CARE *that*
CHANGES LIVES.

NEW PATIENT FORM

Patient Information

Patient Name: ____ Patient Gender: ☐ Male ☐ Female
Last First MI

Patient Date of Birth: ____/____/______ Primary Care Physician: ______________________________

Caregiver/Contact Person Information

Name of Person Completing Form: ______________________________

Relationship to Patient: ______________________________

Phone Number: ____________________ Email Address: ______________________________

Patient Demographic Information

Highest Level of education completed?
- ☐ 9 years or less Years: ________
- ☐ 10 years
- ☐ 11 years
- ☐ High school graduate
- ☐ GED
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Graduate degree

Did the patient receive learning support?
- ☐ Primary school
- ☐ Secondary school

Current Employment Status:
- ☐ Full time/Part time
- ☐ Retired
- ☐ Disabled

Major Lifetime Occupation:
- ☐ Professional
- ☐ Executive
- ☐ Clerical
- ☐ Sales
- ☐ Manual trade
- ☐ Factory
- ☐ Homemaker
- ☐ Never worked

Marital Status:
- ☐ Married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated
- ☐ Never married
- ☐ Cohabitating

Current Living Arrangement:
- ☐ Alone
- ☐ With spouse
- ☐ With other relative
- ☐ Retirement community
- ☐ Assisted living facility
- ☐ Nursing facility

Is the patient considered:
- ☐ Right handed
- ☐ Left handed

Children?
- ☐ Yes - #________
- ☐ No

Patient Background Information

Has the patient ever had neuropsychologic testing? ☐ Yes ☐ No

Does the patient have a health care proxy? ☐ Yes ☐ No

Why is the patient seeking an evaluation in our clinic? ______________________________

____

____

____

Please check the box next to the problems that the patient is experiencing. If they do not have a particular problem, please leave it blank.

- ☐ Memory troubles
- ☐ Speaking problems
- ☐ Knowing date/time
- ☐ Writing problems
- ☐ Reading problems
- ☐ Numbers/calculating
- ☐ Concentration
- ☐ Planning/organization
- ☐ Getting lost
- ☐ Recognizing familiar people
- ☐ Starting & finishing a project
- ☐ Change in personality
- ☐ Being inappropriate
- ☐ Disinhibited/overly friendly
- ☐ Change in sex drive
- ☐ Change in food preferences
- ☐ Unaware of other's emotions
- ☐ Lack of concern for appearance
- ☐ Shorter attention span
- ☐ Reduced drive/Lack of motivation
- ☐ Lacking social graces
- ☐ Easily distractible
- ☐ Depression/feeling down
- ☐ Anxiety/nervousness
- ☐ Lack of interest in activities
- ☐ Lack of energy
- ☐ Hallucinations
- ☐ Suicidal thoughts
- ☐ Change in sleep pattern
- ☐ Change in appetite

Please rate the patient's ability to perform the following tasks by checking the appropriate box.

Activity	**Able to do without assistance**	**Needs some assistance**	**Unable to do**
Using the telephone			
Shopping			
Cooking/food preparation			
Household chores			
Laundry			
Managing medication			
Managing money/finances			
Bathing/personal grooming			
Dressing (including selection clothing)			
Bathroom functions			
Taking part in activities outside of the home			

Please indicate whether the patient has had any of the following by checking "Yes" or "No".

	Yes	**No**
Hallucinations (see or hear things others don't)?		
Violent dreams that they act out in their sleep		
Times when their flow of ideas seems disorganized, unclear or not logical		
Drowsiness during the day despite getting enough sleep at night		
Stars off into space for long periods of time		

Patient Medical History

Please indicate whether the patient has had any of the following by checking "Yes" or "No".

Medical Condition	Yes	No
Stroke		
Mini-stroke or "TIA"		
Bleeding or hemorrhage in the brain		
Head injury/concussion		
Heart disease/heart attack		
Parkinson's disease		
Seizure		
Diabetes or pre-diabetes		

Medical Condition	Yes	No
Elevated cholesterol		
High blood pressure		
Depression		
Anxiety		
Bipolar disorder		
Thyroid problem		
ADD/ADHD		
Learning disability		

Please list any other medical conditions or surgeries here: ______________________________

____

____

____

Tobacco Use

Does the patient currently or has he/she ever smoked regularly? ☐ Yes ☐ No

If he/she did smoke in the past, how many packs per day? ____________

How old was the patient when he/she started? ____________

If the patient quit, how old was he or she? ____________

If the patient still smokes, how many packs per day? ____________

Alcohol Use

How much alcohol does the patient drink currently?

☐ None

☐ Fewer than 4 drinks per week

☐ 5-14 drinks per week

☐ More than 14 drinks per week

Known drug allergies and reactions: ______________________________

____

____

____

Medications: Please list everything, including vitamins, over-the-counter medications, herbals, etc. Attach an additional sheet if necessary.

Name	Strength (i.e., milligrams)	Dosage (#of times per day)	Reason for medication

Pharmacy Name: ______________________________ Location: ______________________________

Current Symptoms: Please circle if the patient is experiencing any of the following symptoms.

General:	Weight loss/gain	Appetite change	Fever/chills	Other:__________
Head/Eyes:	Headache	Loss of vision	Blurred/double vision	Other:__________
Ear/Nose/Throat:	Hearing Change	Drainage	Pain	Other:__________
Heart/Chest:	Chest pain	Heart palpitations	Fainting	Other:__________
Respiratory:	Shortness of breath	Wheezing	Cough	Other:__________
Gastrointestinal:	Stomach pain/nausea	Constipation	Heart burn	Other:__________
Urinary:	Leaking urine	Difficulty urinating	Frequent urination	Other:__________
Musculoskeletal:	Joint pain	Back/neck pain	Muscle cramps	Other:__________
Endocrine:	Excessive sweating	Dry mouth	Excessive thirst	Other:__________
Skin:	Rash	Bruises	Moles/lumps	Other:__________
Reproductive:	Erectile dysfunction	Change in menstrual cycle	Pain with intercourse	Other:__________

Family Medical History

Please provide the following information about the patient's **biological/blood relatives only.**

Family Member	Alive	Deceased	Current age/Age when deceased	Medical problems/Cause of death
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Mother				
Father				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Sister/Brother				
Daughter/Son				
Daughter/Son				
Daughter/Son				
Daughter/Son				
Daughter/Son				

Please note any biological relatives with neurodegenerative disease (including Alzheimer's disease, fronto-temporal dementia, other types of dementia, Parkinson's disease, ALS (Lou Gehrig's disease), multiple sclerosis, etc.) and their diagnosis. ______________________

Please add anything else that may help us better serve the patient. ______________________

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