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SELSON CLINICS NEUROLOGY
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INITIAL NEURO EVALUATION 2023

PATIENT'S PERSONAL INFORMATION

DATE:

REFERRED BY:

PATIENT NAME:

GENDER: **DATE OF BIRTH:** **SOC SEC NUMBER (last 4 numbers)::** **MARITAL STATUS:**

ADDRESS:

STREET ADDRESS:

CITY/STATE/ZIP:

CELLPHONE: _____HOME PHONE: _____EMAIL_____

NEXT OF KIN:

RELATIONSHIP TO YOU: **PHONE NUMBER:**

NAME OF PERSON TO CALL IN CASE OF EMERGENCY:

PHONE NUMBER OF PERSON TO CALL IN CASE OF EMERGENCY:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:

ID#: **PHONE NUMBER:**

SUBSCRIBER NAME: **SUBSCRIBER DATE OF BIRTH:**

SECONDARY INSURANCE NAME:

ID#: **PHONE NUMBER:**

SUBSCRIBER NAME: **SUBSCRIBER DATE OF BIRTH:**

TO PAY BENEFITS TO SELSON CLINICS , INC.

In order to control the cost of billing, we request that our charges for office visits or any co-pays be paid in full, before each visit.
The responsibility for paying for the services provided, lies with you the patient, even if you have insurance coverage for our inpatient and outpatient health care services. Some companies pay fixed allowances for certain procedures, and it is your responsibility to pay for any deductible amount or any other balances not paid for by your insurance.
I hereby assign to Selson Clinics Inc., all medical and laboratory benefits rendered by Selson Clinics Neurology, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health care plans. This assignment (responsible party) is responsible for all charges whether or not paid by insurance. I hereby authorize the assignee, Selson Clinics Neurology, to release all information necessary to secure payment.

RESPONSIBLE PARTY SIGNATURE:_____
RESPONSIBLE PARTY NAME:_____DATE:

PLEASE LIST THE NAMES OF THE PHYSICIANS OR OTHER AUTHORIZED PERSONS TO WHOM WE SHOULD SEND COPIES OF THIS INITIAL ASSESSMENT, FOLLOW-UP ASSESSMENTS AND LAB REPORTS.

PLEASE SUPPLY ALL REQUESTED INFORMATION.

PHYSICIAN
Name:
Phone: **Fax:**

PHYSICIAN

Name:
Phone: **Fax:**

PATIENT'S SIGNATURE: **DATE:**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I acknowledge that I have received a copy of Selson Clinics' Notice of Privacy Practices. This notice describes how medical information about me (or the child/patient named below) may be used and disclosed and how I can get access to this information.

Print Name:

If not signed by patient, please indicate relationship:
[ ] parent/guardian of minor patient
[ ] guardian/conservator of incompetent patient
[ ] beneficiary/personal representative of deceased patient

Signature: _____

Relationship: **DATE:**

PRESCRIPTION DRUG HISTORY

PATIENT NAME:
I am giving my permission for Dr. McPherson and his staff at Selson Clinics Neurology, to electronically review my prescription history, including but not limited to narcotics, benzodiazepines, psychotropic and stimulant drugs

PATIENT'S SIGNATURE: _____ **DATE:**

SELSON CLINICS NEUROLOGY
SELWYN-LLOYD M^{c} PHERSON MBBS, MD.

DATE:

SECTION I – BIOGRAPHICS

PATIENT NAME: **GENDER:** **DATE OF BIRTH:**

EDUCATION: GRADE: HIGH SCHOOL DIPLOMA: ☐ ASSOC. DEGREE: ☐ TERTIARY DEGREE: ☐

PERSONAL PHYSICIAN NAME:

Name: **Fax:** **Phone:**

Have you been seen by another NEUROLOGIST in the past year:

If so, whom:

Reason why:

SECTION II

CHIEF COMPLAINT

SECTION III

BRIEF HISTORY OF PRESENT ILLNESS

SECTION IV --- REVIEW OF SYSTEMS

Circle: Y= YES OR Circle: N= NO

SKIN

Do you have any lumps in your skin? Y/N.

