



Account # _____

PATIENT REGISTRATION

Please answer all questions completely.

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED

Date _____

New

Update

Name _____ Date of Birth _____ Male
Last First Middle Female

Home Address _____

City/State/Zip _____

Phone (____) _____

Cell (____) _____

Patient's Soc. Sec. # _____

Driver License No/State _____

Employer _____ Employer's Address _____

Who is your Primary Care Physician? _____ Referring Physician? _____

PATIENT'S E-MAIL ADDRESS _____

Race	<input type="checkbox"/> White/Caucasian	<input type="checkbox"/> Black or African American	<input type="checkbox"/> Asian
	<input type="checkbox"/> American Indian	<input type="checkbox"/> Native Hawaiian or Other Pacific	
	<input type="checkbox"/> Decline to State		

Ethnicity	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
	<input type="checkbox"/> Decline to State	

Primary Language Spoken	_____
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Financially Responsible Party (subscriber info)

If other than self _____ Relationship _____

Address _____ Phone (____) _____
Number Street City

Patient's Primary Insurance _____ **Subscriber's Social Security #** _____

Subscriber ID # _____ **Subscriber's Group ID#** _____ **DOB** ____/____/____

Patient's Secondary Insurance _____ **Subscriber's Social Security #** _____

Subscriber ID # _____ **Subscriber's Group ID#** _____ **DOB** ____/____/____

Subscriber to Secondary Insurance _____ **Relationship to Patient** _____

Emergency contact _____ Relationship _____
Last Name First Middle

Please check box if authorized to release appointment/medical information.

Address _____ Phone (____) _____
Number Street City

I have read and understand all of the above and hereby give my consent for medical treatment.

I understand that I am responsible for my bill.

I hereby authorize The Neurology Center to release medical and/or billing information to my insurance company.

Patient's Signature

Date

6010 Hidden Valley Road, Suite 200, Carlsbad, CA 92011
1955 Citracado Pkwy, Suite 102, Escondido, CA 92029
9850 Genesee Avenue, Suite 470, La Jolla, CA 92037
15611 Pomerado Road, Suite 505., Poway, CA 92064
(P) 760-631-3000 (F) 760-631-3016
www.neurocenter.com

PERMISSION TO FURNISH MY MEDICAL INFORMATION

Patient Name: _____

1. FURNISH TO RELATIVES AND/OR PERSONAL ASSOCIATES

I hereby give my consent to The Neurology Center to furnish medical information about me (e.g., blood test results, other test results, doctor's instructions, etc.) in the event I am not immediately available.

Approved Person(s)

Relationship to Patient

- I hereby authorize The Neurology Center to disclose medical information in the purpose to contact me with routine results and to remind me of my future appointments. You may email, send text messages and or leave this information on my answering machine.
- I hereby instruct The Neurology Center to furnish information **only** to me. In this instance, I understand you will leave a message for me to call the office if I am not immediately available.
- Other special instructions regarding furnishing my medical information: _____

X _____
Patient Signature

Date

Designated Power Of Attorney

2. FURNISH TO PHYSICIANS OR OTHER MEDICAL PROVIDERS

I understand that The Neurology Center will furnish and/or discuss medical information (e.g., examination findings, laboratory and test results, etc.) about me with my Primary Care Physician and/or the Provider or entity that referred me to The Neurology Center.

In addition, I hereby give my consent to The Neurology Center to furnish and/or discuss my medical information with the following additional Medical Providers or Entity(ies)

Providers Name

Phone Number

City

X _____
Patient Signature

Date

Designated Power Of Attorney

NEW PATIENT HISTORY

Name _____ **Birthdate** _____ **Date** _____

Age: _____ I am: Right Handed Left Handed Ambidextrous

Referring Physician: _____

What is your primary language spoken? _____

How do you prefer to receive information about your diagnosis? ___ Verbal ___ Written ___ Pictures

Chief Complaint

Please list the main problems, which bring you to the doctor

- 1. _____
- 2. _____
- 3. _____
- 4. _____

Please describe the problems:

