# Center for Neurological Treatment & Research

Smyrna /Clarksville –PH (615) 355-5510 / F (615) 355-8699

Welcome to Center for Neurological Treatment & Research. Please take time to complete this questionnaire to the best of your knowledge. These forms will allow the doctor to know more about you, your medical condition, your family and your habits. **If possible, we ask that you fill out the forms in ink prior to your visit and bring it with you on the date of your appointment**.This questionnaire is confidential and will be kept as part of your medical record.

Date of Visit: _____ Email Address: _____

Patient Name: _____ M/F:_____

Address: _____City/State: _____ Zip: _____

Date of Birth: _____ SS#: _____

Phone Numbers: (H) _____(W)_____(C) _____

Marital Status: ___ Married ___ Divorced ___ Widow(er) ___ Single ___ Separated ___ Life Partner

Emergency Contact Name/Relationship: _____ Phone: _____

Check all that apply:Message can be left on: □Home □Work □ Cell Message may be: □ Brief□ Extended

**RACE: C**heck one
__Native American/Alaskan
__ Black or African American
__Middle Eastern
__Asian
__Hispanic or Latino
__Hawaiian/other Pacific Islander
__White
__ Other: _____

**PRIMARY LANGUAGE:** Check one
__English
__Spanish
__French
__Arabic
__ Chinese
__ Other: _____

**ETHNICITY:** Check one
__ Hispanic or Latino
__ NOT Hispanic or Latino
__ Decline to Report

**INSURANCE INFORMATION:**

**Primary Insurance**_____Relationship to Policyholder: _____

Policy #:_____Group #:_____

Name of Policyholder: _____ DOB: _____SS#: _____

Employer of Policyholder: _____

**Secondary Insurance** _____Relationship to Policyholder: _____

Policy #:_____ Group #:_____

Name of Policyholder: _____ DOB: _____ SS#:_____

Employer of Policyholder:_____

**Worker's Compensation** Date of Injury: _____

Insurance Carrier: _____Claim #:_____

Employer: _____Phone:_____

Adjustor's Name: _____Phone: _____

**WHO REFERRED YOU TO OUR OFFICE?**

Physician Name: _____Specialty: _____

Address: _____ City/State/Zip: _____ Phone: _____

**OTHER?** If referral is not from Physician, please provide source and details (Example, internet/friend/relative with name):

_____

**WHO IS YOUR PRIMARY CARE PHYSICIAN?** ☐SAME AS REFERRING PHYSICIAN

Physician Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

**PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:**

Physician Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

Physician Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

**PLEASE LIST BELOW ANYONE ELSE THAT YOU WOULD LIKE TO HAVE ACCESS TO YOUR MEDICAL INFORMATION WITH OUR OFFICE:**

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

**I authorize Center for Neurological Treatment & Research to upload my prescription history from my insurance.**

**I authorize the release of any medical information necessary to process insurance claims. I authorize payment of medical benefits to Center for Neurological Treatment & Research.**

_____ _____

Patient's or Authorized Signature Date

_____

Printed Name

Date: _____

Patient Name: _____ DOB:_____

Right-handed: ____ Left-handed: ____ Height: _____ Weight: _____

**REVIEW OF SYSTEMS**:Please check all conditions that currently apply to you.

**GENERAL:**

__Unable to sleep __ Fainting __ Excessive sleepiness

**EARS, NOSE & THROAT:**

__Dizziness __Blurred vision __Ringing in ears

**RESPIRATORY:**

__ Shortness of breath __ Trouble breathing __ Chronic cough

**GENITOURINARY:**

__ Urinary incontinence __ Painful urination __ Frequent urination

**PSYCHIATRIC:**

__ Anxiety __ Depression __ Trouble concentrating

**GASTROINTESTINAL:**

__ Vomiting __ Constipation __ Reflux

**NEUROLOGICAL:**

__ Headache __ Memory loss __ Seizure __ Weakness
__Fallingdown __ Vertigo __ Concussion __ Loss of consciousness

**MUSCULOSKELETAL:**

__ Low back pain __ Neck pain __Numbness

**HEMATOLOGICAL:**

__ Blood disorder __ Hepatitis __HIV

**ALLERGIES:**

__ Sinus problems __ Watery eyes & nose __ Rash & itching

Date: _____

Patient Name: _____ DOB:_____

**PAST MEDICAL HISTORY:**
If female, are you currently Pregnant or Breastfeeding?O Yes O No

| | | | | |
|---|---|---|---|---|
| __ GERD/Heartburn | __ Ulcers | __ Colon Polyps | __ Pancreatitis | |
| __ Ulcerative Colitis | __ Hypertension | __ Coronary Artery Disease | __ Congestive Heart Failure | |
| __ Atrial Fibrillation | __ Pacemaker | __ AICD(Defibrillator) | __ COPD | |
| __ Diabetes | __ Thyroid Problems | __ Elevated Cholesterol | __Pneumonia | |
| __ Fibromyalgia | __ Arthritis | __ Chronic back pain | __ Cancer | __ Hernia |
| __ Kidney Failure | __ Heart Attack | __ Seizures | __ Glaucoma | __ Stroke |

**FAMILY HISTORY:** ☐N/A

| Relationship | Age | Medical Problems | Deceased? (If yes, from what cause?) |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Brothers/Sisters | | | |

**SURGERY AND DATES:** ☐ N/A

| Surgery | Date |
|---|---|
| | |
| | |
| | |

**SOCIAL HISTORY:**

Do you drink alcohol? O Yes O No

**IfYes,** approximately how many drinks per week? _____

Do you smoke? O Yes O No

**If Yes,** how often?O every day O some days **If Yes,** how many per day? _____

Do you use recreational drugs? O Yes O No

**If Yes,** how often?O every day O some days

Was the injury due to a work-related accident? O YesO No

Was the illness/injury caused by an automobile accident? O Yes O No

Was another party responsible for the accident? O Yes O No

Is there any attorney involved? O Yes O No

**If Yes**, please list attorney name and phone number. _____

Date: _____

Patient Name: _____ DOB:_____

**MEDICATIONS:** Please list all medications and dosages you are currently taking, including any over-the-counter medications. (List any additional medications on back of this sheet.)

☐N/A

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

**PHARMACY:** Please provide the name and phone number of your pharmacy so that we may keep this information on file.

Pharmacy Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

**PAIN MANAGEMENT:** Are you currently in Pain Management or receiving pain medications from another physician? O Yes O No

**If Yes**, please list pain medications and dosages: _____

**If Yes**, please list physician info below:

Physician Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

**ALLERGIES:** Please list any known drug and/or food allergies.

☐N/A

| | |
|---|---|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |