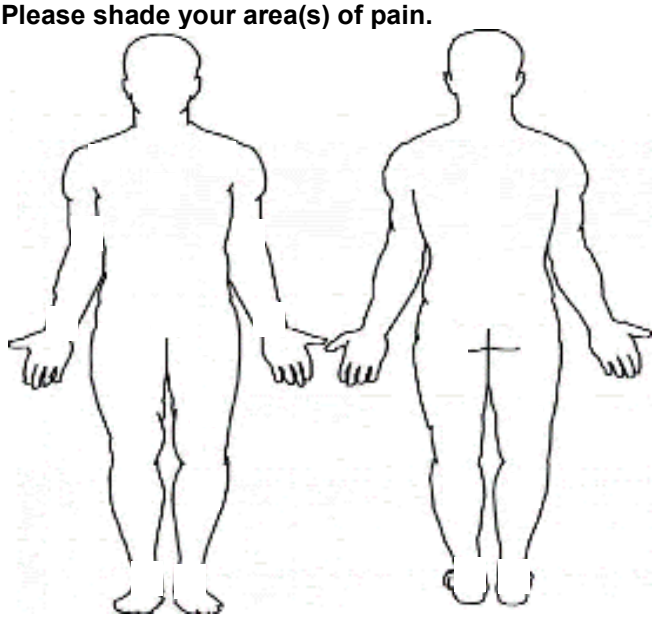
Please shade your area(s) of pain.



Patient Signature:_____Employee's Initials: _____ Provider's Initials:_____