PACIFIC CENTER FOR NEUROLOGICAL DISEASE, INC.

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

Concussion Clinic / Traumatic Brain Injury Intake Form

PATIENT INFORMATION:

First Name :________________________Last Name:____________________________ DOB:_____/_____/_________

Address:_______________________________________City:___________________State:_______Zip:_____________

Home Phone: __________________ Work/Cell Phone: __________________ Email: __________________________

Sex: Male Female Marital Status: Single Married Partnered Divorced Widowed Separated

INFORMANT INFORMATION:

Name: __________________________________ Phone: _______________________ Cell: _____________________

Email:____________________________ Relationship to patient: _______________ Number or years known: _______

How often do you see each other?_______________ Permission to share/obtain information Yes No

PRIMARY CARE PHYSICIAN: _____________________________ **PCP PHONE NUMBER:** ________________________

INSURANCE INFORMATION: (circle/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:________

CAUSE OF INJURY: SPORT _______________________ MOTOR VEHICLE ACCIDENT FALL ASSAULT

MILITARY STROKE ANEURYSM FALLING OBJECT WORK RELATED OTHER_____________________

SOCIAL HISTORY:

Handedness: Left Handed Right Handed Ambidextrous Job/occupation: _______________________________

Current Job Status? ☐ Full duty ☐ Temporary disability ☐ Permanent disability ☐ Applied or receiving disability

☐ Volunteer ☐ Light duty ☐ Modified duty/job restrictions are: ____

Do you feel you are able to work/go back to school: YES NO Why or why not: _____________________________

Years of education: High School (12) Some College (14) College (16) Post Graduate (20) Occupational Training

Retired Yes No year __________ Do you exercise regularly? Yes No Frequency_______________________

Number of children ______ Live with you? Yes No Visitation _________ Number of persons in home___________

Do you smoke cigarettes? Yes No Former Packs/day _________ Age started ________ Age stopped_________

Do you drink alcohol? Yes No Drinks/day ___________ Age started ____________ Age stopped_______________

Do you use narcotics? Yes No Previously Prescribed for you? Yes No Type _______________________

Do you use recreational drugs? Yes No Former Type/frequency ______________________________________

Hobbies: ____

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DEVELOPMENTAL HISTORY: Elementary to High School

Diagnosed learning disability/developmental delay Yes No ADD/ADHD Dyslexia Visual Auditory Writing

Special Education Yes No IEP **Therapies:** Speech Yes No Occupational Yes No Physical Yes No

Repeat one or more years of school? Yes No **Hearing problems** Yes No

Mood disorders Yes No **History of migraines/chronic headaches** Yes No **Vision problems** Yes No

Age start playing sports/type _________ ____________________ Concussions Yes No Times 1 2 3 4 5 6+

Loss of consciousness Yes No Times 1 2 3 4 5+ Longest Duration ______________

Longest symptoms lasted ☐ Days ☐ Weeks ☐ Months ☐ Years

Return to game Yes No Typically Immediate medical attention Yes No Usually By: ER Doctor Trainer

Return to school immediately Yes No Seizures observed Yes No Memory of event Yes No

Surgical History - Please list all operations you have had and approximate year

____ ____

____ ____

____ ____

____ ____

____ ____

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

____

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

Medication:	Dose:	Frequency:
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________
______________________	______________	______________

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MEDICAL HISTORY: Current/Recent

