Neurological History

Patient Name _____ **SS#**_____
Address _____**City/State/Zip**_____
Home Phone_____ **Cell Phone**_____ **Date of Birth** _____
Sex M F **Age** _____ **Email Address**_____
Occupation_____
Maritial Status: ___Single __Married ____Separated/Divorced ____Widowed
Name of Spouse_____ **Do you have children? Y N If so, ages**_____
How did you hear about our clinic?_____
Primary health challenge: _____ **Severity** 0-10_____
Secondary challenge (if any)_____**Severity** 0-10_____
Medications:_____
Supplements:_____

Please rate the following 0-10 (0 = not at all 10 = worst you can imagine)

____Anxiety	____Learning Disorder	____Obsessive Behavior
___Depression	____Unable to Focus	____Insomnia (getting to sleep)
____ADD / ADHD	____Memory Problems	____Insomnia (staying asleep)
____Fatigue	____Headaches	____Difficulty using body parts
____Mood Swings	____Ringing in Ears	
____Anger	____Poor Concentration	

Do you have family members with any of the above difficulties? Yes____ N____If so, who?

Have you had a seizure at any time? Yes___ No____ If so, when?_____

Are your eyes sensitive to light? Yes____ No____

Have you had any head injuries (diagnosed or undiagnosed?) Yes____ No____

If yes, please explain_____

How many Auto Accidents have you been in? (fender benders count)_____

Please list any other accidents or falls_____

Please list any surgeries_____

What specific behaviors do you hope to see improve or be eliminated? _____
_____

Initial History

Onset and Character of Health Complaints

Describe your symptoms and where they occur _____
_____
When did the symptoms first occur?_____
Was there any illness, trauma or significant event prior to the onset? _____
If so, please describe_____
What is the nature of the sensations, disabilities or problems that have arisen? _____
_____

Pain/Headaches/Energy or Weight Changes

Have you experienced any pain, headaches, fever, energy or weight changes? _____
Please describe_____
If weight change has occurred, was it expected from a diet or exercise program? _____

Duration and Frequency

How long do the symptoms last and how often do they occur? _____
_____
Are they recurrent in nature? _____

Course
Has your condition or the symptoms changed since the onset of your condition? _____
If so, please describe_____
Aggravating Factors
Is there anything that makes your symptoms worse? _____
Is there anything that makes your symptoms better? _____
Do the symptoms occur at a particular time of day, month or year? _____
Are the symptoms aggravated by pressure changes in the thorax or abdomen? _____
Are the symptoms affected by changes in position, such as rising from a sitting position or lying position?
_____
Have you received any treatment? _____ If so, what did it involve?_____
_____

1. General Health History
Family History
Have any immediate or extended family members suffered from a major or hereditary illness?
_____
Have any immediate or extended family members expressed symptoms similar to yours?
_____
Accidents/Trauma
Please list all past traumas such as motor vehicle accidents, falls, concussions, fractures, etc.
_____
_____
Medications / Supplements
Please list all past (long term) and present medications
_____
_____
Are you taking any vitamins, remedies or supplements? _____
Please list _____
_____
_____
Are you exposed to any chemicals at home or work? _____
_____
Illnesses
Are there any current or past illnesses you have experienced? _____
_____
Tests and Imaging
What laboratory, imaging or electrodiagnostic procedures have been performed? _____
_____
_____
Operations/Hospitalizations
Please list any operations or hospitalizations you have had _____
_____
Nutrition
Describe your diet (poor, moderate or good) _____
What are your 3 favorite foods? _____
Do you have any strong cravings for a particular food? _____

2. Social History
Family Life
What is your marital status? _____

Do you have any dependants, if so how many? _____
What is your stress level at home (scale 1-10, 10 being highest) _____
Recreation
What type of recreational activities do you participate in? _____
Do you exercise regularly? _____ How many days per week? _____
Education
What is your level of education? _____
Occupation
What is your occupation/ job description?_____
Have there been any recent changes at work? _____
Social Drugs
Do you smoke? _____ If so, how many packs per day?_____
Do you drink alcohol? _____ If so, how much? _____

3. Systems History
Smell and Taste
Have there been any changes to your sense of smell or taste?_____
Have you recently noticed any smells or tastes that don't seem to go away? _____
_____
Vision
Have you noticed any cloudiness, haziness, blurring or double vision? _____
Do you have any difficulty in stabilizing your focus? _____
Do you ever experience movement of your visual environment? _____
Do you experience any pain in or around your eyes? _____
Are you sensitive to light in one or both eyes? _____
Hearing
Have you ever noticed any changes to your hearing in either ear? _____
Do you find it difficult to listen when there is background noise? _____
Do you experience any ringing or whooshing noises in either ear? _____
Do you experience pain or itchiness in or around your ears? _____
Do you experience a "fullness" or "blocked" sensation in either ear? _____
Balance
Do you find it difficult to walk in a straight line? _____
Do you tend to deviate more to the right or left when walking? _____
Do you ever feel like you are leaning or falling to one side? _____
Do you feel as though you are spinning or moving when you are still? _____
Have you experienced any nausea or vomiting in the last 6 months? _____
If so, please explain _____
Do you feel light headed or dizzy when looking at moving objects? _____
Do you feel light headed or dizzy when you change your position? _____
Motor
Do you have any difficulty with chewing or swallowing your food? _____
Have you noticed any difficulties with speech (e.g. slurring or stuttering)? _____
Have you noticed any clumsiness (e.g. using tools or utensils, or tripping)? _____
Have you noticed any tremors or uncontrollable movements? _____
Have you noticed any stiffness, cramping or twitching anywhere? _____
Have you noticed any weakness or wasting of muscles? _____
Sensory
Have you noticed any changes in skin sensitivity anywhere? _____
Have you noticed any unusual sensations anywhere (e.g. tingling, coldness)? _____
Autonomic

Have you noticed any changes in saliva or tearing? _____
Have you noticed any changes in sweating on either side of the body? _____
Have you noticed any coldness or puffiness in your extremities? _____
Do you feel light headed or dizzy when you change your posture? _____
Do you experience arrhythmia or rapid changes in your heart rate? _____
Do you experience any breathing difficulties? _____
Do you have any problems with digestion or bowel movements? _____
Do you suffer from ulcers or irritability in the GI tract? _____
Do you have any difficulties with initiating or controlling urination? _____
Have you experienced any signs of sexual dysfunction? _____

Mental

Have you noticed any changes in decision-making, planning or organization skills? _____
Have you noticed any changes in attention levels or concentration? _____
Have you noticed any changes in behavior, mood, or personality? _____
Have you noticed any changes in your ability to express thoughts or words? _____
Have you noticed any changes in the comprehension of speech or the written word? _____
Have there been any problems with the recognition of people or objects? _____
Have there been any changes with regard to orientation or spatial awareness? _____
Have there been any changes in short or long term memory? _____
Have you experienced any seizures, anxiety or panic attacks? _____

In order to serve you better, please check which of the following is most accurate:

1. This is the first place I have come seeking treatment.
2. I am currently under care, but not satisfied with the results and looking to make a change.
3. I am just curious about brain mapping and want to see what the results look like.

In the space below, please give us a little background on yourself. Things such as:

A brief summary of what treatments you have tried and how they have worked
Your major concerns
Treatment Goals
Anything important we should know