

CENTER FOR NEUROLOGICAL DISORDERS, P.A.

1319 Summit Avenue, Suite 200

Fort Worth, TX 76102

(817) 336-0551 1-888-339-9629 FAX (817) 339-3940

NEUROSURGERY

GEORGE F. CRAVENS, M.D., F.A.C.S.

LEE KESTERSON, M.D.

GREGORY A. WARD, M.D.

J. KEVIN KAUFMAN, M.D.

GREGORY H. SMITH, D.O., F.A.C.O.S.

ANESTHESIA & PAIN MANAGEMENT

PETER LEONARD, M.D.

PHYSICAL MEDICINE AND REHABILITATION

SANKAR PEMMARAJU, D.O.

NEUROLOGY

G.A. GUZMAN, M.D.

THOMAS TRESE, D.O., F.A.C.N.

PSYCHOLOGY

ANDREW HOUTZ, Ph.D.

PATIENT REGISTRATION SHEET

Date _____

Patient Name _____
Last First MI

Address _____
Street Address City State Zip

Date of Birth _____ Age _____ Social Security# _____

Marital Status _____ Sex _____ Telephone (____) _____

Employer _____

Occupation _____ Business Phone (____) _____

Who can we contact in case of emergency of if we need to change an appointment and cannot reach you?

Name _____ Relationship _____

Address _____ Phone (____) _____

Referring Physician _____ M.D./D.O.

Address _____

Were you injured on the Job? _____ Date of Injury/accident _____

Were you injured in a car wreck? _____ Date of wreck _____

Name of Attorney _____

Address _____ Phone (____) _____

INSURANCE INFORMATION:

Primary Insurance Name _____

Group# _____ Policy# _____

Subscriber's Name _____

Relationship _____

Secondary Insurance Name _____

Group# _____ Policy# _____

Subscriber's Name _____

Relationship _____

Workman's Comp Carrier Name _____

Group# _____ Policy# _____

Subscriber's Name _____

Relationship _____

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MEDICAL HISTORY

How were you Injured?

Last working day _____ Are you under a physician's care at this time _____ If yes, name and address _____

Have you had any X-rays? _____ Where? _____

Any other treatment? _____

Family Doctor _____ M.D. / D.O.

Address _____

CHIEF COMPLAINT:

HEAD:

Unconscious _____

Headache: Where? _____

How Long? _____

How frequent? _____

Vision or Hearing Changes _____

Fainting or Dizziness _____

Numbness or Tingling _____

Other _____

BACK AND NECK:

Back and Neck Pain _____

Leg/Arm Pain _____

Numbness and Tingling _____

Urinary Incontinence _____

Weakness _____

Improving _____

Worsening _____

Other _____

PAST HISTORY:

1. List all allergies to food drugs _____

2. Surgeries: Type _____

3. Chronic Diseases _____

4. Serious Medical diseases requiring hospitalization (Dates) _____

NAME: _____

DATE: _____

5. All medications being taken now, including over-the-counter medications, dosage, and who prescribed: _____

6. Immunizations _____

FAMILY HISTORY:

	Age	Living	Deceased	Health Problems
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Children	_____	_____	_____	_____

Circle any disease that “runs in the family”: Tuberculosis , Diabetes , Cancer , Heart Disease , Kidney Disease , Mental Disease , Stroke.

SOCIAL HISTORY:

Alcohol (How much; how often?) _____
Caffeine (How much; how often?) _____
Tobacco (How much daily?) _____
Drug Use YES _____ NO _____

REVIEW OF SYSTEMS: (Past and Present)

Circle if you have had:

HEENT: Failing vision , Blurring or vision , Watering or eyes , Itching of eyes , Trouble with sinus , Frequent colds , Nose bleeds , False teeth , Bleeding gums , Hoarseness.

RESPIRATORY SYSTEM: Asthma , Emphysema , Bronchitis , COPD.

CARDIOVASCULAR SYSTEM: Angina , Blocked arteries , Palpitations , Heart Attack , High blood pressure Heart failure , Irregular heartbeat.

GASTROINTESTINAL SYSTEM: Is you appetite good? _____ Do you have or have you ever had an ulcer? _____ Have you had a change in your bowel habits in the last few months? _____ Do you have bloody stools? _____ Have you ever had jaundice or hepatitis? _____

GENITOURINARY SYSTEM: Have you ever had blood in your urine? _____ Have you been told that you have albumin in your urine in the past? _____ Do you have trouble getting your stream of urine started? _____ Have you had surgery on your prostate gland? _____ Have you had venereal disease? _____ Do you have or have you had impotence/sexual dysfunction? _____ Do you have incontinence? _____

NAME: _____

DATE: _____

OBSTETRICAL HISTORY: How may pregnancies? _____ Miscarriages? _____ Abortions? _____
Full term deliveries? _____ How many children? _____ Age of children,
living and incontinence? _____

BREASTS: History of breast cancer? _____ Have you had discharge from nipples? _____
Soreness? _____ Lumps? _____ Biopsies? _____

MUSCULOSKELETAL: Rheumatoid arthritis? _____ gout? _____ other? _____

ENDOCRINE: Diabetes? _____ Thyroid disease? _____

PSYCHIATRIC: *Circle if you have had:* Depression , Schizophrenia , Manic – depressive disorder ,
Bipolar disorder , Learning disorder.

Circle if you have / ever had or now have:

HEMOTOLOGICAL/ONC: History of cancer , anemia , sickle-cell disease , neoplasms , other _____.

NEUROLOGICAL HISTORY:

Previous neck injury	_____ NO	If YES, when? _____
Previous back injury	_____ NO	If YES, when? _____
Previous head injury	_____ NO	If YES, when? _____
Stroke	_____ NO	If YES, when? _____
Hemorrhage	_____ NO	If YES, when? _____
Seizures	_____ NO	If YES, when? _____
Loss of consciousness	_____ NO	If YES, when? _____
Visual disturbances	_____ NO	If YES, when? _____

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NAME: _____

DATE: _____

PLEASE CIRCLE IF YOU ARE TAKING ANY OF THE FOLLOWING

ECHINACEA

GARLIC

GINGER

GINKO BILOBA

GINSENG

ST. JOHN'S WORT

METABOLIFE

OR ANYTHING SIMILAR IE:

METABOLIFT, METABOLOSS, MEABOLIZE

KAVA KAVA

FEVERFEW

EPHEDRA