Constitutional:	***Circle One***	
Fever/chills	Yes	No
Weight loss >10 lbs	Yes	No
Excessive fatigue	Yes	No
History of Falls	Yes	No
Insomnia	Yes	No
Eyes:		
Wear glasses	Yes	No
Infections/redness	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Loss of vision	Yes	No
Ear, Nose, Throat& Mouth:		
Wear hearing aid(s)	Yes	No
Hearing loss	Yes	No
Ear pain/infections	Yes	No
Ringing in ears	Yes	No
Nose bleeds	Yes	No
Nasal congestion/drainage	Yes	No
Double or blurred vision	Yes	No
Loss or inability to smell	Yes	No
Skin disease (ulcers, cancer)	Yes	No
Difficulty swallowing	Yes	No
Balance (vertigo, spinning, etc.)	Yes	No
Cardiovascular:		
Chest pain or angina	Yes	No
High blood pressure	Yes	No
Irregular pulse/murmur	Yes	No
Heart attack (MI)	Yes	No
High cholesterol	Yes	No
Swelling in hands or feet	Yes	No
Awake unable to breath	Yes	No

Endocrine:	***Circle One***	
Diabetes	Yes	No
Thyroid disease	Yes	No
Excessive thirst/urination	Yes	No
Low blood sugar	Yes	No
Genitourinary:		
Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Difficult start or stop of stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Discharge (vaginal/penile)	Yes	No
Musculoskeletal:		
Broken bones	Yes	No
Arm or leg weakness	Yes	No
Arm or leg pain	Yes	No
Joint pain, swelling, stiffness	Yes	No
Arthritis	Yes	No
Difficulty walking	Yes	No
Neck/Back/Hip pain	Yes	No
Integumentary:		
Hives	Yes	No
Rash	Yes	No
Unusual moles	Yes	No
Neurological:		
Fainting spells or "black outs"	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Problems with memory	Yes	No
Disorientation	Yes	No
Difficulty with speech	Yes	No
Inability to concentrate	Yes	No

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CURRENT/ RECENT MEDICAL HISTORY (continued):

Respiratory:

Asthma	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Pneumonia	Yes	No
Bloody sputum	Yes	No
Bronchitis (chronic)	Yes	No
Apnea	Yes	No
COPD	Yes	No

Gastrointestinal:

Nausea	Yes	No
Vomiting	Yes	No
Bloody stool	Yes	No
Liver disease/jaundice	Yes	No
Bloating	Yes	No
Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Ulcers or gastritis	Yes	No
Loss of appetite	Yes	No

Dizziness	Yes	No
Numbness/tingling	Yes	No
Loss of sensation	Yes	No
Difficulty with balance	Yes	No

Psychiatric:

Anxiety	Yes	No
Depression	Yes	No
Mood swings	Yes	No
Substance abuse	Yes	No
Sleep disorder	Yes	No

Hemotologic/Lymphatic:

Anemia	Yes	No
Hemophilia	Yes	No
Blood transfusion	Yes	No
Persistent swollen glands/node	Yes	No
Hepatitis	Yes	No
HIV	Yes	No

Allergies/Immunologic:

Food, Inhalant (nasal) allergies	Yes	No
Autoimmune disease (i.e.,lupus)	Yes	No

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	☐	☐	
Depression	☐	☐		Dementia	☐	☐	
Epilepsy	☐	☐		Diabetes	☐	☐	
Parkinson's	☐	☐		Hypertension	☐	☐	
M.S	☐	☐		Neuropathy	☐	☐	
Lung disease	☐	☐		Migraine/Headaches	☐	☐	
Thyroid dis.	☐	☐		Psychiatric disorder	☐	☐	
Kidney disease	☐	☐		Other Neuro cond.	☐	☐	

Other conditions:____

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SYMPTOM SCALE

After a head injury or accident some people experience symptoms which can cause worry or nuisance. We would like to know if you NOW suffer from any of the symptoms given below. As many of these symptoms occur normally, we would like you to compare yourself now with before the accident. For each symptom, please circle the number closest to your answer.

