South Atlanta Neurology & Spine Clinic, P.C.

Initial Clinical Data Form

Please fill out the following questionnaire as best as you can. This will help us evaluate your medical condition more effectively and thoroughly. Your cooperation will be greatly appreciated.

Patient Name:_____**DATE**:_____

Who referred you to our clinic (if no one, write "self-referral")?_____

Who is your primary care doctor? _____

AGE:_____ **Which hand is dominant**? Right / Left / Equal **GENDER**: Male / Female

RACE: White / African American / Asian / Indian / Native American/ Hispanic / Other

Person filling out paperwork (if not patient) _____ **(relationship)** _____

Is your visit related to an accident or injury? Yes / No **If so** (circle one) : Work Related / Auto / Other

Have you been seen by a Neurologist or Pain Management in the past year? Yes / No

Have you been in the hospital recently? Yes / No

Did you bring any records, MRIs or CTs with you? Yes / No

Please list the **symptoms you are being seen for today (LIMIT 5 SYMPTOMS). List the symptoms highest priority to least. (Do not give details)**

1._____

2._____

3._____

4._____

5._____

Are you currently experiencing any of the following symptoms that were not listed above? Please circle all that apply:

Fever
Weight loss
Weight gain
Fatigue
Sleep disturbance
Memory loss
Sad feeling
Hallucination
Blurry vision
Low back pain
Double vision
Swallowing difficulties
Slurry Speech
Headache
Dizziness
Hearing loss
Ringing in the ears
Sinus/nasal congestion
Shortness of breath
Chest pain
Abdominal pain
Nausea/vomiting
Diarrhea
Urinary incontinence
Stool incontinence
Changes in menstrual cycle
Weakness
Numbness
Neck pain
Arm pain
Leg Pain

PAST MEDICAL HISTORY: **If you have **any** of the following medical conditions, please **circle them and write the year you were diagnosed with the conditions**.

Stroke	Lung Disorder	High Blood Pressure
Seizure	Asthma	Heart Attack
Head Trauma	Emphysema	Kidney Disease
Diabetes	Autoimmune Disorder	Liver Disorder
Arthritis	Sinusitis	Stomach/GI Disease
Spine Disorder (what type)	Skin Disease	Sleep Disorder
Blood Disorder	High Cholesterol	Depression
Blood Vessel Disorder	Heart Disease	Cancer(what type)

LIST ANY OTHER medical conditions that were not listed above

_____

_____

List ANY surgeries you've previously had and the year they were preformed.

_____

_____

_____

List ANY medication you are currently taking (including vitamins and supplements), how often you take it, and the dose of the medication.

_____

_____

_____

_____

_____

Are you allergic to any medications? Yes / No **If so, what medications?**_____

_____

SOCIAL HISTORY: Occupation:_____ Marital Status:_____

Tobacco use: Previous use / Current use / Never

If previous, when did you quit?_____

If current, how often?_____pack/can per day

Alcohol: Regular / Social / Occasional / Rare / Never

Regular use: _____times per week

Any history of illegal drug use? Yes / No If yes, what substances?_____

current use / past use / experimented with

FAMILY HISTORY: Do any of the following medical diseases affect any of your family members, not including yourself, spouse or step-parents? **Circle them and list family member** (F=Father M=Mother S=Sister ect.)

Stroke	Asthma	Heart Attack
Seizure	Autoimmune Disorder	Kidney Disease
Bone Disease	Sinusitis	Liver Disorder
Arthritis	Skin Disease	Stomach/GI Disease
Spine Disorder	High Cholesterol	Sleep Disorder
Blood Disorder	Heart Disease	Depression
Blood Vessel Disorder	Lung Disorder	Diabetes
Emphysema	High Blood Pressure	Cancer (what type)