LUCENT NEUROLOGY
A BETTER BRAIN- A BETTER YOU.

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New Patient Intake Form

Welcome to our Neurology Clinic! The nervous system is very complex; and to serve you better, it's important that we learn more about your past and present medical history. Thank you for filling out this form prior to your scheduled appointment.

Patient Name: _____ Preferred Name:_____

Street: _____ Apt: _____

City: _____ State: _____ Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Relationship Status: ☐S ☐M ☐W ☐D ☐Partnered

Sex assigned at birth: ☐Male ☐Female ☐Decline to State Handedness (R/L): _____

Preferred Pronouns: ☐He/Him ☐She/Her ☐They/Them

Who referred you to a Doctor? _____ Reason for referral: _____

Name of Primary Care Physician? _____ Facility: _____ City/Town: _____

Date of last physical examination: _____ Height: _____ Weight: _____

Please list any Non-Medication Allergies: (Animals, bees, chocolate, etc.) _____

_____

Please list all Medication Allergies: _____

_____

Please list any surgeries, please include the date of surgery: _____

_____

Please list (or attach a copy) of any current medications you are currently taking and what condition this medication is treating.

Medications: _____

_____

Nutritional Supplements: _____

_____

If you have any other medical records you would like us to have, i.e. x-rays, blood work, office notes, please inform the front desk staff. Please note that you will need to request records if they are from out-of-state.

Please describe in detail the problem or symptoms in which you're seeing the neurologist for. (symptoms you're having, what body part it affects, how often it happens, how severe, etc.)_____

_____

_____

When did this problem start? (date)_____

Is there anything specific that triggered this problem?

_____

_____

Does anything specific make this problem better or worse?

_____

_____

Describe any of the following treatments you've tried and if they worked for you:

Self-care routes tried: _____

Medications tried: _____

Therapy/ Therapies Tried: _____

Surgery: _____

Other treatments: (chiropractic, etc.) _____

_____

What diagnostic tests have been done so far? (e.g., blood work, MRI, EMG, EEG, etc.)

_____

_____

_____

Have you seen a Neurologist before for this problem? ___Y___N

If so, what was the Neurologist's name / location? _____

Date/ Dates you saw this doctor?_____

Do you experience any sadness or depression at this time? ___Y ___N

If Yes, please rate from 1-10, 1 being the least, and 10 being the worst. ____

Do you have any thoughts of suicide? ___Y ___N

Do you struggle with self-harm? ___Y ___N

What is your current occupation? _____ How many hours a day is your shift? _____

Have you ever smoked or chewed tobacco?

__Never

__No, I quit (include quit date) _____

__Yes, about how much per day? _____

How much alcohol do you consume per week? _____

How much caffeine do you intake per week? _____

Do you exercise? ___Y __N What forms and how often, if yes? _____

Do you have a regular sleep pattern? ___Y ___N About ____ Hours per night

Do you experience nightmares __Y __N ___Nightly

Please list any family history that may be helpful for the Neurologist: (Indicate which family member: Father, Mother, Sister, Brother, Paternal Grandparent (PG), or Maternal Grandparent (MG)

_____

_____

_____

Are you able to drive a motor vehicle? ____Yes ____No ____ Partially

Are you able to work or study? ____Yes ____No ____ Partially

Are you able to sustain a close relationship with someone? ____Yes ____No ____ Partially

Do you feel safe in your current state of mind? ____Yes ____No ____ Partially

Please CIRCLE if you've ever had any of these Neurological or Muscle Illnesses:

Stroke TIA	Seizures	Concussion
Carotid Stenosis	Brain Aneurysm	Spells or loss of consciousness
Multiple Sclerosis	Bleeding in or Around the brain	Brain Radiation
Parkinson's Muscle diseases	Brain Surgery	Vision Loss
Genetic/ Inherited Neurological Diseases	Brain Tumor	Optic Neuritis
Neuromas or Neurofibromas	Meningitis	Sleep Disorders
Altimeters or Dementia	Head Injury	Problems with walking
Heart Attack	Tremors	Balance Difficulties
Heart Murmur	Neuropathy	Post Covid
Arthritis	Heart Surgery	Any other conditions not listed: _____
Fibromyalgia	Pneumonia	_____
Osteoporosis	Irritable Bowel (IBS)	_____
Stroke	Frequent Ulcers	_____
Head injury	Prostate disease	_____
Nervous Breakdown	Endometriosis	_____
Depression	Insomnia	
Anxiety	Schizophrenia	
ADHD or ADD		

Please check the appropriate box(es) to indicate your current symptoms: If a symptom is severe, please put a circle around the check mark.

GENERAL	Y	N	STOMACH	Y	N	NEUROLOGICAL	Y	N
Headache			Trouble swallowing			Seizures		
Lethargy/ Tiredness			Heartburn/ Indigestion			Memory Loss		
Chills/ Night Sweats			Change in bowel habits			Confusion		
Fever			Loose stools/diarrhea			Trouble speaking		
Fainting			Bloody stools			Trouble swallowing		
Weight loss			Frequent stomach pain/ aches			Unsteady gait/ trouble walking		
Dizziness			Vomiting blood			Arm/ leg weakness		
EAR/ NOSE/ THROAT			Constipation			Arm/ leg tingling		
Deafness			KIDNEY/ PROSTATE			Arm/ leg numbness		
Noise/ ringing in ears			Frequent voiding			PSYCHIATRIC		
Sore throat or tongue			Burning urination			Panic attacks		
Congestion/ sneezing			Pus/ blood in urine			Cry often		
Sinus pain/ trouble			Trouble starting urinating			Worry a lot		
Nose bleeds			Constant urge to urinate			Considered suicide		
Hoarse voice			Loss of urine control			Loss of interest in eating		
Dental problems			Sexual difficulty			Tension in mind or body		
HEART			SKIN			Loss of energy		
Chest pain with exertion			Rashes			Loss of motivation		
Racing heart/ palpitations			Constant/ frequent acne			Nightmares (check Y & N both if they're frequent)		
Irregular heartbeat/ AFIB			Sores			ENDOCRINE		
High blood pressure			Dry/ Oily skin			Unwanted weight		
Swollen feet/ ankles			Hair growth/ loss			Change in skin		
Chest pain			MUSCLE/ BONES			Breast discharge		
LUNG			Back pain			Excessive thirst		
Shortness of breath			Neck pain			Excessive tiredness		
Coughing up phlegm			Aching muscles/ joints			Excessive want to eat		
Coughing up blood			HEMATOLOGIC/BLOOD			BREAST/ MENSTRUAL		
Wheezing/ coughing			Enlarged glands			Are you pregnant?		
Dizziness with exertion			Bleed/ bruise easily			Irregular menstrual period		
SLEEP			OTHER (write in)			Lumps in breast(s)		
Snores								
Breath holding/ gasping								
Legs twitch								

Please Indicate Your Goals/ Hopes of Neurofeedback Therapy *(Please number your goals in order of importance, 1 being the most important.)*