Review of Symptoms

Check boxes if you are having any of these symptoms; write in details:

Constitutional

- Chills
- Fatigue
- Changes in Weight

Eyes

- Double vision
- Eye Pain
- Blurred vision

Ears, Nose and throat

- Hearing loss
- Ringing
- Dizziness
- Sore throat

Cardiovascular

- Ankle swelling
- Night sweats
- Chest Pain or Pressure
- Skipped beats
- Blackouts

Respiratory

- Cough
- Shortness of breath
- Hyperventilation

Gastrointestinal

- Abdominal Pain
- Appetite loss
- Blood in stool
- Constipation
- Diarrhea
- Nausea
- Vomiting

Hematologic/Lymphatic

- Easy bruising or bleeding
- Anemia

Musculoskeletal

- Joint stiffness
- Joint swelling
- Joint Limitation
- Joint pain
- Neck pain
- Back pain

Genitourinary

- Blood in urine
- Burning with urination
- Hesitancy
- Night time frequency
- Difficulty with urination

Skin/Breast

- Rashes
- Nipple discharge

Endocrine

- Intolerant of heat or cold
- Excessive urination
- Excessive hunger
- Increased thirst

Allergic/Immunologic

- Allergies to medication, Iodine, shellfish,

Neurological

- Difficulty with speech
- Impaired memory
- Confusion
- Headaches
- Seizures
- Blackouts
- Fainting
- Trouble swallowing
- Arm pain
- Leg pain
- Weakness or paralysis
- Tremors
- Incoordination
- Uncontrolled movements
- Stroke
- Imbalance
- Numbness
- Tingling

Psychiatric

- Mood swings
- Depression
- Anxiety
- Memory
- Hallucinations

Current height _____

Current weight _____

Patient Name: _____

Past Medical History

Check if you have had any of these problems. Give details.

- | | |
|--|---|
| <input type="checkbox"/> Angina | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Blindness, part or full | <input type="checkbox"/> Irregular heart beats |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous breakdown |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Psychiatric conditions |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures (epilepsy) |
| <input type="checkbox"/> Head trauma | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Swallowing problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Venereal infections |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Vertigo |
| <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Walking problems |

Have you had any of these tests? Give details.

- | | |
|--|---|
| <input type="checkbox"/> Angiogram of the brain | <input type="checkbox"/> Spinal tap |
| <input type="checkbox"/> CAT scan | <input type="checkbox"/> Skull X-ray |
| <input type="checkbox"/> EEG (brain wave test) | <input type="checkbox"/> Spine X-ray |
| <input type="checkbox"/> EMG (nerve-muscle test) | <input type="checkbox"/> Magnetic Resonance (MRI) |

Medications – Please list all of the medications you are currently taking. Include aspirin, birth control pills, hormones, water pills, sleeping pills, tranquilizers, vitamins, etc.

Medication	Dosage	How often taken?	For how long have you taken it?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Surgical Procedures – List chronologically

Operations	Hospital & City	Date
1.		
2.		
3.		

Patient Name: _____

Other Hospitalizations or Other Medical Problems

1.	_____
2.	_____
3.	_____
4.	_____

Allergies:

Please list any allergies to medications _____

Are you allergic to X-ray dye? _____

Are you allergic to shellfish? _____

Social History

Your place of birth: _____

Marital Status: Married Single Divorced Widowed

Education Completed: (YEARS) 9 10 11 12 13 14 15 16 16+

Occupation: _____

Do you exercise regularly? Yes No, if so what do you do? _____

Habits

Check any of the following that you have used and state amount:

Caffeine How much per day? _____

Alcohol How much per day? _____

Tobacco How much per day? _____

Family History

Have any of your relatives has any of the following? If yes, indicate relationship (e.g., father):

