IDEAL NEUROLOGY
CLINIC

Welcome to the Ideal Neurology Clinic!

Thank you for choosing us for your neurology care. We're here to support you on this journey. Our website has valuable information. You can prepare for your first visit using the following checklist. We look forward to working with you!

Please fill out or ***bring*** the following completed forms to your initial visit. This will ensure a complete evaluation. Dr. Chalfin will review them at the time of your visit.

- ☐ Signed Patient Agreement with Credit Card Authorization Form…..*Page 7*
- ☐ Completed Registration Form…..*Page 10*
- ☐ Completed Questionnaires ….*Page 13*
- ☐ Tremor and Movement Questionnaire..….*Page 18*
- ☐ Any and all **medications and supplements** you take regularly
- ☐ Copies of **prior evaluations** including doctor's notes, hospital discharge summaries, laboratory studies, MRI/CT scans (reports & discs appreciated), EEGs, EMGs/Nerve Conduction Studies, and PT/OT/ST assessments

If you have any questions, do not hesitate to ask. I am looking forward to meeting with you.

Warm Regards,

Renata Chalfin, M.D.

Summary of Office, Financial, and Cancellation Policies

We're delighted that you're considering Dr. Chalfin for your neurology care. Our practice is committed to delivering evidence-based, personalized, and compassionate neurology services. To ensure that we're the right fit for your nonurgent outpatient neurology care, we ask you to carefully review this agreement. Your continued care with Dr. Chalfin signifies your agreement with our policies, which form the basis of our strong doctor-patient relationship.

Here are some essential points to keep in mind:

- **Patient Selection**: Dr. Chalfin reserves the right to accept or decline patients based on her capability to appropriately handle their neurological needs.
- **Primary Care Practitioner**: We recommend all patients have a primary care physician for preventive care, regular bloodwork, and other health maintenance.
- **Insurance and Payments**: We accept Traditional Medicare and Medigap plans. While we'll make our best attempt to estimate your out-of-pocket costs, the final charges are determined by the complexity of your case and your insurance coverage.
- **Appointment Reservations**: To secure your appointments and protect against no-shows or late cancellations (within 48 hours), we require a credit card on file.
- **Hours of Operation**: Our practice operates on Tuesdays through Thursdays, from 9 am to 3 pm, excluding holidays. Please note that these hours are subject to change.
- **Prescriptions and Referrals**: These are provided during appointments only. Patients are typically offered follow-up appointments during their initial visits.
- **Urgent Care**: We are not an emergency facility. If you have acute symptoms that may be life-, limb-, or vision-threatening, such as sudden-onset vision or hearing loss, slurred speech, or weakness in face or limbs, please seek care at your local ER.
- **After-Hours Contact**: If you need to urgently speak with Dr. Chalfin after hours, you can request to page the doctor, and she will return your call as soon as possible. However, please use this service for genuine emergencies, as nonurgent, frequent, or abusive use may result in charges, warnings, or dismissal from the practice.
- **Non-Urgent Matters**: For non-emergent concerns, such as scheduling appointments or asking a medical question, please call during office hours. After hours, you're welcome to leave a nonurgent voicemail for a callback during office hours.

We are here to provide you with top-notch neurology care and look forward to being part of your healthcare journey.

Warm Regards,

Dr. Chalfin and the Ideal Neurology Clinic

IDEAL NEUROLOGY CLINIC PATIENT AGREEMENT

This is an Agreement between Ideal Neurology Clinic, PLLC (**Practice**), a Florida LLC located at 7280 W Palmetto Park Rd, Ste 104, Boca Raton, FL 33433, Dr. Renata Chalfin (**Physician**) in her capacity as an agent of the **Practice**, and you (**Patient**).

1. **Background**
   The Physician practices neurology and delivers care on behalf of Practice in Boca Raton, Florida. In exchange for certain fees paid by You, Practice, through its Physician(s), agrees to provide Patient with the Services described in this Agreement on the terms and conditions set forth in this Agreement. The practice website is https://www.idealneurology.com.

