

NEUROCARE CENTER, INC

4105 Holiday Street, NW

P.O. Box 35006

Canton, OH 44735

Date _____

Name _____ DOB _____ Age _____

Sex: Male Female

Insurance Coverage(s) _____

Handedness: Right Left Ambidextrous

Referring physician _____

Other physicians you would like a progress report sent to _____

Current symptoms:	For how long:
1)	
2)	
3)	
4)	
5)	
6)	

What medications are you currently taking?

Please list allergies below.

REVIEW OF SYMPTOMS

		YES	NO			YES	NO
<u>Constitutional:</u>	Fever	___	___	<u>Gastrointestinal:</u>	Nausea	___	___
	Weight loss	___	___		Vomiting	___	___
<u>Visual problems:</u>	Vision loss	___	___		Diarrhea	___	___
	Double vision	___	___		Constipation	___	___
<u>ENT:</u>	Hearing loss	___	___	<u>Psychiatric:</u>	Depression	___	___
	Hoarseness	___	___		Anxiety	___	___
	Throat pain	___	___	<u>Endocrine:</u>	Tremulous	___	___
<u>Cardiovascular:</u>	Chest pain	___	___		Weight gain/loss	___	___
	Heart racing/palpitations	___	___	<u>Hematologic:</u>	Low blood count	___	___
<u>Musculoskeletal:</u>	Joint pain	___	___		Easy bleeding	___	___
	Joint swelling	___	___		Blood clots	___	___
<u>Integumentary:</u>	Rash	___	___	<u>Neurological:</u>	Memory loss	___	___
<u>Respiratory:</u>	Cough	___	___		Speech/swallowing difficulty	___	___
	Shortness of breath	___	___		Walking/balance difficulty	___	___
<u>Sleep:</u>	Snoring	___	___		Loss of consciousness	___	___
	Insomnia	___	___		Weakness/paralysis	___	___
	Day time sleepiness/fatigue	___	___		<i>If you answered yes:</i>	<input type="checkbox"/> Right	<input type="checkbox"/> Left
<u>Urinary:</u>	Incontinence	___	___		Sensory disturbance	___	___
	Urgency	___	___		<i>If you answered yes:</i>	<input type="checkbox"/> Right	<input type="checkbox"/> Left
	Nocturia	___	___				

Neurological Testing

Have you had any of the following testing:	YES	NO	DATE	PLACE
MRI - brain/cervical/thoracic/lumbar	___	___		
CT - brain or chest	___	___		
EEG	___	___		
Carotid Ultrasound	___	___		
EMG	___	___		
LP (Spinal tap)/myelogram	___	___		
Angiogram	___	___		
Sleep study - PSG/CPAP/MSLT	___	___		

PAST MEDICAL HISTORY

Have you had any of the following illnesses?

		YES	NO			YES	NO
<u>Childhood illness:</u>	Chicken pox	___	___	<u>Endocrine:</u>	Diabetes	___	___
	Measles	___	___		Thyroid problems	___	___
<u>Neurological:</u>	Stroke	___	___	<u>Renal:</u>	Kidney Failure	___	___
	Multiple Sclerosis	___	___	<u>GI:</u>	Ulcer	___	___
	Parkinson's Disease	___	___	<u>GU:</u>	Kidney Stone	___	___
	Neuropathy	___	___	<u>Musculoskeletal:</u>	Arthritis	___	___
	Epilepsy	___	___	<u>Cardiac:</u>	Heart Attack	___	___
<u>Pulmonary:</u>	Asthma	___	___		Congestive Heart Failure	___	___
	Emphysema	___	___		High Blood Pressure	___	___
				<u>Injuries:</u>	Head/Neck Injury	___	___

Cancers: Breast Lung Colon Other

Other illnesses

PAST SURGICAL HISTORY

Have you had any of the following surgeries?

	YES	NO		YES	NO
Appendectomy	___	___	Back Surgery	___	___
Tonsillectomy	___	___	Bypass	___	___
Hernia	___	___	Craniotomy	___	___
Hysterectomy	___	___	Carotid Endarterectomy	___	___

Other

FAMILY HISTORY

	ALIVE	DECEASED	AGE	CAUSE OF DEATH	MAJOR ILLNESSES
Father	___	___	___	___	___
Mother	___	___	___	___	___
Brother	___	___	___	___	___
Sister	___	___	___	___	___
Children	___	___	___	___	___
Other	___	___	___	___	___

SOCIAL HISTORY

Are you: (Check one) Single Married Separated Divorced Widow(er)

Do you have children? Yes No If yes, how many? _____

Highest grade level completed

Occupation

Do you use any of the following? (Check all that apply)

	YES	NEVER	QUIT	TYPE	AMOUNT PER DAY
Drug(s)	_____	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____	_____

FUNCTIONAL HISTORY

Do you have trouble performing on your own? (Circle all that apply)

Walking Bathing Dressing Household chores Personal Hygiene

Eating Standing Driving Balancing Check Book

How far can you walk before you have to sit/rest?

How long can you stand before you have to sit/rest?

Do you have trouble going up and down the stairs? Yes No

Do you have trouble living independently? Yes No

Do you need to use a cane, walker, or wheelchair? Yes No

Do memory problems cause poor interaction? Yes No

Are your symptoms:

	YES	NO	WHEN
Work related?	_____	_____	_____
Injury related?	_____	_____	_____
Did you retain a Lawyer?	_____	_____	_____
Did you stop working?	_____	_____	_____
Did you return?	_____	_____	_____