

NEW PATIENT INTAKE FORM
Movement Disorders

Patient Name: _____ Date: _____ Age: _____

Referring Physician: _____ Family Physician (PCP): _____

Handedness: Left Right Both

Reason for Appointment:

GENERAL QUESTIONS:

1. Do you have tremor? Yes No If No, skip to question #2.
 - a. If yes, where: Right hand Left hand Right arm Left arm Right leg Left leg
 Head Face Tongue Trunk
 - b. Does your tremor bother you:
 at Rest with Action (writing, eating, using a tool) Holding an arm/leg outstretched
 Other _____
 - c. What makes your tremor better? Medication Certain positions Alcohol
 Other _____

2. Do you have balance difficulty? Yes No If No, skip to question #3.
 - a. If yes, have you fallen? Yes No
 - b. How often? Daily Weekly Monthly Yearly

3. Do you have any sleep difficulty? Yes No If No, skip to question #4.
 - a. Is the problem: *(check all that apply)*
 Falling asleep Staying asleep Vivid dreams Talking/kicking/fighting in your sleep
 Excessive daytime sleepiness A feeling of needing to move the legs and walk around
 Waking up short of breath

4. Do you have anxiety, depression, mood/personality changes? Yes No If No, skip to question #5.
 - a. Please check all that apply:
 Anxiety Depression Personality change Mood change

5. Do you have any problems with your memory? Yes No If Yes, see below.

a. Please check all that apply:

- Remembering short term events (events from past week/month)
- Remembering long term events (childhood/early adulthood memories)
- Difficulty concentrating
- Difficulty finding words
- Other _____

PAST MEDICAL HISTORY:

Check below if applicable:

- Diabetes Hypertension Stroke Heart Disease GERD
- Breathing Problems Arthritis Kidney Problems Thyroid Cholesterol
- Cancer Type(s): _____

Please list any other medical conditions below:

PAST SURGICAL HISTORY/HOSPITALIZATIONS:

Date (Year)	Surgery or Reason for Hospitalization

MEDICATIONS: (please include any over-the-counter medications and supplements). If you already have a list prepared, please attach a copy. You do not need to rewrite it.

MEDICINE	DOSE	# OF TIMES PER DAY

ALLERGIES:

- No known drug or food allergies
- Drug Allergy: _____
- Food Allergy: _____

SOCIAL HISTORY:

- a. Single Married Widowed Divorced Significant other
- b. Tobacco use None Quit Year: _____ Current Type/Frequency: _____
- c. Alcohol None Current Type/Frequency: _____
- d. Illicit drug use None Current Type/Frequency: _____
- e. Do you exercise? Yes No If yes, frequency: _____
- f. Current stressors? _____
- g. Any exposures to toxins or chemicals? (occupational or personal) Example: Heavy exposure to pesticides, welding, working with heavy metals.
 Yes No If yes, Type: _____
- h. Highest level of education completed? _____
- i. Current or prior occupation. If retired, please list the year of retirement: _____
- j. Do you have children? Yes No If yes, how many? _____

FAMILY HISTORY: For Aunt, Uncle, and Grandparents, please list M for Mom's side and P for Dad's side.

	None	Son	Daughter	Mother	Father	Brother	Sister	Aunt	Uncle	Gmother	Gfather
Parkinson's disease											
Memory loss											
Dystonia											
Tremor											
Symptoms like yours											
OTHER:											
OTHER:											
OTHER:											

REVIEW OF SYSTEMS:

Please check the "Yes" or "No" box to indicate if you currently have any of the following symptoms:

	YES	NO		YES	NO		YES	NO
Weight loss			Shortness of breath			Depression		
Fatigue			Constipation			Hallucinations		
Blurred vision			Diarrhea			Numbness		
Double vision			Frequent urination			Loss of sense of smell		
Nasal discharge			Urinary urgency			Loss of sense of taste		
Hoarseness			Loss of control of urine			Rashes		
Difficulty chewing			Bleeding disorders			Skin changes		
Difficulty swallowing			Bruising easily			Abnormal moles		
Chest pain			Problems with easy bruising			Intolerance to cold		
Fainting spells			Muscle pain			Excessive thirst		
Cough			Anxiety			Enlarged lymph nodes		

Please list any medications you have tried and failed. Failed may represent a side effect on the medication or no effect.

Please list any other concerns or specific questions that you would like addressed today.

*Thank you for taking the time to complete this form.
This helps us to spend our visit addressing your primary concerns
and reviewing recommendations for your neurological care.*