2. **Definitions**
   a) **Patient.** A patient is defined as those persons for whom the Physician shall provide Services, and who are signatories to this agreement.
   b) **Services.** As used in this Agreement, the term Services are those offered by Practice. This Agreement is for ongoing nonurgent outpatient neurology care. The Patient is expected to maintain a relationship with a primary care practitioner, preferably a physician (M.D. or D.O.), for preventative care, including regular bloodwork, annual exams, and referrals for health maintenance examinations such as colonoscopies. The Patient may need to visit other specialists, the emergency room, or urgent care from time to time. The Patient will be provided with methods to contact the Physician. Physician will make every effort to address the needs of the Patient in a timely manner and to be available via phone when appropriate, but Physician cannot guarantee availability and cannot guarantee that the patient will not need to seek treatment in the urgent care or emergency department setting.
   c) **Outpatient**. Outpatient neurology care is defined as evaluation and management of neurological conditions that is performed outside of a hospital setting, including in-office, over the phone, or via telemedicine.
   d) **Acceptance of Patients**. Practice reserves the right to accept or decline patients based upon its capability to appropriately handle the patient's neurological needs. It may decline new patients pursuant to the guidelines proffered in Section 14 (Term), because the Physician's panel of patients is full, or because the patient requires medical care not within the Physician's scope of services.

3. **Medicare Patients**. If Patient holds a traditional Medicare Part B policy, Patient acknowledges the following policies.
   a) Patient understands claims for covered services will be submitted to Medicare.
   b) Copays, coinsurance, deductibles, and any other noncovered charges are the patient's responsibility and will be expected to be paid at the time of service.
   c) Patient understands Medicare will send an Explanation of Benefits (EOB) to both Patient and the Practice showing what total patient responsibility is. If Patient disagrees with the amount owed, it is Patient's responsibility to contact Medicare immediately.
   d) Patient acknowledges that insurance coverage must be valid and verifiable at the time of services, or Patient will be charged the direct-pay fees.
   e) Patient understands that telemedicine (video) consultations will be billed in the same manner as regular office visits. Medicare may or may not cover the visit in the same manner, though.

4. **Non-Participation in Insurance**. Patients without Medicare Part B acknowledge the following policies.
   a) Neither Practice nor the Physicians participate in any other health insurance or HMO plans except for **traditional Medicare** only.
   b) Neither the Practice nor Physicians make any representations regarding third party insurance reimbursement of fees paid under this Agreement.
   c) The Patient shall retain full and complete responsibility for any such determination.
   d) Patient acknowledges that their insurance coverage is a contract between Patient and Patient's insurance, and that Patient is responsible for determining their insurance's coverage for services.
   e) Patient agrees to pay for each visit according to the fee schedule.

f) Patient agrees that payment is due at the time of service.
g) Patient agrees to pay an out-of-pocket fee of $100 for telephone calls. This fee will be charged to the credit card on file.

5. **Credit Card on File Policy**. Patient acknowledges that Practice requires keeping credit or debit card on file both to reserve each dedicated appointment slot, as well as a convenient method of payment for services.
   a) Fees charged to the credit card on file include but are not limited to visit fees, co-payments, coinsurance, payments toward deductibles, and non-covered charges such as late cancellation/no-show fees, telephone encounters, and refill/form fees.
   b) Patient certifies that he or she is the authorized user of the credit card supplied.
   c) Patient acknowledges their credit card information is kept confidential and secure via Stripe, and only the last four digits of my credit card number can be seen by the Practice staff.
   d) Patient acknowledges that estimated fees will be charged at the time of appointment to the credit card on file. These are just estimates and may change at the time of insurance claim processing, if applicable. Once processed, any remaining charges will be immediately charged to the credit card on file. If there is any credit on Patient's account, a refund will be posted to the credit card on file as soon as possible.
   e) With the exception of payments due at the time of service, payments to the card on file are processed only after any applicable insurance claim has been filed and processed, if applicable.
   f) Patient acknowledges that out-of-pocket expenses incurred between visits will be charged to the credit card on file immediately and without warning. These expenses include but are not limited to no-show/late cancellation fees, telephone encounters, refills, and forms fees.
   g) Patient agrees to update credit card on file when needed. Patient will receive a statement in the event the credit card cannot be charged, and there will be a **$25 statement fee** added.

6. **Late Cancellation Policy**. Patient acknowledges there will be a $50 charge if Patient cancels or changes their appointment less than 48 hours prior to their appointment time. Multiple late cancellations or no-shows may result in dismissal from the practice.