Are any moles getting larger or changing in color?: Y/N.

Changes in hair or nails?: Y/N..

Do you have dry skin?: Y/N.

CONSTITUTIONAL

Has your weight changed more than 10 pounds in the last year:? Y/N.

If so, how much? Loss: lbs.

Gain: lbs.

Do you suffer from night sweats: Y/N..

Do you wear glasses?: Y/N.

Last eye examination:

Right-handed?: Y/N.

Left-handed: Y/N.

Ambidextrous: Y/N.

EAR NOSE AND THROAT

Have you or your family noticed your hearing has changed: ? Y/N.

Do you frequently have ringing in the ears?: Y/N.

Are you often hoarse?: Y/N.

Do you have sinus trouble, if so, at any particular time of the year or location: ? Y/N.

RESPIRATORY

Do you have any hay fever or asthma?: Y/N.

Do you have a chronic cough?: Y/N.

Are you bothered with shortness of breath on exertion, at night, or at rest:? Y/N.

CARIOVASCULAR

History of heart disease?: Y/N.

Do you notice chest pain, Y/N. **discomfort, or tightness?:** Y/N.

If so:

a. How long does it last? :

b. Is it caused by exertion? ; Y/N.

c. Is it related to sleep, cold air, emotional stress, or food ingestion?: Y/N.

Do you notice an Irregular or rapid heartbeat? If so: Y/N.

Do you become lightheaded, or lose consciousness?: Y/N.

Do you suffer from hypertension:? Y/N.

If yes; how long:

Do you suffer from diabetes:? Y/N.

If yes; how long:? Y/N.

GASTROINTESTINAL

Any trouble swallowing?: Y/N.

Are you bothered with heartburn?: Y/N.

Are you bothered with frequent abdominal pain?: Y/N.

Do you complain of nausea:? Y/N.

Do you complain of vomiting: Y/N.

Do you complain of abdominal bloating: Y/N.

Have you had any black stools?: Y/N.

Have you passed blood in your stool?: Y/N.

Have you had a change in bowel habits? Y/N.

With diarrhea:? Y/N.

With constipation: Y/N.

Have you passed blood with one or more bowel movements?: Y/N.

GENITOURINARY

Do you wake up at night to urinate:? Y/N.

How many times:

Have you had a kidney or bladder infection?: Y/N.

Have you had problems emptying your bladder completely?: Y/N.

Have you been bothered with burning on urination?: Y/N.

Have you noticed blood in your urine?: Y/N.

Are you having any problems with sexual function:? Y/N.

If so, what:

NEUROLOGICAL

Do you have frequent or periodic headaches:? Y/N.

Does your vision blur:? Y/N.

Do you see double:? Y/N.

Do you see haloes about a light? Y/N.

Do you lose your balance or fall? Y/N.

Do you have numbness:? Y/N.

Do you have tingling:? Y/N.

Do you have weakness:? Y/N.

Do you have tremors:? Y/N.

Do you suffer from poor memory:? Y/N.

Poor concentration:? Y/N.

MUSCULOSKELETAL

Do you suffer from back pain? If so:? Y/N.

Does it go down your buttock, thigh, calf, or foot?: Y/N.

Which side: LEFT RIGHT BOTH

Have you noticed pain in the legs when walking?: Y/N.

If so:

Does it leave immediately with rest:? Y/N.

Have you noticed swelling of the feet, ankles, or hands?: Y/N.

Do you have muscle weakness in the legs?: Y/N.

Do you suffer from leg cramps?: Y/N.

Do you have joint pain, redness, or swelling?: Y/N.

MISCELLANEOUS

Are you frequently tired (sleepy:? Y/N.

You frequently fatigued (lack of energy:? Y/N.

Are you often nervous:? Y/N.

Do you feel irritable?: Y/N.

Do you have any problems with depression:? Y/N.

Do you have any problems with anxiety:? Y/N.

Did you ever need professional help for alcoholism:? Y/N.

Did you ever need professional help for substance abuse:? Y/N.

Did you ever need professional help for mental health problems:? Y/N.

Has your blood cholesterol or triglycerides been elevated?: Y/N.

