Center Neurorestoration Associates
5448 Ave de Las Robles, Suite B Visalia, CA 93291
Phone: (559) 202-0282 Fax: (559) 553-0837

Neurosurgery Clinic New Patient Intake Form Date:_____

Demographic Information

Name:_____ DOB:_____ Age:_____

Home Address:_____

Home Phone:_____Cell Phone:_____

Email:_____

Do you authorize us to communicate with you by e-mail and/or text messaging?: Yes_____ No_____

Care Information

Primary Care Physician:_____

Address:_____

Phone:_____ Fax:_____

Referring Physician (if different from PCP):_____

Address:_____

Phone:_____ Fax:_____

Pharmacy:_____

Address:_____

Phone:_____ Fax:_____

Reason for visit

Please describe the major problem that brings you in today to see a Neurosurgeon:

_____

_____

Is this visit related to worker's compensation? (circle one) Yes No

Is this problem the result of an accident? (circle one) Yes No

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Surgical History Please list all operations you have had:

_____

_____

_____

_____

Medical History Please list all active medical conditions:

_____

_____

_____

_____

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

1.	11.
2.	12.
3.	13.
4.	14.
5.	15.
6.	16.
7.	17.
8.	18.
9.	19.
10.	20.

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Are you **ALLERGIC** to any medications, latex, X-ray dye or iodine? (circle one) Yes No
If yes, please explain

_____

_____

Are you taking any "blood thinning" medications such as: (please circle)

Aspirin Anti-inflammatory medication Plavix Coumadin Fish oil

Social History

Occupation:_____

Marital Status:_____ # of Children:_____

Do you smoke cigarettes? _____ If yes, how many packs a day? _____

Do you drink alcohol? _____ If yes, how often? _____

Do you use any type of drugs? _____ If yes, what type? _____

Family History

Does any of your parents or siblings have any medical history listed below? If so, who?

Asthma _____

Diabetes _____

High Blood Pressure _____

High Cholesterol _____

Cancer _____

Stroke _____

Any other condition not listed: _____

_____