7. **Late Arrival Policy**. Patient acknowledges that Physician operates under a "therapist" model, meaning each appointment has a reserved duration of time dedicated to it, allowing patients to be seen for their entire scheduled visit time. Patient acknowledges that arriving late for an appointment may result in a visit being truncated to allow others to be seen on time. A truncated visit may result in an incomplete assessment and the patient may need to return for further assessment. Patient acknowledges if they arrive late for the visit, they may not be seen and may be charged the late cancellation fee.

8. **Telemedicine Consultations**. Patient acknowledges that Physician will sometimes engage Patient in a telemedicine (video) consultation. Patient understands:
   a) the telemedicine consultation will not be the same as a direct office visit since Patient will not be in the same room as Physician.
   b) Physician assumes Patient is alone during the consultation, and Physician will not know if there are any other people in the same room as me, or within hearing distance, unless Patient says so, thus confidentiality may be breached.
   c) There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. Physician or Patient can discontinue the visit at any time.
   d) As an alternative to a telemedicine consultation, Patient can cancel and reschedule the visit for a later time or seek care from another doctor's office. Patient understands if Physician believes a direct physical examination or other testing are necessary, she will ask Patient to come in for another visit in order to complete the assessment.

9. **Hospital, Emergencies, and Services Between Visits**
   a) This agreement is for ongoing nonurgent outpatient neurology care, not primary, emergency, or urgent care. Physician will make reasonable efforts to be available by telephone for urgent needs and to see

you as needed the next available business day that the Physician is available, **but there is no guarantee of after-hours availability.**

b) Patient may be asked to schedule an appointment if issues or questions arise between scheduled appointment times. The best way to discuss their care is in a scheduled appointment to allow for examination and enough time for discussion.
c) Patient acknowledges that Practice is not an emergency facility, and if they have emergency needs, Patient agrees to call 911 or go to the nearest ER. Patient understands they can page Physician after hours for urgent matters, but Patient may be charged $50 for nonurgent matters at the doctor's discretion. Patient may be dismissed from the Practice if this recurs.
d) Patient acknowledges that Physician does not go to the hospital. She may recommend you go to the Emergency Room if you are having symptoms of an emergent condition or need to be seen urgently, but in that case, your care will be under the hospital doctor(s).
e) Though Dr. Chalfin will make every best effort to communicate with Patient's treating doctors at the hospital, it is ultimately Patient's responsibility to communicate the names and contact information of Physician and other members of Patient's treatment team to the ER/hospital. If Patient has questions or needs clarification while hospitalized, Patient agrees to ask the doctor, nurse, or charge nurse responsible for Patient's care in the hospital because Dr. Chalfin does not have access to hospital records and is not involved in decision-making in the hospital.

10. **Results**, **Refill, Forms, and Paperwork Policy**
    a) You agree to discuss any and all results during follow-up appointments.
    b) You agree to request all refills at the time of visits and that you will be provided with enough refills to last you until your next appointment. You acknowledge that if you cancel or reschedule an appointment, you may run out of medication. You agree to pay $50 for any refill requests between appointment times, and that these refills will be honored at the Physician's professional discretion.
    c) You agree to request paperwork, forms, or letters during appointments. You agree to pay the out-of-pocket fee of $50 for any letters, forms, or other paperwork that require completion by Physician outside of scheduled appointment times. You understand that you can avoid this charge by scheduling an appointment and bringing the forms to the visit. You also understand Physician will only fill out paperwork and sign statements she agrees with.

11. **Controlled Medications/Marijuana Policy**
    a) Dr. Chalfin does not prescribe opiates or medical marijuana for the treatment of chronic pain, or benzodiazepines for the treatment of chronic anxiety or insomnia. She does not take over the prescribing of these medications from other physicians.
    a) As required by law, Dr. Chalfin reviews your prescription refill habits through the Prescription Drug Monitoring Program, even if she is not prescribing a controlled substance.
    a) Dr. Chalfin communicates with prescribing physicians about your treatment plan if it is related, even if she is not also prescribing me controlled substances.
    a) If such medications are required for treatment of my condition, Patient agrees to bring in medication bottles to each visit for pill counts. Random urine drug screens may also be ordered between office visits to ensure compliance. Any unwillingness to participate in pill counts or drug screens will result in discontinuation of the prescription and dismissal from the practice. Any diversion or abuse of prescribed medications will result in dismissal from the practice and reporting to authorities.