Do you follow a low cholesterol diet or any other special diet? Y/N.

SECTION V –-- PAST MEDICAL/ SURGICAL/ ALLERGY- DRUG HISTORY/ SLEEP

COVID 2020 – 2022

Circle: Y= YES OR Circle: N= NO

COVID INFECTION: Y/N
COVID VACCINATION: Y/N

COVID BRAIN FOG: Y/N
Inattention: Y/N
Decision-making problems: Y/N
Language problems: Y/N
Memory problems: Y/N

LONG COVID: Y/N
Anxiety: Y/N
Depression: Y/N
Sleep Disorder: Y/N
Fatigue: Y/N

LIST MEDICAL ILLNESSES/INJURIES

LIST SURGERIES/OPERATIONS

SLEEP HISTORY **Circle: Y= YES OR Circle: N= NO**

What time do you go to bed:? Y/N.

How long does it take you to fall asleep:

Do you awaken during the night: Y/N. **Why?**
If so, how often:? Y/N. **Total time awake each night:**
Do you snore during sleep: Y/N. **Do you awaken short of breath during sleep:?** Y/N.
Is your mouth dry on awakening:? Y/N. **Toss & turn in bed?** Y/N.
Time awake in the morning: AM. **Time out of bed after awakening:**
Do you feel refreshed on awakening:? Y/N. **Do you feel tired on awakening:?** Y/N.
Do you nap during the day Y/N. **At what time: For how long: Minutes/Hours**
Any other sleep problems:

MEDICATION HISTORY

(Include all over-the-counter drugs including vitamins, antacids, and aspirin products)

NAME OF MEDICATION	DOSE	FREQUENCY	CONDITION

NAME OF OVER-THE-COUNTER DRUGS	DOSE	FREQUENCY	CONDITION

DRUG ALLERGIES

PHARMACY **FAX** **PHONE:**

DRUG HISTORY

ILLEGAL DRUGS USED IN THE LAST FIVE (5) YEARS

Y/N.

SECTION VI --- SOCIAL HISTORY

Circle: Y= YES OR Circle: N= NO

EXERCISE

Do you have a regular exercise program: Y/N.
If so, how often=
If so, what activity:

SMOKE

Do you smoke now: Y/N.			
If so, Cigarettes/day=	**Cigar/day=**	**Chew Pouches/week=**	**Total years smoking=**

If you do not smoke now, did you previously smoke: Y/N.	
When did you stop smoking=	**Total years smoking=**

ALCOHOL

Do you consume alcohol? Y/N.		
If so, what type\\\ Liquor Drinks/week=	**Wine Glasses/week=**	**Beer Bottles/cans (12 oz.)week=**

CAFFEINE

Do you drink coffee?: Y/N. **(8 oz)/day=**
Do you drink caffeinated soda? Y/N.
Do you drink caffeinated tea? Y/N.

SECTION VII --- FAMILY HISTORY –LIST MEDICAL PROBLEMS

Circle: Y= YES OR Circle: N= NO

ADHD: Y/N	**Emphysema:** Y/N	**Hypertension:** Y/N	**Parkinson's:** Y/N
Allergies: Y/N	**Epilepsy:** Y/N	**Kidney disease:** Y/N	**Sleep apnea:** Y/N
Alzheimer's: Y/N	**Fainting spells**	**Liver disease:** Y/N	**Sleep disorders:** Y/N
Anxiety: Y/N	**Fatigue:** Y/N	**Lupus:** Y/N	**Snoring:** Y/N
Arthritis: Y/N	**Fibromyalgia:** Y/N	**Mental illness:** Y/N	**Sleep disorders:** Y/N
Cancer: Y/N	**Gallbladder disease:** Y/N	**Migraine:** Y/N	**Stroke:** Y/N
COPD: Y/N	**Gout:** Y/N	**Multiple sclerosis:** Y/N	**Tremor:** Y/N
Depression: Y/N	**Hearing Loss** Y/N.	**Neuropathy** Y/N.	**Vascular disease:** Y/N
Diabetes: Y/N	**Heart attack:** Y/N	**Pancreatitis:** Y/N	

OTHER COMMENTS