Check if positive

Relationship

Alcoholism _____

Cancer _____

Diabetes _____

Heart Disease _____

Mental Illness _____

Migraine _____

Seizures _____

Stroke _____

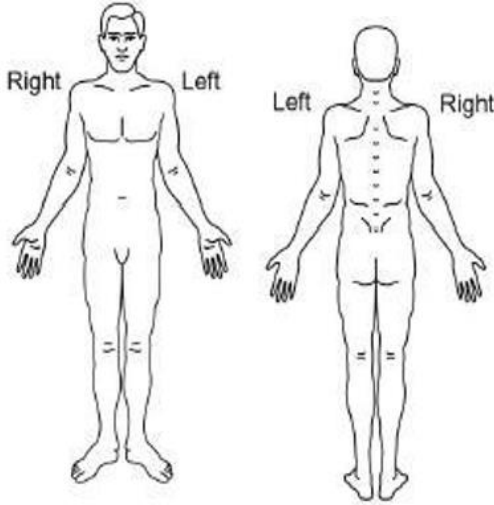
Tuberculosis _____

Are there any other diseases that run in the family? _____

Patient Name: _____

What is your chief complaint for which you are being seen in Pain Management Clinic?

On the diagram, mark the areas you are experiencing pain. Use the following symbols to describe your pain:
Aching: **A** Burning: **B** Cramping: **C**
Numbness: **N** Pins & Needles: **P** Stabbing: **S**
Put an **X** on the area that hurts the most.



How long ago did your symptoms start?

How often do you have symptoms?
 All the time Sometimes

If sometimes, how long does your pain last?
_____ Minutes _____ Hours _____ Days

Using the pain scale below, please answer the questions:

What is your pain score right now? _____/10

How bad does it get? _____/10

What is the lowest? _____/10

What medications for pain do you take? Helpful?

 Yes No

 Yes No

 Yes No

What activities worsen your symptoms?
Please circle:
Sitting, standing, walking, lifting, driving, exercise
Other: _____

What activities improve your symptoms?
Please circle:
Sitting, standing, walking, lying, exercise
Other: _____

Any history of:
Cancer? Yes No
Unexplained weight loss? Yes No

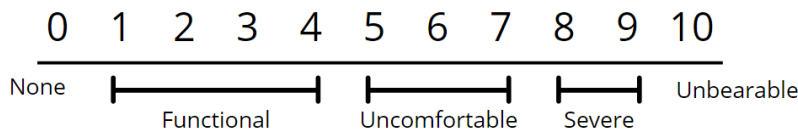
Have you had spine surgery? Yes No
If yes, when was your operation(s)? _____

What treatments have you had? Was it helpful?
 Physical Therapy Yes No
 Ice or Heat Yes No
 TENS Unit Yes No
 Acupuncture Yes No
 Massage Therapy Yes No
 Chiropractor Yes No
 Yoga or Pilates Yes No
 Spine Injections Yes No

Are you employed? Yes No
If yes: Full-time Part-time
What do you do? _____
What city do you live in? _____

Do you smoke? Yes No
How much do you smoke? _____ #years? _____
Have you ever smoked in the past? Yes No
Date(s) quit? _____
Alcohol use: None _____ Drinks per _____
Illegal drugs: None _____ Type

Over the past two weeks, have you been bothered by:
Feeling down, depressed, or hopeless? Yes No
Little interest or pleasure in doing things? Yes No
Difficulty sleeping at night? Yes No



Sleep Survey

Name: _____ DOB: _____

Do you snore? Yes ____ No ____

Do you feel tired, fatigued or sleepy during the day? Yes ____ No ____

Has anyone observed you stop breathing while you sleep? Yes ____ No ____

Do you nap during the day? Yes ____ No ____

Do you have any of the following?

- | | | |
|---|------------------------------|-----------------------------|
| Heart Disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| History of Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Morning Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Trouble with Memory Or Concentration | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

<p>Sleep Orders For Office Use Only</p> <p><input type="checkbox"/> Sleep Consult</p> <p><input type="checkbox"/> PSG</p> <p><input type="checkbox"/> CPAP Titration Study</p>
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Physician Signature

Did you need any assistance filling out this form? ____ Y ____ N ____

Signature _____ Date _____