12. **Services Practice Does Not Provide**. The following services are not offered in our office at this time, usually due to their cost prohibitive nature for such a small size practice. These may change in the future. Practice will make an effort to help you obtain needed services elsewhere in the most cost-effective manner possible.
    a) In-Office Procedures
    b) Laboratory Studies and blood draws
    c) Electrocardiograms (ECGs)
    d) MRIs, CTs, USs, and other imaging studies
    e) Electroencephalograms (EEGs)

f) Sleep studies
g) Dispensing medications
h) Pathology studies
i) Radiology studies
j) Vaccinations
k) Hospital Services. Due to mandatory “on call” duties required at local institutions; we have elected NOT to obtain formal hospital admission privileges at this time. See Section 10 for more information.

13. **Term.** This Agreement will commence on the date it is signed by the Patient and Physician below and will extend indefinitely thereafter or until either party terminates the Agreement. Notwithstanding the above, both Patient and Practice shall have the absolute and unconditional right to terminate the Agreement, without the showing of any cause for termination. The Patient may terminate the agreement with twenty-four hours prior notice, but the Practice shall give thirty days prior written notice to the Patient and shall provide the patient with a list of other Practices in the community in a manner consistent with local patient abandonment laws. Examples of reasons the Practice may wish to terminate the agreement with the Patient may include but are not limited to:
    a) The Patient fails to pay applicable fees.
    b) The Patient has performed an act that constitutes fraud.
    c) The Patient repeatedly fails to adhere to the recommended treatment plan, especially regarding the use of controlled substances.
    d) Patient makes threats or directs any aggressive or violent behavior toward staff, other patients, or neighboring businesses, or presents an emotional or physical danger to the staff or other patients of Practice.
    e) Practice discontinues operation; and
    f) Practice may terminate a patient without cause as long as the termination is handled appropriately (without violating patient abandonment laws).

14. **Privacy & Communications.** Practice abides by federal privacy regulations and keeps Patient protected health information (PHI) confidential. Information will only be shared with Patient’s verbal or written permission. Exceptions to this include for the purposes of treatment, payment, or healthcare operations, as well as if you are a danger to yourself or others; and if Practice or Physician are obligated to comply with an investigation. You can request a digital copy of your records at no charge, and they will be shared with you via our secure, online password-protected patient portal through Elation. You further acknowledge that communications with the Physician using e-mail, facsimile, video chat, instant messaging, and cell phone are not guaranteed to be secure or confidential methods of communications. You agree to use the online, password-protected patient portal through Elation for any general, non-urgent questions. The practice will make an effort to secure all communications via passwords and other protective means. The practice will make an effort to promote the utilization of the most secure methods of communication, such as software platforms with data encryption, HIPAA familiarity, and a willingness to sign HIPAA Business Associate Agreements. This may mean that conversations over certain communication platforms are highlighted as preferable based on higher levels of data encryption, but many communication platforms, including email, may be made available to the patient. If the Patient initiates a conversation in which the Patient discloses “Protected Health Information (PHI)” on one or more of these communication platforms, or specifically requests release of information on one or more of these platforms, then the Patient has authorized the Practice to communicate with the Patient regarding PHI in the same format.

15. **Attorneys.** In the event Physician is required to retain an attorney or to appear in court, the current hourly rate, billed by the quarter hour or fraction thereof, will be charged based on the most recent Attorney Fee Schedule, which can be obtained upon request.

16. **Severability.** If for any reason any provision of this Agreement shall be deemed, by a court of competent jurisdiction, to be legally invalid or unenforceable in any jurisdiction to which it applies, the validity of the remainder of the Agreement shall not be affected, and that provision shall be deemed modified to the

minimum extent necessary to make that provision consistent with applicable law and in its modified form, and that provision shall then be enforceable.

17. **Assignment.** This Agreement, and any rights Patient may have under it, may not be assigned or transferred by Patient.

18. **Jurisdiction.** This Agreement shall be governed and construed under the laws of the State of Florida and all disputes arising out of this Agreement shall be settled in the court of proper venue and jurisdiction for the Practice address in Boca Raton, Florida

19. **Updates.** We will update these policies from time to time. You may review the latest policies on request.

