COASTNEURO
2 James Way, Suite 101 Pismo Beach, CA

Patient History

Patient Name: _____ **Date:** _____

Age: _____ **Birth Date:** _____ **Right or left handed?** _____

Occupation: _____

Previous Occupations: _____

Names of family members or roommates who live with you: _____

Primary Physician: _____

Why have you been referred here? _____

Referring Physician: _____

The next section is to be completed by the patient for a *handwriting analyses*.

Please describe what problems brought you here. How long have you been having symptoms? What symptoms? When do they occur? What makes them worse? Does anything make them better?

_____

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Please fill in the box ■ for any of the following symptoms that you have been experiencing:

- ☐ Memory loss
- ☐ Seizures or convulsions
- ☐ Fainting or black-outs
- ☐ Staring spells
- ☐ Loss of time
- ☐ Hallucinations or strange perceptions
- ☐ Confusion/ Disorientation
- ☐ Difficulty with word finding
- ☐ Difficulty with balance
- ☐ Difficulty with coordination
- ☐ Difficulty swallowing
- ☐ Difficulty concentrating
- ☐ Difficulty understanding speech
- ☐ Difficulty expressing yourself
- ☐ Difficulty reading or writing
- ☐ Uncontrolled limb movements
- ☐ Excessive daytime sleepiness
- ☐ Nightmares
- ☐ Tongue biting
- ☐ Teeth grinding
- ☐ Loud snoring
- ☐ Difficulty initiating (starting) sleep
- ☐ Difficulty maintaining (staying) sleep
- ☐ Loss of vision : ☐ R ☐ L ☐ Both
- ☐ Eye pain: ☐ R ☐ L ☐ Both
- ☐ Visual disturbances (flashing lights, spots)
- ☐ Double/ blurred vision
- ☐ Sinus problems
- ☐ Headache: ☐ Mild ☐ Moderate ☐ Severe
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Appetite poor or changed
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Frequent falls
- ☐ Facial tic/twitching
- ☐ Rash
- ☐ Hearing loss ☐ R ☐ L ☐ Both
- ☐ Ringing in the ears
- ☐ Ear pain: ☐ R ☐ L ☐ Both
- ☐ Jaw pain: ☐ R ☐ L ☐ Both
- ☐ Slurring of speech
- ☐ Voice changes
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Neck pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Joint pain
- ☐ Muscle tic/ twitching
- ☐ Muscle pain
- ☐ Tingling or numbness:
  - ☐ Face
  - Arm: ☐ R ☐ L
  - Leg: ☐ R ☐ L
- ☐ Weakness:
  - ☐ Face
  - Arm: ☐ R ☐ L
  - Leg: ☐ R ☐ L
- ☐ Pain:
  - ☐ Face
  - Arm: ☐ R ☐ L
  - Leg: ☐ R ☐ L
- ☐ Erectile dysfunction
- ☐ Decreased sexual drive
- ☐ Bed wetting
- ☐ Frequent urination at night
- ☐ Incontinence of bowel or bladder
- ☐ Change in menstrual cycle
- ☐ Frequent nose bleeds
- ☐ Increased time to stop bleeding
- ☐ Easy Bruising
- ☐ Dizziness
- ☐ Depression
- ☐ Anxiety

Check any of the following tests you have had performed and note where and when:

- ☐ EMG or NCS: _____
- ☐ Spinal Tap: _____
- ☐ CT Scan: _____
- ☐ ECHO or EKG: _____
- ☐ Carotid U/S: _____
- ☐ EEG or TCD: _____
- ☐ MRI or MRA: _____
- ☐ DEXA/Bone Scan: _____

Have you ever had any of the following?

- ☐ Head injury
- ☐ Back injury
- ☐ Neck injury
- ☐ Spinal cord injury
- ☐ Back surgery
- ☐ Neck surgery
- ☐ Injured by falling or MVA
- ☐ Radiation therapy
- ☐ Chemotherapy

Please check any illness you have been treated for or diagnosed with:

- ☐ High blood pressure
- ☐ Stroke
- ☐ Ulcers
- ☐ Thyroid disease
- ☐ Migraine
- ☐ Depression
- ☐ Muscle disorders
- ☐ Diabetes I or II
- ☐ Asthma
- ☐ Arthritis
- ☐ Blood clots
- ☐ Meningitis
- ☐ Anxiety
- ☐ Heart attack
- ☐ Emphysema
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Alcoholism
- ☐ Gout
- ☐ Anemia
- ☐ STDs
- ☐ Seizure/ Epilepsy
- ☐ Tuberculosis
- ☐ Rheumatic fever
- ☐ High cholesterol
- ☐ TMJ
- ☐ Polio
- ☐ Sleep Apnea
- ☐ Multiple Sclerosis
- ☐ Schizophrenia
- ☐ Suicide attempt
- ☐ GERD/ Heart burn
- ☐ Osteoporosis
- ☐ Lupus
- ☐ Alzheimer's disease
- ☐ Menopause
- ☐ Fracture:_____
- ☐ Cancer:_____
- ☐ Other:_____

Please list the dates and reasons for any hospitalizations. Include any surgeries.

1.	4.	7.
2.	5.	8.
3.	6.	9.

What methods of birth control do you use? Type? Dose? _____

Are you allergic to any medications? Which? _____

Do you smoke? _____ In the past? _____ How much and for how long? _____

Do you drink alcoholic beverages? _____ How much and how often? _____

Do you drink caffeinated beverages? _____ How much and how often? _____

If you use or have ever used any illegal drugs, please inform the doctor during your appointment.

Please check any disorders that run in your family:

☐ High blood pressure	☐ Diabetes I or II	☐ Kidney disease	☐ Lupus
☐ Gout	☐ Asthma	☐ Alcoholism	☐ Alzheimer's disease
☐ Stroke	☐ Arthritis	☐ Seizure/ Epilepsy	☐ Bipolar
☐ Thyroid disease	☐ Blood clots	☐ Tuberculosis	☐ Gluten intolerance
☐ Migraine	☐ Anxiety	☐ High cholesterol	☐ Autoimmune disorder
☐ Depression	☐ Heart attack	☐ Schizophrenia	☐ Cancer:_____
☐ Dementia	☐ Liver disease	☐ Osteoporosis	

Is your father: alive / deceased Age:_____ Cause of death? _____

Is your mother: alive / deceased Age:_____ Cause of death? _____

How many brothers do you have? _____ Ages? _____

How many sisters do you have? _____ Ages? _____

Do any of your siblings have any serious medical problems? _____

_____

Please list the doctors you have seen in the past five years, and reason for seeing them:

Doctor Name	Reason for visit
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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