Allina Health
John Nasseff Neuroscience Specialty Clinic
New Patient Intake Form

Today's Date: _____

Name:_____ Date of Birth:_____ Age:_____

Last First Middle Initial

Address: _____ Phone: (Home/Cell):_____

Street Apt

_____ Phone:(Work):_____

City State Zip

Marital Status: S M W D
Occupation: _____
Name of doctor referring you here: _____
Family doctor if different from above: _____
Reason for visit: What symptoms are you having, and when did they start? _____
_____
_____
_____
_____

Have you missed any days of work due to this problem? (Circle) Yes or No If yes, how many? _____

Are you currently on medical disability? (Circle) Yes or No Last Day Worked? _____

Have you been evaluated for this problem in the past? (Circle) Yes or No
If so, when and where:_____

LIST CURRENT MEDICATIONS, DOSAGE and FREQUENCY, including nonprescription drugs:

_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

_____

Do you smoke (Circle): Yes or No How Much? _____
Have you ever smoked? (Circle): Yes or No For how long?_____
Alcohol Use? (Circle): Yes or No__How Much? _____

PHARMACY NAME & ADDRESS:

_____
_____
_____
Pharmacy
Phone:_____Fax:_____

HAVE YOU EVER HAD THE FOLLOWING?
IF YES, WHERE AND WHEN:
CT _____
MRI_____
Cerebral Angiogram_____
EEG_____
EMG_____
Myelogram_____
Holter EKG (24hr) _____
Spinal Tap_____
Previous Neurological Consultation_____
_____
Carotid Ultrasound/Surgery_____
Neurosurgery _____

(Please Flip Over to Complete)

Please answer each line YES or NO:

YES	NO		YES	NO	
O	O	Neck Pain	O	O	Sleeping Problems
O	O	Back Pain	O	O	Headaches
O	O	Arm I Leg Pain	O	O	Seizures
O	O	Joint Pain	O	O	Blackout Spells
O	O	Numbness I Tingling	O	O	Memory Loss
O	O	Weakness I Paralysis	O	O	Anxiety
O	O	Difficulty Walking	O	O	Depression
O	O	Falling	O	O	Chest Pain
O	O	Balance I Coordination Problems	O	O	Palpitations
O	O	Movement Disorder or Tremor	O	O	Cardiac I Heart Problems
O	O	Bladder Symptoms	O	O	Bloating
O	O	Impotence	O	O	Stomach Pain I Distress
O	O	Dizziness	O	O	Bowel Problems
O	O	Speech Disturbance	O	O	Respiratory Problems
O	O	Difficulty Swallowing	O	O	Skin Changes I Rash
O	O	Ringing in Ears	O	O	Weight Gain or Loss
O	O	Hearing Loss	O	O	Appetite Problems
O	O	Visual Symptoms	O	O	Snore Loudly
O	O	Sleepy During the Day	O	O	Stop Breathing During Sleep

SELF

Have you ever been diagnosed of:

PLEASE CHECK		
	YES	NO
Stroke	O	O
Aneurysm	O	O
High Cholesterol	O	O
High Blood Pressure	O	O
Diabetes	O	O
Epilepsy or Seizures	O	O
Migraine or Severe Headache	O	O
Bleeding or Clotting Tendency	O	O
Tremor or Movement Disorder	O	O
Parkinsons Disease	O	O
Multiple Sclerosis	O	O
Mental lllness	O	O
Memory Loss I Alzheimer's	O	O
Arthritis	O	O
Visual Loss	O	O
Heart Attack	O	O
Suicide or Attempt	O	O
Depression	O	O
Osteoporosis (Brittle Bones)	O	O
Cancer I Leukemia	O	O
Sleep Disorder	O	O

FAMILY HISTORY

Any blood relatives have history of:

PLEASE CHECK			
	YES	NO	WHICH RELATIVE?
Stroke	O	O	
Aneurysm	O	O	
High Cholesterol	O	O	
High Blood Pressure	O	O	
Diabetes	O	O	
Epilepsy or Seizures	O	O	
Migraine or Severe Headache	O	O	
Bleeding or Clotting Tendency	O	O	
Tremor or Movement Disorder	O	O	
Parkinsons Disease	O	O	
Multiple Sclerosis	O	O	
Mental lllness	O	O	
Memory Loss I Alzheimer's	O	O	
Arthritis	O	O	
Visual Loss	O	O	
Heart Attack	O	O	
Suicide or Attempt	O	O	
Depression	O	O	
Osteoporosis (Brittle Bones)	O	O	
Cancer I Leukemia	O	O	
Sleep Disorder	O	O	

RELATIVE AGE AT DEATH & CAUSE:

Father_____

Mother_____

Sister (s)_____

Brother(s) _____