20. **Patient Understandings (INITIAL EACH):**

_____ This Agreement is for ongoing nonurgent outpatient neurology care. I have a Primary Care Practitioner (PCP) for preventive care.

_____ I do NOT have an emergent medical problem at this time and understand in the event of a medical emergency, I agree to call 911 or go to an ER first.

_____ I do NOT expect the practice to file or fight any insurance claims on my behalf except Traditional Medicare only.

_____ I agree to place a credit/debit card on file to pay for fees due. I agree to the Practice charging all fees to the credit/debit card on file at the time of service. By submitting my credit card, I certify I am the authorized user on the account.

_____ I agree to the Late Cancellation and Late Arrival Policies, including a $50 fee for changes made within 48 hours of an appointment.

_____ I understand there is no guarantee of after-hours availability.

_____ I agree to receive results, ask for refills, request letters or referrals, and fill out any paperwork during visits only, or I will be subject to additional fees.

_____ I do NOT expect the practice to prescribe chronic controlled substances on my behalf.

(These include commonly abused opioid medications, benzodiazepines, and stimulants.)

_____ In the event I have a complaint about the Practice I will first notify the Practice directly.

_____ I am signing this agreement and seeking neurology care from this practice voluntarily and because I believe Dr. Chalfin and Ideal Neurology Clinic are a good fit for my needs.

_____	_____	_____
Patient (or Guardian) Signature	Patient (or Guardian) Name	Date

_____	_____
Physician Signature	Date

APPENDIX

Summary of Fees for Non-Medicare Patients [Direct-Pay Fee Schedule]

The following fees include a discount for payment at the time of service.

• New patient appointment (direct pay)	$395*
• Follow-up patient appointment (direct pay)	$195*
• Telephone calls	$100
• Late cancellation/No Show fee	$50
• Between-visit refill fee	$50
• Between-visit form or paperwork fee	$50
• Nonurgent after-hours page penalty	$50
• Statement fee for declined Credit Card	$25

* Patients with Medicare will have their own rates as determined by Medicare; their responsibility will be noted in their Explanation of Benefits (EOB).

Medicare Patients are usually responsible for the following fees

- 2023 Part B **Deductible** (before any Part B benefits are paid by Medicare): **$226**
- After the deductible is paid for the year, **20% coinsurance**: 20% of the allowable charge for each visit or fee billed, depending on the level of complexity of the visit. For example, for a Dementia Care visit, the allowable charge is approximately $280, of which you would be responsible for 20% which is $56. These allowable charges change yearly.
- There is no copay for visits with traditional Medicare Part B.
- *If you have a secondary plan such as United American Plan F*:
    - Your secondary plan may pay some or all of your Part B Deductible and your 20% coinsurance.
    - However, your secondary plan may have a deductible of its own before its benefits kick in.
    - It may require a copay of its own for each visit.
    - If it is an official Medigap plan (titled Plan A, B, F, etc), you can look up the plan type and what it covers online, and we will do our best to estimate your responsibility.
    - If it's not an official Medigap plan, it is your responsibility to know your benefits, and you may need to fight for reimbursement from your secondary insurance company yourself.
    - Practice will charge you up-front for any estimated patient responsibility. However, these are just estimates.
    - Any change to the actual amount of your Patient Responsibility will be settled to your credit card on file once the insurance's Explanation of Benefits is posted.

CREDIT CARD ON FILE AUTHORIZATION FORM

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

At Ideal Neurology Clinic, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover for which you are liable. This includes, but is not limited to, co-payments, coinsurance, and payments toward your deductible.

Your credit card information is kept confidential and secure. With the exception of payments due at the time of service per our Financial Policies, payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Card Information:

Card Type (circle): Visa Mastercard Discover Amex Other

Name on Card: _____

Card Number: _____ Zip: _____

Expiration Date: _____ CVV/Security Code: _____

Cardholder Signature: _____

I authorize and request Ideal Neurology Clinic to charge my credit card, indicated above, for balances due for services rendered that are the patient's financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to Patient by Ideal Neurology Clinic.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Ideal Neurology Clinic in writing and the account must be in good standing.

