MR #: _____

Date: _____

Patient Registration Form

QUALITY NEUROLOGY

Patient's Name: _____

Date of Birth: _____

Social Security #: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Mobile: _____

May we leave a message on your voicemail? ___ Yes ___ NO

Would you like to receive text messages for reminders/updates? ___ Yes ___ No

Preferred method of contact? ___ Home Phone ___ Mobile ___ Email

Email Address: _____

Gender: ___ Male ___ Female ___ Other ___ Choose not to disclose

Race: ___ Asian ___ Black/African American ___ Hispanic ___ White ___ Other ___ Choose not to disclose

Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino ___ Other ___ Choose not to disclose

Preferred language? _____

Insurance Information: Please provide your insurance card(s) and driver's license to the front desk at check-in.

MR #: _____

Date: _____

QUALITY NEUROLOGY

Name: _____ **DOB:** _____

Who Referred you to us? _____

Please list any other physicians that you would like to receive correspondence regarding your care:

_____

_____

What problem were you referred for? _____

Preferred Pharmacy? _____

Preferred Lab? _____

Preferred Imaging Facility? ___ Invision ___ Titan

___ Other (please list) _____

MR #: _____ **Patient History Form**

QUALITY NEUROLOGY

Date: _____

Name:_____

Date of Birth: _____

Medical History – *Have you had any of the following? If yes, please circle.*

Cancer	High Blood Pressure	Seizure
Depression	Heart Condition	Stroke
Diabetes	Obesity	

Have you had any surgeries? ___ Yes ___ NO

Social History

Tobacco use? ___ Current ___ Former

Type? ___ Cigarettes ___ Cigars/Pipe ___ Snuff/Chewing Tobacco ___ Vape/ECigarette

Amount per day? _____ **Number of years used?** _____

Alcohol use? ___ Yes ___ No If yes, how many per day? _____

Any illegal drug use? ___ Yes ___ No **Substance abuse?** ___ Yes ___ No

Family History – *Has any blood relative had any of the following? Please Circle.*

____ Unknown ____ Adopted

Alcoholism	Dementia	Thyroid problems	Cancer
Depression	Alzheimer's	Diabetes	Heart condition
Early death	Parkinson's	Lupus	High Blood Pressure
Mental illness	Stroke	Rheumatoid Arthritis	Kidney disorder
Substance abuse	Migraine	Multiple Sclerosis	Leukemia
Suicide	Seizure/Epilepsy	Aneurysm	

MR #: _____

Date: _____

Medications

QUALITY NEUROLOGY

Name: _____ **DOB:** _____

Medication	How Much	How Often

Allergies? ___ Yes ___ No *(If yes, please list)*

Allergy	Reaction

MR #: _____

Review of Systems

QUALITY NEUROLOGY

Date: _____

Name: _____ **DOB:** _____

PLEASE CIRCLE ALL THAT APPLY

Fatigue	Cough	Thyroid Problems
Vision Changes	Constipation	Diabetes
Loss of Smell	Reflux/GERD	Weakness
Sinus Problems	Incontinence	Headaches/Migraines
Difficulty Hearing	ED	Seizures
Rashes	Muscle Aches	Tremor
Chest Pain	Muscle Weakness	Memory Loss
Palpitations	Joint Pain	Depression
	Neck Pain	Anxiety
		Poor Sleep/Restless Sleep

Who do you live with? ___ Alone ___ With others

What is/was your occupation? _____

Are you retired? ___ Yes ___ No

Handedness: ___ Right-handed ___ Left-handed ___ Ambidextrous

MR #: _____

Date: _____

Patient Health Questionnaire (PHQ-9)

QUALITY NEUROLOGY

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answer)

	NOT AT All	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. OR the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

_____

Patient's Signature