NEUROLOGICAL GROUP, PC
MEDICAL QUESTIONNAIRE

Name (Legal Name):_____ Birth Date:_____

Nickname:_____ Maiden or other name:_____

Gender: _____

Address: E-mail address:_____
Street:_____
City:_____State_____Zip_____ Social Security #:_____

Mailing Address: (if different) Patient's Home Phone #:_____
Street or PO Box: _____ Cell phone #:_____
City: _____State_____Zip_____ Other phone#:_____

Patient's Employer:_____ Patient's Work Phone #:_____

Preferred contact: home _____ cell _____ work _____ other _____

Emergency Contact Person:_____ Emergency contact's phone numbers:
Relationship:_____ Home:_____ Work:_____

Who is your primary care doctor? Who referred you to this office?

_____ _____

What pharmacy do you use?_____

INSURANCE INFORMATION (Primary)
Name of carrier_____ Insured's date of birth: _____
Policy #: _____ Insured's SS#:_____
Group#: _____ Phone#: _____

INSURANCE INFORMATION (Secondary)
Name of carrier_____ Insured's date of birth: _____
Policy #: _____ Insured's SS#:_____
Group#: _____ Phone#: _____

FINANCIAL AND PRIVACY POLICY (PLEASE READ CAREFULLY)

Charges for medical services are due and payable by the patient at the time of service. Co-payments, deductibles and coinsurance are due at the time of service for Medicare and other Insurance Plans that are accepted by this office. Obtaining proper referrals to this practice is the patient's responsibility and, if proper referrals are not obtained, the patient is responsible for payment in full for professional services rendered. Charges for patients with insurance plans we do not participate with are due and payable in full at the time of service. The patient is responsible for all fees, regardless of insurance coverage. Motor vehicle and liability claims are the patient's responsibility. If patient misses an appointment, a No-show fee will be charged. The patient is liable for all collection costs (collection agency fees, legal fees and court costs) in addition to professional fees charged by this practice. Checks returned by the bank will incur a $25.00 service fee. I have read the above and request that all payments by my insurance carrier, including Medicare, be paid directly to the Neurological Group, PC. I also authorize the release of any medical or other information to my insurance carrier necessary to process my claims. The signature below acknowledges that I have received a copy of Neurological Group's Privacy Policy. I have read and understand its contents and agree to abide by the terms and conditions therein.

Signature of patient / guardian: _____Date:_____

FOR WORK-RELATED INJURIES ONLY:

Date of Injury: _____ Employer: _____
Was injury reported? _____ To Whom?_____
What dates have you missed from work: _____
What was the first day you were out of work? _____
Worker's Comp. Carrier: _____ CLAIM#: _____
Adjuster's Name: _____ Carrier/Adjuster's Phone#:_____
Name of Attorney (if any) _____ _____
Firm name and address: _____ Attorney's Phone #:_____

FOR AUTO ACCIDENTS ONLY:

Date of Accident:_____ Where did accident occur? _____
Name of Attorney (if any_____
Firm name & address:_____ Attorney Phone #: _____

MEDICAL HISTORY:

List all medications, doses & frequency (including over-the-counter medications):

1)_____ 6_____
2)_____ 7)_____
3)_____ 8)_____
4)_____ 9)_____
5)_____ 10)_____

List any alternative therapies, herbal medicines, dietary supplements, etc:

1)_____ 3)_____
2)_____ 4)_____

List all allergies (medications, foods, environmental, etc):

1)_____ 3)_____
2)_____ 4)_____

What are your current complaints? (What are you being seen for today?)

_____
_____

Is this condition related to any injury or accident? Please describe:_____
_____

Are you right or left handed?_____

Have you ever had surgery? If so, please list below, and dates:

1)_____ 4)_____
2)_____ 5)_____
3)_____ 6)_____

Do you have a history of any of the following? (Please circle)

AIDS/HIV
Anemia
Arthritis
Asthma/emphysema
Atrial Fibrillation
Cancer
Concussion
Congestive heart failure
Coronary artery disease
Dementia
Depression
Diabetes
Emphysema
Gallbladder disease
Glaucoma
Hepatitis
High blood pressure
Kidney infections
Kidney stones
Lyme disease
Migraines, headaches
Multiple sclerosis
Pacemaker
Parkinson's Disease
Phlebitis, blood clots
Pneumonia or bronchitis
Polio
Prostate disorders
Psychiatric disorders
Seizures
Serious Injuries
Sexually transmitted disease
Sinus infections
Stomach ulcers
Stroke
Thyroid disease
Traumatic brain injury
Tuberculosis

Additional medical history or comments:

_____

_____

Have you had any of the following symptoms? (Please circle)

Back pain
Balance problems
Bladder problems
Bloody sputum
Chest pain, angina
Chronic cough
Chills
Circulatory problems
Cold hands/feet
Confusion
Depression, anxiety
Difficulty walking
Dizziness or vertigo
Easy bruising
Fainting
Fatigue
Fever
Frequent falls
Gastrointestinal problems
Headaches
Hearing loss
Heat/cold intolerance
Irregular periods
Joint pain
Limb weakness
Loss of appetite
Memory loss
Muscle aches
Muscle cramps
Muscle weakness
Nausea/vomiting
Neck pain
Numbness
Paralysis
Pinched nerves
Problems with urination
Rash or itching
Sexual problems
Shortness of breath
Sleep problems
Speech problems
Swelling in joints
Tender muscles
Tremors
Visual disturbances
Weight loss
Writing problems

Additional complaints or comments:

_____

_____

List any medical providers you are currently being treated by: _____

_____

EMPLOYMENT HISTORY:

Employment status: retired ___ employed ___ disabled ___ student ___ other ___

If disabled or unemployed, when did you last work? _____

What type of work do you do now or have you done in the past? _____

How long have you been at your present job?_____

Have you had any occupational exposure to chemicals/toxins? _____

SOCIAL HISTORY

Smoking History: Never Smoked _____ How much did you smoke?_____
Former Smoker_____ When did you quit?_____
Current Smoker_____ How much do you smoke daily? _____

Do you drink alcohol?_____ How much do you drink per week? _____

Do you have a history of illegal drug use? _____ If yes, explain: _____

Height: _____ Weight: _____

Marital status: _____ Education:_____

Primary Language: _____

Race:_____ Ethnicity: _____ Hispanic or Latino? yes _____no_____

Have you ever been a victim of violence or abuse (physical, emotional or sexual)? _____

FAMILY HISTORY:

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure:	_____	Kidney Disease:	_____	Asthma:	_____
Stroke:	_____	Bleeding Disorders:	_____	Tuberculosis:	_____
Cancer:	_____	Emphysema:	_____	Colitis:	_____
Seizures:	_____	Heart Disease:	_____	Anemia:	_____
Diabetes:	_____	Ulcers:	_____	Mental Illness:	_____
Multiple Sclerosis:	_____	Gout:	_____	Headaches:	_____
Dementia	_____	Migraine:	_____		

Other Serious Illness:_____

Provide additional information on condition checked:_____
_____

COMMENTS

Any other information you feel may be helpful to the physicians regarding your medical history, your current condition or treatment:

_____
_____