Patient or Guardian's Name (print): _____

Patient Signature: _____ Date: _____

Patient Registration Form

Today's Date: _____ DOB: _____

Name: _____ Age: _____ R or L handed M F

What should I call you? (First Name, Nickname, Dr., Mr., Mrs., etc.) _____

Primary Care Physician Name: _____ Phone: _____

SSN: _____ Marital Status: S M Se D W

Address: _____

Cell Phone: _____ Home Phone: _____ Other:_____

Email: _____

Employer: _____ Address:_____

Pharmacy Name and Cross-Streets: _____ Phone:_____

How do you prefer to be contacted for appointment reminders? Text Email Voice None

Responsible Party (if different than patient)

Name: _____DOB:_____

SSN: _____

Address: _____

Cell Phone: _____ Home Phone:_____ Other:_____

Email: _____

Employer: _____Address:_____

Emergency Contact

Name: _____Phone #:_____

Address: _____Relationship:_____

Email:_____

How did you hear about Dr. Chalfin's practice? _____

If you have an advanced directive (living will), please give us a copy. If you would like to create one, there are several boilerplate templates online. Otherwise, you may state some general wishes here:

> *If I am hospitalized with a terminal condition or am not expected to regain significant functional recovery as determined by my treating physicians,* ***I DO / DO NOT wish to be resuscitated.***

_____ _____

Signature of patient or guardian *Date signed*

Consent To Treatment

The undersigned, as patient or guardian of patient, authorizes Dr. Chalfin to evaluate the above-named patient and provide treatment. I authorize release of medical information that may be necessary for continuity of care, for reimbursement from insurers, and as needed for investigations. I assign all medical benefits payable for services to the Ideal Neurology Clinic, PLLC. I permit a copy of this authorization to be used in place of the original. I have reviewed, accepted, and will comply with office policies. I have received the privacy practices. I accept financial responsibility for all charges regardless of insurance, except where prohibited by law.

Patient/Guardian Signature: _____ Date: _____

Disclosure of Medical Information

I give Dr. Chalfin permission to discuss my medical condition with the following people: (names)

Spouse/Significant Other: _____

Parent(s):_____

Sibling(s):_____

Children: _____

Other: _____

Place a star next to the one person you would like to make medical decisions on your behalf if you are unable.

Other *medical providers* I would like to receive a copy of my medical notes (include contact info):

I may change this at any time by notifying the office and following up with a written notification.

Patient/Guardian Signature: _____ Date: _____

CONSENT TO OBTAIN PATIENT MEDICAL RECORDS

Patient's Name: _____
Last First Middle

Date of Birth: _____

I consent to the medical records of the above named patient to be released to:

Ideal Neurology Clinic, PLLC
hello@idealneurology.sprucecare.com
fax: (561) 898-1710 | phone: (561) 961-8575
P.O. Box 880761
Boca Raton, FL 33433

The records may be emailed, faxed, or mailed. This authorization applies to all healthcare information for the purpose of continued healthcare.

I understand that my express consent is required to release any healthcare information if I have been tested, diagnosed, and/or treated for HIV/AIDS, sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release **all** health information relating to such diagnosis, testing, or treatment.

_____ _____
Signature of patient or guardian Date signed

Relationship to patient: _____

Patient Phone number: _____

General Questionnaire for All Patients – Reason for Visit

What issue are you seeing the doctor for? How long have you had this symptom?

Who recommended this evaluation, and why? What goals do you have for this evaluation?

Have you seen any other physician for this problem? Have you received any diagnoses?

What have you tried that has worked or not worked? Did anything cause side effects?

Please circle the following tests you have had and make sure you bring **all results** with you to your appointment.

CT/MRI of the brain
CT/MRI of the spine
CT/MRI of neck
Carotid ultrasound
MRA/CTA of the blood vessels
Electroencephalogram (EEG, brain wave study)
EMG/Nerve Conduction study
Lumbar puncture (spinal tap)
Neuropsychological testing
Sleep study

Anyone in your family with similar problems?

Do you experience any other symptoms?

General Questionnaire for All Patients - Health History

Name:_____ Today's Date:_____

Height:_____ Current weight:_____

When filling out the following, please consider your *current* health status as well as your medical *history*, *even if* issues are *resolved*.

