NAME: _____ DATE: _____/_____/_____

DATE OF BIRTH _____/_____/_____ Circle: RIGHT HANDED LEFT HANDED BOTH

REFFERING DOCTOR: _____
PRIMARY DOCTOR: _____
REASON FOR VISIT: _____

KNOWN MEDICAL CONDITIONS:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

SURGERIES:

1.	5.
2.	6.
3.	7.
4.	8.

DRUG ALLERGIES: _____|_____ Reaction:_____|_____

Ever Smoke: Y N Currently Years Smoked _____ packs per day _____
Drink Alcohol: Y N Use Illicit Drugs: Y N Work? N Y: _____
Exercise: Y N Pregnant: Y N **Height:** ____'____" **Weight:** _____ pounds
Married: Y N

NEUROLOGICAL DISEASES IN FAMILY? N Y: _____

MEDICATIONS (don't include vitamins & supplements) (new patients or new from last visit):

Name	Dose	Times per day

MEDICATION (CONT'D)

Name	Dose	Times per day

CIRCLE IF ARE YOU **CURRENTLY** EXPERIENCING ANY OF THE FOLLOWING?

Check Here ___ if none

Constitutional	Eyes	Gastrointestinal	Endo/Heme/Allergies
Fever	Blurred Vision	Heartburn	Easy Bruising
Chills	Double Vision	Nausea	Allergies
Weight Loss	Bothered by Light	Vomiting	Increased Thirst
Fatigue/Malaise	Eye Pain	Abdominal Pain	Neurological
Sweating	Eye Discharge	Diarrhea	Dizziness
Weakness	Red Eyes	Constipation	Tingling
Skin	Heart and Vessels	Blood in Stool	Tremors/Shakes
Rash	Chest Pain	Rectal Bleeding	Loss of Sensation
Itching	Palpitations	Urinary	Change in Speech
HEENT	Short of Breath Lying Flat	Painful Urination	Weakness in a Limb
Headaches	Pain in Legs Walking	Urgent Urination	Seizures
Hearing Loss	Leg Swelling	Frequent Urination	Loss of Consciousness
Ear Pain	Short of Breath at Night	Blood in Urine	Psychiatric
Ear Discharge	Respiratory	Flank Pain	Depression
Nosebleeds	Cough	Musculoskeletal	Suicidal Thoughts
Congestion	Bloody Sputum	Muscle Aches	Substance Abuse
Breathing Sounds	Excess sputum	Neck Pain	Hallucinations
Sore Throat	Shortness of Breath	Low Back Pain	Nervous/Anxious
	Wheezing	Joint Pain	Insomnia
		Falls/Imbalance	Memory Loss