CTNC Central Texas Neurology Consultants

Diseases of the Brain, Spine, Nerves and Muscles

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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.

Central Texas Neurology Consultants has a tradition of excellence in clinical research, having participated in over 50 clinical trials. All of us at CTNC want our patients to be aware of our dedication to clinical research. Our physicians have extensive experience and are committed to advancing medical science through clinical research studies.

Are you interested in participating in Research Studies?

- ☐ ***Yes***
- ☐ ***No***
- ☐ ***Maybe***

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.

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