Have you **ever** had any of these medical issues? (circle)

Abuse/trauma	Head/neck injury/Concussion	Lung problems
Anxiety	Headaches/Migraines	Meningitis/encephalitis
Arrhythmia/Atrial fibrillation	Heart attack/heart problems	Multiple sclerosis
Autoimmune disease	High blood pressure	Osteoporosis
Birth injury/developmental issue	High cholesterol	Pregnancies
Blood clots	HIV/other infection	Seizures/Epilepsy
Cancer/Brain Tumor/Surgery	Kidney disease	Sleep apnea
Depression	Liver disease	Stroke
Diabetes	Loss of consciousness	Thyroid disease

Please explain (include general dates):

Any other medical problems?

Any previous surgeries? (include general dates):

Have you ever been hospitalized for anything (else)?

List all food and drug allergies:

_____

List current medications: (can attach a list or continue on the back). Please include pain medications, over the counter medications, vitamins, herbal supplements, etc.

Medication Name Pill strength # pills Frequency of doses

1._____

2._____

3._____

List family members who have had the following: (M= mother, F = father, B = brother, S = sister, etc)

Alcohol or substance/drug addiction:	Memory problems/Alzheimer's disease:
Anxiety, depression or suicide:	Multiple sclerosis:
Blood clots:	Premature death:
Cancer (include type):	Seizures:
Diabetes:	Stroke:
Headaches:	Thyroid problems:
Heart attack/problems:	Other illnesses:

Who lives at home? Describe your home life: _____

Children's Names:_____

Where are you from originally?_____ Ethnicity?_____

Religion/spirituality?_____Rabbi/priest/clergy:_____

What's the highest level of education you had?_____

Previous/current occupation:_____ Satisfied?_____

Sleep quality?_____ How many hours?____

What are your exercise habits?_____ Diet?_____

How much caffeine do you consume?_____ Any energy drinks?_____

How's your stress level?_____

What are your stressors?_____

How do you relieve stress?_____What do you do for fun?_____

Health risks:

21. Do/did you use tobacco? Y | N _____
22. Do/did you drink alcohol? Y | N _____
23. Do/did you use street drugs or other substances? Y | N _____
24. Any other bad habits or addictions? _____
25. How many sexual partners have you had in the last 12 months? _____In your lifetime? ____ Do you use any sexual protection?_____
26. Exposures: Have you ever been exposed to chemicals or travel-related infections? _____
27. Do you have firearms in your home? Y | N Locked & unloaded? Y | N
28. Do you *or anyone in your life* have concerns about your driving safety? Y | N
    Explain (accidents? tickets? getting lost?)_____
29. Do you need assistance paying bills, doing household chores, getting dressed/showering, eating, toileting, etc? Do you use any medical equipment? _____

Vaccines up to date? Y | N Flu shot? Y | N Pneumonia shot? Y | N Shingles shot? Y | N

Date and result of last: (NL = normal; ABNL = abnormal)

Eye exam	NL | ABNL	Mammogram	NL | ABNL
Dental exam	NL | ABNL	Pap smear	NL | ABNL
Hearing exam	NL | ABNL	PSA	NL | ABNL
Cardiac stress test or EKG	NL | ABNL	Sleep study	NL | ABNL
Colonoscopy	NL | ABNL		

General Questions – Share if you are willing

What are your health goals?

What is your life purpose?

Anything else you wish to share?

Ladies:

OB/Gynecologist name_____Phone_____

Age of first menstrual period_____ Date of last menstrual period_____

Are you planning to become pregnant? Y | N When? _____

What form(s) of birth control do you use?_____

How many pregnancies have you had? _____ Are you breastfeeding? Y | N

Review of Systems

(circle any symptoms in the last month)

General/Constitutional
Weight +/- ____lbs
Change in appetite
Fatigue
Fever/chills
Night sweats

Ophthalmologic
Vision loss
Blurry vision
Double vision
Eye pain
Eyelids drooping

HEENT
Pain/Difficult swallowing
Pain/Difficulty chewing
Loss of smell
Hearing loss
Ringing in ears
Snoring
Dry mouth
Change in voice

Respiratory
Shortness of breath
Cough
Bloody sputum

Cardiovascular
Chest tightness
Palpitations/Irregular Heartbeat
Leg swelling

Gastrointestinal
Abdominal pain
Difficulty controlling bowels
Nausea/vomiting
Diarrhea
Constipation
Blood in stool
Black stools