Compared with before the accident, do you now (i.e., over the last couple of weeks) suffer from:

	Not Experienced At All	As Much As Usual	Mild Problem	Moderate Problem	Severe Problem
Headaches	0	1	2	3	4
Feelings of Dizziness	0	1	2	3	4
Nausea and/or Vomiting	0	1	2	3	4
Noise Sensitivity, easily upset with loud noise	0	1	2	3	4
Sleep Disturbance	0	1	2	3	4
Fatigue, tires easily	0	1	2	3	4
Irritable, easily angered	0	1	2	3	4
Feeling Depressed or Tearful	0	1	2	3	4
Feeling Frustrated or Impatient	0	1	2	3	4
Forgetfulness, poor memory	0	1	2	3	4
Poor Concentration	0	1	2	3	4
Taking Longer to Think	0	1	2	3	4
Blurred Vision	0	1	2	3	4
Light Sensitivity, easily upset by bright light	0	1	2	3	4
Double Vision	0	1	2	3	4
Restlessness	0	1	2	3	4
Discomfort, difficultly when reading/focusing on objects	0	1	2	3	4

Are you experiencing any other difficulties?

____

____

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Activity Rating Scale

Please indicate by ☑ if you are having difficulty now with the following activities compare to before your injury:

	Home	**Comments:**
	1. Preparing Meals	
	2. Housekeeping	
	3. Managing Finances	
	4. Listening to radio/watching T.V.	
	5. Following Conversations	
	6. Talking on the phone	
	7. Laundry	
	8. Gardening/Yard Work	
	9. Parenting/Caring for Family Members	
	10. Self Care	
	11. Entertaining	
	12. Other	

	Community	**Comments:**
	1. Driving	
	2. Following Directions/Using a Map	
	3. Attending Activities/Functions with children	
	4. Eating in Restaurants	
	5. Socializing in Groups	
	6. Grocery Shopping	
	7. Errands	
	8. Using ATM/Banking	
	9. Making/Keeping Appointments	
	10. Automobile Repairs & Maintenance	
	11. Using Public Transportation	
	12. Other	

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Please indicate by ☑ if you are having difficulty now with the following activities compare to before your injury:

	Work/School	Comments:
	1. Following Schedule	
	2. Initiating Tasks	
	3. Reading Complex Material	
	4. Remembering a Task List	
	5. Completing Work in a Timely Manner	
	6. Working in Presence of Distractions	
	7. Socializing in Groups	
	8. Making or Keeping Appointments	
	9. Getting Along with Co-workers	
	10. Maintaining Stamina	
	11. Composing Written Documents	
	12. Working on a Computer	
	13. Other	

Do you have dizziness, spinning or vertigo? Yes No

IF YES, please complete the following dizziness handicap inventory:

1. Does looking up increase your problem? Yes Sometimes No
2. Because of your problem, do you have difficulty getting into or out of bed? Yes Sometimes No
3. Do quick movements of your head increase your problem? Yes Sometimes No
4. Does turning over in bed increase your problem? Yes Sometimes No
5. Does bending over increase your problem? Yes Sometimes No

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Authorization to Release Medical Information

By signing below, you (or your designee) hereby authorize us to use, obtain or disclose information about yourself that is protected under federal law, for the sole purpose and duration of time you are under our care.

You may refuse or revoke this authorization. Please be advised however that any revocation will be effective only to the extent we have not already taken action in reliance to your authorization.

I authorize reports of my evaluation, treatments and any follow up evaluations to be sent or discussed with my referring/primary/consulting physician(s), as well as any other healthcare provider/professional associated with my care. I understand that the information obtained will become part of my medical chart and may be revealed to the claims examiner/adjuster responsible for my claim or to my insurance company as applicable.

I have read and understand the authorization above.

Patient Name: ___________________________

DOB: ___________________________

SS#: ___________________________

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

Patient Signature: ____ Date:__________________

Parent or Designee Signature:______________________________ Date:__________________

TO BE RELEASED:

☐ Billing ☐ Chart Notes ☐ Entire Chart

☐ Lab Results ☐ EEG / EMG/ NCV Report ☐ Imaging Results

☐ Other ____

TO BE RELEASED TO: PRIMARY CARE PHYSICIAN FOR REFERRALS FOR BILLING

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

____