NEUROCARE CENTER, INC

4105 Holiday St Canton OH, 44718

Date:_____

Name:_____ DOB:_____ Age:_____

Sex (Circle): Male Female

Handedness (Circle): Right Left Ambidextrous

PCP:_____

Referring Physician:_____

Name of Pharmacy Preference:_____

Pharmacy Address:_____

Current Symptoms	For How Long:
1)	
2)	
3)	
4)	
5)	
6)	
7)	

Are your symptoms work related? Yes_____ No_____

Did you stop working? Yes_____ No_____

Do you have a current/active workers compensation case for this symptom? Yes_____ No_____

Current Medications and Dosages below:	
1)	8)
2)	9)
3)	10)
4)	11)
5)	12)
6)	13)
7)	14)

Allergies:	
1)	4)
2)	5)
3)	6)

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REVIEW OF SYMPTOMS- Have you had any of the following symptoms in the past 3 months:

	YES	NO		YES	NO
Constitutional:			***Neurological:***		
Fever	_____	_____	**Dizziness**	_____	_____
Weight Loss	_____	_____	**Memory Loss**	_____	_____
Weight Gain	_____	_____	**Speech Changes**	_____	_____
Vision Changes	_____	_____	**Walking/ Balance Difficulty**	_____	_____
ENT:			**Headache**	_____	_____
Hearing Loss	_____	_____			
			Loss of Consciousness	_____	_____
Dysphasia (trouble swallowing)	_____	_____			
			Extremity Weakness	_____	_____
Respiratory:			**if answered yes:**	**right____**	**left____**
Cough	_____	_____	**Extremity Numbness**	_____	_____
			if answered yes:	**right____**	**left____**
Snoring	_____	_____	**Seizures**	_____	_____
Shortness of breath	_____	_____	**Tremors**	_____	_____
Cardiovascular:			***Psychiatric:***		
Claudication	_____	_____	**Depression**	_____	_____
Chest Pain	_____	_____	**Insomnia**	_____	_____
Heart Racing/ Palpitations	_____	_____	**Anxiety**	_____	_____
					_____
Gastrointestinal:			***Endocrine:***		
Nausea	_____	_____	**Change In Sleep Patterns**	_____	_____
Vomiting	_____	_____	***Musculoskeletal:***		
			Joint Pain	_____	_____
Constipation	_____	_____			
			Back Pain	_____	_____
Urinary:					
Incontinence	_____	_____	**Muscle Weakness**	_____	_____
Nocturia	_____	_____	***Hematologic:***		
			Easy Bruising	_____	_____
Integumentary:					
Rash	_____	_____	**Vitamin D Deficiency**	_____	_____

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PAST MEDICAL HISTORY- Have you been diagnosed with any of the following:

	YES	NO		YES	NO
ADD	_____	_____	**Headache, Migraine**	_____	_____
ADHD	_____	_____	**Hearing Disorder**	_____	_____
Alzheimer's	_____	_____	**Hepatitis/ Liver Disease**	_____	_____
Angina	_____	_____	**Hypertension**	_____	_____
Arthritis	_____	_____	**Intracranial Tumor**	_____	_____
Asthma	_____	_____	**Mental Disorder**	_____	_____
Blood Disease	_____	_____	**Mumps**	_____	_____
Cancer	_____	_____	**Myocardial Infarction**	_____	_____
Cardiac Arrhythmia	_____	_____	**Osteoporosis**	_____	_____
Carpal Tunnel	_____	_____	**Parkinson's Disease**	_____	_____
Cerebral Atherosclerosis	_____	_____	**Peripheral Nerve Disease**	_____	_____
Cerebral Infarction	_____	_____	**Polio**	_____	_____
COPD	_____	_____	**Renal Disease**	_____	_____
Coronary Artery Disease	_____	_____	**Seizure Disorder**	_____	_____
Depression	_____	_____	**Spinal Cord Injury**	_____	_____
Diabetes	_____	_____	**Spinal Disease**	_____	_____
			Cervical_____	**Spinal_____**	
Elevated Lipids	_____	_____	**STD**	_____	_____
Epilepsy	_____	_____	**Stroke**	_____	_____
Fibromyalgia	_____	_____	**Thyroid Disease**	_____	_____
Head Injury	_____	_____	**Cancer:_____**		

Other:_____

Other:_____

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PAST SURGICAL HISTORY

Adenoidectomy	_____	_____	**Craniotomy**	_____	_____
Appendectomy	_____	_____	**Dental Surgery**	_____	_____
Back Surgery	_____	_____	**Hernia Repair**	_____	_____
			Inguinal_____	**Umbilical**_____	
Blood Transfusion	_____	_____	**Tonsillectomy**	_____	_____
Carotid Endarterectomy	_____	_____	**Other:**_____		
Coronary Artery Bypass	_____	_____	**Other:**_____		

FAMILY HISTORY

	ALIVE	DECEASED	AGE	CAUSE OF DEATH	MAJOR ILLNESSES
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Siblings: Brother	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____
Children: Son	_____	_____	_____	_____	_____
Daughter	_____	_____	_____	_____	_____

SOCIAL HISTORY

Are you: (Check One) **Single**_____ **Married**_____ **Separated**_____ **Divorced**_____**Widow**_____

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**
Eating	**Standing**	**Driving**	**Personal Hygiene**

	YES	NO
Do you have trouble living independently?	_____	_____
Do you need to use a cane, walker, or wheelchair?	_____	_____
Do memory problems cause poor interaction?	_____	_____