Genitourinary
Frequent urination
Leaking urine
Painful urination
Unable to urinate
Sexual dysfunction
Vaginal bleeding

Hematology
Easy bruising
Prolonged bleeding
Blood clots

Musculoskeletal
Back pain
Neck pain
Joint pain
Muscle pain
Weakness
Spasticity

Skin
Moles Color changes
Rash

Neurologic
Dizziness
Balance difficulty
Change in handwriting
Change in voice
Difficulty speaking
Difficulty with coordination
Falls
Headache
Language difficulty
Loss of consciousness
Memory loss
Numbness/tingling
Seizures
Speech changes
Tremor
Walking difficulty

Psychiatric
Abnormally elevated mood
Anxiety
Depressed mood
Difficulty concentrating
Difficulty sleeping
Hallucinations
Irritability
Mood swings

Endocrine
Heat intolerance
Cold intolerance
Excessive thirst

None of the above.

Tremor and Movement Questionnaire

In general, how would you **rate your overall health**? (0 = very poor health, 100 = perfect health)
Circle: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

How would you **rate your quality of life**? (0 = very poor, 100 = perfect)
Circle: 0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

In the past month,
have you had **side effects** from your tremor medications? Y | N
Have you been **satisfied with the tremor control** achieved by your medications? Y | N

For the purposes of this questionnaire, **tremor** is defined as uncontrollable shaking or quivering of the body part in question.

On a typical day, how many of your waking hours do you have tremor in ANY body part?
Circle: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

Please check (√) **the severity of your tremor in each of the body parts** listed.

	None	Mild	Moderate	Marked	Severe
Head					
Voice					
RIGHT arm/hand					
RIGHT leg/foot					
LEFT arm/hand					
LEFT leg/foot					

Have you experienced any of the following **symptoms in the last month**? (please **circle or highlight**)

Dribbling of saliva during the day

Loss or change in ability to taste or smell

Difficulty swallowing food/drink or choking

Nausea or vomiting

Constipation or straining

Fecal incontinence

Incomplete bowel emptying

Urinary urgency

Frequent urination at night

Unexplained pains not due to arthritis

Unexplained change in weight not due to change in diet

Problems remembering things, or forgetting to do things

Loss of interest in what is happening around you

Seeing or hearing things you know or are told are not there

Difficulty concentrating/staying focused

Feeling sad, low, or blue

Feeling anxious, frightened, or panicky

Feeling less or more interested in sex

Finding it difficult to have sex when you try

Feeling lightheaded, dizzy, or weak when standing from sitting or lying

Falling

Finding it difficult to stay awake during activities such as working, driving, or eating

Difficulty getting to sleep or staying asleep at night

Intense, vivid, or frightening dreams

Talking or moving about in your sleep as if you are “acting out” a dream

Unpleasant sensations in your legs at night or while resting, and a feeling you need to move

Swelling of your legs

Excessive sweating

Double vision

Believing things are happening to you that other people say are not true

Please check (√) **how frequently your tremor impacts the following activities**.

	Never	Sometimes	Frequently	Always
Ability to communicate with others				
Ability for others to understand my speech				
My job/profession Have you had to change jobs because of your tremor? Y | N Have you had to retire because of your tremor? Y | N Have you had to cut down on hours because of your tremor? Y | N Have you had to use special aids or accommodations for your job? Y | N				
My finances				
My hobbies Have you had to quit some of your hobbies? Y | N Have you had to change or develop new hobbies? Y | N				
Writing (letters, completing forms)				
Using a computer or typewriter				
Use the telephone (dialing, holding the phone)				
Fix things around the house (changing light bulbs, minor plumbing, fixing broken items, etc)				
Dressing (buttoning, zipping, typing shoes)				
Brushing/flossing teeth				
Eating (bringing food to mouth, spilling)				
Drinking liquids (bringing to mouth, spilling, pouring)				
Reading or holding reading material				
My relationships with others (family, friends, coworkers)				
My self-confidence				
I feel embarrassed about my tremor.				
I feel depressed about my tremor.				
I feel isolated or lonely because of my tremor.				
I worry about the future due to my tremor.				
I am nervous or anxious.				
I use alcohol more frequently because of my tremor.				
I have difficulty concentrating because of my tremor.				