UNITED NEUROSCIENCE INC

9330 Stockdale Hwy, Ste 200, Bakersfield, CA 93311

NEW PATIENT DEMOGRAPHIC & NEUROLOGY INTAKE FORM

Please complete all applicable sections. Bring your current medication list, insurance cards, identification, and relevant medical records or test results.

PATIENT INFORMATION

Patient First Name: _____ Patient Last Name: _____

Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____

Apt/Unit: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

INSURANCE INFORMATION

Primary Insurance Name: _____ Primary Insurance ID #: _____

Secondary Insurance Name: _____ Secondary Insurance ID #: _____

PHARMACY & PRIMARY CARE

Preferred Pharmacy Name: _____ Pharmacy Phone (optional): _____

Pharmacy Address: _____ Primary Care Physician: _____

CURRENT MEDICATIONS

Please list all prescription medications, over-the-counter medications, vitamins, and supplements.

Medication	Dosage	Frequency

ALLERGIES

Medication Allergies: _____ Reaction: _____

Food Allergies: _____ Reaction: _____

Other Allergies: _____ Reaction: _____

COMMUNICATION NEEDS

Do you need a translator/interpreter for this appointment? ☐ Yes ☐ No Language: _____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Phone: _____

NEW PATIENT HISTORY

SOCIAL & MEDICAL HISTORY

Do you smoke? ☐ Never ☐ Former ☐ Current If current/former, packs per day: _____

Do you drink alcohol? ☐ No ☐ Yes Frequency: _____

Diabetes? ☐ No ☐ Yes High Cholesterol? ☐ No ☐ Yes

High Blood Pressure? ☐ No ☐ Yes Other significant condition: _____

Height: _____ Weight: _____

FAMILY HISTORY

Please indicate whether the condition applies to the family member and provide details if known.

FATHER ☐ Living ☐ Deceased ☐ Unknown

Cancer: ☐ No ☐ Yes Details: _____

Heart Disease: ☐ No ☐ Yes Details: _____

Alzheimer's Disease: ☐ No ☐ Yes Dementia: ☐ No ☐ Yes

Depression: ☐ No ☐ Yes Other Neurological Condition: ☐ No ☐ Yes

Other/Additional Family History: _____

MOTHER ☐ Living ☐ Deceased ☐ Unknown

Cancer: ☐ No ☐ Yes Details: _____

Heart Disease: ☐ No ☐ Yes Details: _____

Alzheimer's Disease: ☐ No ☐ Yes Dementia: ☐ No ☐ Yes

Depression: ☐ No ☐ Yes Other Neurological Condition: ☐ No ☐ Yes

Other/Additional Family History: _____

PREVIOUS NEUROLOGY CARE

Have you previously seen a neurologist? ☐ No ☐ Yes

If yes, neurologist's name: _____ When (approx.): _____

REASON FOR TODAY'S NEUROLOGY VISIT

Why are you being seen by the neurologist today?

_____

_____

_____

_____

IMAGING / DIAGNOSTIC TESTING — LAST 12 MONTHS

Check any test/service you have had and provide the approximate date and facility/location.

Test	Had Test?	Date	Facility / Location
MRI	☐ Yes ☐ No		
CT Scan	☐ Yes ☐ No		
DaTscan	☐ Yes ☐ No		
PET Scan	☐ Yes ☐ No		
EMG	☐ Yes ☐ No		
EEG	☐ Yes ☐ No		
Physical Therapy	☐ Yes ☐ No		
Home Health	☐ Yes ☐ No		

LABORATORY TESTING — LAST 6 MONTHS

Have you had any laboratory tests within the last 6 months? ☐ No ☐ Yes

If yes, approximate date(s): _____ Facility / Location: _____

Additional details (optional): _____

PATIENT SIGNATURE

I certify that the information provided on this form is true and complete to the best of my knowledge. I understand that I should notify the office if any information changes.

Patient Signature: _____ Date: _____