NEW PATIENT INTRODUCTORY QUESTIONNAIRE

Please fill out <u>both</u> sides of <u>both</u> pages

Name:	**Today's Date:**	**Medical Record #:**	**Age:**	**Sex:** ( ) male ( ) female

Referring provider:	**Primary care provider:**

Other specialists you see:

Dominant Hand ( ) Right ( ) Left	**Race/ethnicity**	**Current or most recent occupation:**	**Best contact phone number:**

Reason for referral:

Past or current medical conditions/issues:	**Past Surgeries** (please include approximate dates, location, and surgeon):

Current medications and dosages (or attach separate list):	**Over-the-counter medications:** **Herbs, vitamins, and supplements:** **Birth Control:**

DIABETES SCREEN

Do you have a history of diabetes? ( ) yes ( ) no If yes, do you take insulin for this? ( ) yes ( ) no	If yes, when was this diagnosed? _____
If yes, do you know what your most recent hemoglobin A1C was? _____	If yes, what range do your sugars typically fall in? _____

CANCER SCREEN

Have you ever had cancer? ( ) yes ( ) no If so, what type(s) of cancer and when? If so, how was it treated? ( ) chemotherapy [dates: _____] ( ) radiation ( ) surgery

Do you have any history of the following (please check those that apply)? ( ) thyroid disease ( ) autoimmune disease ( ) Vitamin B12 deficiency ( ) excessive alcohol use ( ) infertility ( ) miscarriages ( ) cataracts ( ) a heart condition ( ) difficulty tolerating anesthesia ( ) HIV ( ) Hepatitis

Women's health issues: Are you currently pregnant? ( ) yes ( ) no ( ) unsure Do you plan to become pregnant within the next year? ( ) yes ( ) no ( ) unsure Are you currently breast-feeding? ( ) yes ( ) no	**Medication Allergies** (if you have an allergy to a particular medication, please list this medication and the reaction/symptoms it caused):

Did your current symptoms start around the time you started a new medication, herb, or supplement? ( ) yes ( ) no	If so, which one?
Have you ever taken a cholesterol-lowering medication? ( ) yes ( ) no	If so, which one?
Did your symptoms start following a trip to another country or another part of the US? ( ) yes ( ) no	If so, where?
Have you ever been exposed to any toxins or heavy metals that you are aware of? ( ) yes ( ) no	Which ones?

What testing have you had done for this issue thus far? ( ) none ( ) MRI brain ( ) CT scan brain ( ) MRI cervical spine/neck ( ) MRI thoracic spine/mid-back ( ) MRI lumbar spine/low back ( ) EMG/nerve conduction studies ( ) muscle biopsy ( ) nerve biopsy ( ) skin biopsy ( ) spinal tap ( ) blood work

Have you undergone any treatments or taken medications for this issue thus far? ( ) yes ( ) no If so, which ones?

SOCIAL HISTORY

Cigarettes/tobacco:	**Alcohol use:**
Do you currently smoke cigarettes/cigars or use other forms of tobacco? ( ) yes ( ) no	Do you drink alcohol? ( ) yes ( ) no
If not, but you once did, when did you quit? _____	About how many alcoholic beverages do you consume each month? _____
If you currently smoke cigarettes or did so in the past, approximately how many years have you/did you smoke(d) for? _____	What type of alcoholic beverage do you typically consume (i.e. beer, wine, hard alcohol, etc.)? _____
While smoking, approximately how many packs of cigarettes do you/did you smoke per day? _____packs or _____cigarettes per day	Do you have any history of significant alcohol use in the past? ( ) yes ( ) no
Recreational drugs: Do you use recreational drugs? ( ) yes ( )no Any significant drug use in the past? ( ) yes ( )no	**Diet:** Are you on any special type of diet (e.g. vegetarian)? ( ) yes ( ) no If yes, please specify type of diet:_____
Driving: Do you drive? ( ) yes ( ) no Do your symptoms impact your driving? ( ) yes ( ) no	**Home life:** Who do you live with? ( ) alone ( ) spouse ( ) children ( ) partner **( )** other
Activities of daily living: Are you UNABLE to perform any of the following tasks on your own? ( ) bathing ( ) grooming ( ) brushing your teeth ( ) selecting proper clothing ( ) putting on clothes ( ) eating ( ) controlling urine/bowel movements ( ) transferring, such as moving from bed to chair or to standing	
Marital status: ( ) single ( ) married ( ) divorced	

FAMILY MEDICAL HISTORY:

Family Member	Alive or deceased?	If alive, current age	If deceased, lived to age:	Medical conditions
Mother				
Father				
( ) Brother/ ( ) Sister				
( ) Brother/ ( ) Sister				
( ) Brother/ ( ) Sister				
( ) Brother/ ( ) Sister				
( ) Son/( ) Daughter Name:				
( ) Son/( ) Daughter Name:				
( ) Son/( ) Daughter Name:				
( ) Son/( ) Daughter Name:				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				
Other Family Members:				

Do you have any family history of nerve or muscle disease, or any family members who experience the same symptoms as you? ( ) yes ( ) no If so, explain:
Does anyone in your family have high foot arches? ( ) yes ( ) no
Does anyone in your family have cataracts? ( ) yes ( ) no
Does anyone in your family have heart disease? ( ) yes ( ) no

PLEASE PUT A CHECK TO THE LEFT OF ANY OF THE FOLLOWING SYMPTOMS YOU HAVE CURRENTLY OR HAD IN THE PAST:

CONSTITUTIONAL	**NEUROLOGIC**
unexplained fevers	muscle twitching or any other unusual movements of the muscles
unexplained chills	balance problems
nightsweats	coordination difficulties
unintentional weight loss	problems with dexterity or fine motor movements
reduced appetite	numbness, tingling, burning, or any other unusual sensation
	muscle stiffness
	difficulty releasing your hand grip
INTEGUMENTARY	muscle aches
rashes or other skin symptoms	cramps
unusual changes in skin color or temperature	falls
	history of seizures
EYES	frequent morning headaches
vision loss	unexplained awakening or gasping during sleep
double vision	
drooping of the eyelids	**PSYCHIATRY**
difficulty moving your eyes	feelings of depression/history of depression
personal or family history of cataracts	thoughts of killing/harming yourself or others
EAR, NOSE, THROAT	**MUSCULOSKELETAL**
difficulty chewing	foot deformities (high foot arches, hammertoes, etc.)
difficulty swallowing, choking, or drooling	neck pain
mouth or genital ulcers	back pain
slurred speech	history of scoliosis
change in voice	joint pain/warmth/stiffness
hearing loss	history of ankle sprains/fractures/injuries
RESPIRATORY	**CARDIOVASCULAR**
breathing difficulties/shortness of breath	chest pain
cough	rapid/pounding/abnormal heartbeats (palpitations)
GENITOURINARY	
tea or coca-cola colored urine	
frequent urination	**AUTONOMIC**
difficulty starting urination	dry eyes
inability to empty bladder completely	dry mouth
	lightheadedness or fainting
GASTROINTESTINAL	urinary incontinence/lack of urine control
a feeling of fullness after eating small amounts of food	bowel incontinence/lack of bowel control
abdominal bloating	erectile dysfunction
diarrhea	excessive sweating
constipation	decreased sweating
nausea or vomiting	
Check here if you have none of the symptoms in either column above	

Do you have any other symptoms that you think are relevant to your visit today? If so, please explain: