PACIFIC CENTER FOR NEUROLOGICAL DISEASE, INC.

CMA The Center For Memory and Aging
A Project of Pacific Center for Neurological Disease, Inc

Offices:
15644 Pomerado Road,
Suite 401
Poway, CA 92064

New Patient Intake Form

I. Demographic Information

Date: _____

Name: _____ Date of Birth: _____ Age: _____ SSN: _____
Home Address: _____
Home Phone: _____ Cell Phone: _____
Email: _____ Marital Status: _____ Sex: _____
ID or Driver License #: _____ Spouse Name: _____

II. Insurance Information

Primary Insurance (circle or write in): Aetna Anthem Blue Cross Blue Shield Community Health Group Cigna Health Net Medicare Sharp / Arch Tricare United Health Care Other: _____
Subscriber Name: _____ Relationship to Patient: _____
ID # _____ Group # _____ Group Name: _____ Co-Pay:_____
Phone: _____

Secondary Insurance (circle or write in): Aetna Anthem Blue Cross Blue Shield Community Health Group Cigna Health Net Medicare Sharp/Arch TriCare United Health Care Other: _____
Subscriber Name: _____ Relationship to Patient: _____
ID # _____ Group # _____ Group Name: _____ Co-pay:_____

III. Point of Contact/Responsible Party if other than Patient

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip:_____
Phone: _____ Fax: _____ Email: _____

IV. Care Information – please list complete name and address of physicians (VERY IMPORTANT)

Primary Care Physician_____
Address: _____ City: _____ State: _____ Zip:_____
Phone: _____ Fax: _____ Email: _____

Referring Physician (if different from PCP): _____ Specialty: _____
Address: _____ City: _____ State: _____ Zip:_____
Phone: _____ Fax: _____ Email: _____

Pharmacy: _____ Address:_____
Phone: _____ Fax: _____City: _____ State: _____ Zip: _____

PLEASE FILL FORMS OUT AS COMPLETELY AS POSSIBLE

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V. Reason for visit – Chief Complaint (History of Present Illness)

Please describe the major problem that brings you in today to see a Neurologist:

_____

_____

Is this visit related to worker's compensation? (Circle one) Yes No

Is this visit related to any legal actions? (Circle one) Yes No

If this problem is the result of an accident, when did the accident occur? _____

VI. Pain Assessment

Do you experience pain as part of your daily life? (Circle one) Yes No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

_____

_____

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain? _____

What makes your pain better? (Circle all that apply) Medications Bending Laying Sitting Standing Walking Changing positions Stretching Nothing Comment:_____

VII. Surgical History - Please list all operations you have had

Operation:	**Date:**	**Operation:**	**Date:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

VIII. Medical History - Please list all active medical conditions:

Medical Condition:	**Date:**	**Medical Condition:**	**Date:**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please **LIST** all **allergies** and sensitivities (e.g. medications, foods, latex, iodine, etc.)

_____

Are you taking any "blood thinning" medications? Yes – indicate below No

Aspirin or aspirin-containing medication Anti-inflammatory medication Plavix Coumadin Fish Oil

Other: _____

IX. Social History

Occupation: _____ Marital Status: _____ Number of children: _____

Hobbies: _____

Do you smoke cigarettes? _____ If so, how many packs a day? _____

At what age did you start? _____ If applicable, at what age did you stop?_____

Do you drink alcohol? _____ If yes, how much daily? _____

At what age did you start? _____ If applicable, at what age did you stop?_____

Do you use recreational drugs? _____ Type _____

Do you exercise regularly? (Circle one) Yes No How frequently? _____

Females: Are you, or could you be pregnant? (Circle one) Yes No

Age at first full-term pregnancy_____ Age at first Menstrual Period _____

Age at last menstrual period _____ Have you ever used Oral Contraceptives_____

Ever used Hormone Replacement Therapy? (Circle one) Yes No Brand_____

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X. Family History Do you have a family member affected with:

Condition	Yes	No	type / relative	Condition	Yes	No	type / relative
Arthritis	☐	☐		Asthma	☐	☐	
Aneurysm	☐	☐		Brain Tumor	☐	☐	
Cancer ☐	☐			Muscle Disease ☐	☐		
Seizures or Epilepsy	☐	☐		Other Neurological Disorder	☐	☐	
Dementia	☐	☐		Diabetes	☐	☐	
Parkinson's	☐	☐		Hypertension	☐	☐	
Multiple Sclerosis	☐	☐		Neuropathy	☐	☐	
				Migraine/Headaches	☐	☐	
Lung disease	☐	☐		Psychiatric disorder	☐	☐	
Kidney disease	☐	☐		Thyroid Disease	☐	☐	

Other conditions:_____

XI. Review of Symptoms Do you currently, or have you had a problem with:

Constitutional:	***Circle One***		***Endocrine***:	***Circle One***	
Fever/chills	Yes	No	Diabetes	Yes	No
Weight loss >10 lbs	Yes	No	Thyroid disease	Yes	No
Excessive fatigue	Yes	No	Excessive thirst/urination	Yes	No
History of Falls Yes	No		Low blood sugar Yes	No	
Insomnia	Yes	No	***Genitourinary:***		
Eyes:			Urinary tract infections	Yes	No
Wear glasses	Yes	No	Painful urination	Yes	No
Infections/redness	Yes	No	Blood in your urine	Yes	No
Injuries	Yes	No	Difficult start/stop of stream	Yes	No
Glaucoma	Yes	No	Incontinence	Yes	No
Cataracts	Yes	No	Kidney stones	Yes	No
Loss of vision	Yes	No	Discharge (vaginal/penile)	Yes	No
Ear, Nose, Throat& Mouth:			***Musculoskeletal:***		
Wear hearing aid(s)	Yes	No	Broken bones	Yes	No
Hearing loss	Yes	No	Arm or leg weakness	Yes	No
Ear pain/infections	Yes	No	Arm or leg pain	Yes	No
Ringing in ears	Yes	No	Joint pain, swelling, stiffness	Yes	No
Nose bleeds	Yes	No	Arthritis	Yes	No
Nasal congestion/drainage	Yes	No	Difficulty walking	Yes	No
Double or blurred vision	Yes	No	Neck/Back/Hip pain	Yes	No
Loss or inability to smell	Yes	No	***Integumentary:***		
Skin disease (ulcers, cancer)	Yes	No	Hives	Yes	No
Difficulty swallowing	Yes	No	Rash	Yes	No
Balance (vertigo, spinning, etc.)	Yes	No	Unusual moles	Yes	No

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Cardiovascular:			***Neurological:***		
Chest pain or angina	Yes	No	Fainting spells / "black outs"	Yes	No
High blood pressure	Yes	No	Headaches	Yes	No
Irregular pulse/murmur	Yes	No	Seizures	Yes	No
Heart attack (MI)	Yes	No	Problems with memory	Yes	No
High cholesterol	Yes	No	Disorientation	Yes	No
Swelling in hands or feet	Yes	No	Difficulty with speech	Yes	No
Awake from sleep unable to	Yes	No	Inability to concentrate	Yes	No
Breath (PND)			Dizziness	Yes	No
Respiratory:			Numbness/tingling	Yes	No
Asthma	Yes	No	Loss of sensation	Yes	No
Emphysema	Yes	No	Difficulty with balance	Yes	No
Shortness of breath	Yes	No	***Psychiatric:***		
Pneumonia	Yes	No	Anxiety	Yes	No
Bloody sputum	Yes	No	Depression	Yes	No
Gastrointestinal:			Mood swings	Yes	No
Nausea	Yes	No	***Hemotologic/Lymphatic:***		
Vomiting	Yes	No	Anemia	Yes	No
Bloody stool	Yes	No	Hemophilia	Yes	No
Liver disease/jaundice	Yes	No	Blood transfusion	Yes	No
Bloating	Yes	No	Persistent swollen glands/node		Yes
No					
Abdominal pain	Yes	No	HIV	Yes	No
Change in bowel habits	Yes	No	***Allergic/Immunologic:***		
Ulcers or gastritis	Yes	No	Food, Inhalant (nasal) allergies	Yes	No
Loss of appetite	Yes	No	Autoimmune disease (i.e.,lupus)	Yes	No

XII. History of Falls

Have you had any significant falls in the past 6 months? Yes No

If yes, please explain: _____

XIII. Handedness

Are you (circle one): Left Handed Right Handed Ambidextrous

The information on this form is accurate to the best of my knowledge and I was offered HIPAA guidelines:

_____ _____

Patient Signature Date completed

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Authorization to Release Medical Information

Patient Name: _____
DOB: _____
SS#: _____

I hereby authorize **PCND Neurology at 15644 Pomerado Road Ste. 401, Poway CA 92064** to disclose and/or receive medical request records (including psychiatric, drug, and/or alcohol-related), films, and/or other information obtained during the course of treatment to the following parties:

_____

_____

_____

With this authorization, I understand that any information obtained will become part of my medical file and may be revealed to the claims examiner/adjuster responsible for my claim or to my insurance company as applicable.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such a disclosure.

Patient Signature _____ Date_____

Parent, Conservator or Legal Representative for the Patient _____

I also permit a copy/fax of this form to serve as an original signature of authorization. **(_____) Initial**

I **DO NOT WANT i**nformation disclosed to: _____

Cancellation and No Show Policy

Our goal is to meet the needs of our patients and we will make every effort to efficiently schedule your appointments. In return, it is your responsibility to make every effort to keep your schedule appointments and arrive promptly at the time designated to you. We do realize that unanticipated events may occur from time to time and prevent you from keeping your appointment. In fairness and consideration to other patients, we hereby request that you notify our office immediately when you realize you will not be able to keep your appointment.

If you need to cancel or reschedule your appointment, you must do so **at least 24 hours before your scheduled appointment** to avoid paying $50 for each missed appointment. Please be aware that this fee is not covered by medical insurance and is the patient responsibility due at the next appointment visit along with any co-payment or fee-for-service.