PATIENT INTAKE FORM

Patient Name_____ **MRN #**_____**(office use only)**

Date of Birth_____

Chief Complaint: Please check all those that apply to today's visit

Brain
- ☐ Headache
- ☐ Seizure
- ☐ Dizziness
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Tumor
- ☐ Trauma

Neck/Arm/Hand

	Left	Right
☐ Neck Pain		
☐ Arm Pain	☐	☐
☐ Arm Numbness	☐	☐
☐ Arm Weakness	☐	☐

☐ Other:_____

Back/Leg/Foot

	Left	Right
☐ Back Pain		
☐ Leg Pain	☐	☐
☐ Leg Numbness	☐	☐
☐ Leg Weakness	☐	☐

Allergies to Medications: Please check any allergies that apply **or check here ☐ if none**

☐ Penicillins ☐ Other:_____

Past Medical History: Please check all that apply to your medial history **or check here ☐ if no to all**

- ☐ Heart Disease
- ☐ Lung Disease
- ☐ Diabetes
- ☐ Lyme Disease
- ☐ Meningitis
- ☐ Lupus
- ☐ Thyroid
- ☐ Hypertension
- ☐ TIA
- ☐ Rheumatoid Arthritis
- ☐ Major Trauma
- ☐ Anxiety
- ☐ Depression
- ☐ Hyperlipidemia
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Shoulder Arthropathy
- ☐ Epilepsy/Seizures
- ☐ Parkinson's Disease
- ☐ Other:
- ☐ Stroke
- ☐ Atrial Fibrillation
- ☐ Asthma
- ☐ COPD
- ☐ Kidney Disease
- ☐ Neuropathy
- ☐ Hip Arthropathy
- ☐ Carotid Stenosis
- ☐ Tumor
- ☐ Ulcers
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Gerd
- ☐ Pulmonary Embolism
- ☐ DVT
- ☐ Knee Arthropathy
- ☐ Arthritis
- ☐ Sleep Apnea

Surgical History: Please check all that apply to your medical history **or check here ☐ if no to all**

- ☐ S/P Craniotomy
- ☐ Hip Replacement
- ☐ Previous Stent Placement
- ☐ Hernia Surgery
- ☐ Thyroid Surgery
- ☐ Back Surgery
- ☐ Knee Surgery
- ☐ DBS
- ☐ Carotid Endarterectomy
- ☐ Vertebroplasty/Kyphoplasty
- ☐ Neck Surgery
- ☐ Heart Surgery
- ☐ VNS
- ☐ Bariatric Surgery
- ☐ IT Pump
- ☐ Shoulder Surgery
- ☐ Pacemaker
- ☐ CTR
- ☐ SCS
- ☐ Other:_____

Social History:

Occupation: _____ Retired? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No Do you drink regularly? ☐ Yes ☐ No