



# Neurology Medical Center

M. Mike Kreidie, M.D.

Fellow of The American Academy of Neurology

Diplomat of the American Board  
of Psychiatry and Neurology

26932 Oso Parkway  
Suite 240  
Mission Viejo, California 92692

(949) 348-8880  
FAX (949) 348-8881  
[www.neuromedcenter.com](http://www.neuromedcenter.com)

## PATIENT REGISTRATION FORM

Please print all information

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone (        ) \_\_\_\_\_

Cell Phone (        ) \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Occupation \_\_\_\_\_

Employer's Name \_\_\_\_\_

Work Number (        ) \_\_\_\_\_

Work Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Referred By \_\_\_\_\_

# Neurology Medical Center

**PATIENT REGISTRATION FORM**

**Please print all information**

**Page 2**

If there are any questions regarding the bill, the person who is registering today will be responsible for payment. If the patient is a minor, the person registering the patient will be responsible.

## RELEASE STATEMENT

1. I authorize NEUROLOGY MEDICAL CENTER and THEIR STAFF to perform diagnostic tests and provide treatment necessary for medical evaluation and health care to the above registered patient.
2. I accept responsibility for all charges incurred in the medical evaluation and health care of the above registered patient.
3. I understand that ongoing primary medical care is the responsibility of the patient, and it is not the responsibility of NEUROLOGY MEDICAL CENTER.
4. NEUROLOGY MEDICAL CENTER will bill your insurance carrier. However, the balance owed will be the sole responsibility of the above registered patient.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_



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## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Neurology Medical Center  
26932 Oso Parkway, #240  
Mission Viejo, CA 92692  
(949) 348-8880

I understand that, under the Health Insurance Portability & Accounting Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal health care operations such as quality assessments and physician certifications

I have received, read and understood the "Notice of Privacy Practices" containing a more complete description of the uses and disclosures of my health information. I understand that Neurology Medical Center has the right to change its "Notices of Privacy Practices" from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the "Notice of Privacy Practices".

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to comply with my requested restrictions.

Patient Name: \_\_\_\_\_

Patient Representative: \_\_\_\_\_

Signature: \_\_\_\_\_

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I attempted to obtain the signature of the patient or patient's representative acknowledging the receipt of the "Notice of Privacy Practices", but was unable to do so, as documented below.

Date	Initials	Reason
_____	_____	_____

*To our patients:* This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**.

### **Our commitment to your privacy**

- Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.
- We realize that these laws are complicated, but we must provide you with the following important information:

### **Use and disclosure of your health information in certain special circumstances**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

### **Your rights regarding your health information**

1. **Communications:** You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request. However, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Neurology Medical Center. If you have questions, please contact the Office Manager at 949-348-8880.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Neurology Medical Center. If you have questions, contact the Office Manager at 949-348-8880. You must provide us with a reason that supports your request for amendment.
5. **Right to a copy of this notice.** You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.
6. **Right to file a complaint.** If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. **Right to provide an authorization for other uses and disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at 949-348-8880.

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HEALTH INSURANCE CLAIM FORM												
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)</small>					1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)							
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)			3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)						
5. PATIENT'S ADDRESS (No., Street)			6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)							
CITY		STATE	8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE				
ZIP CODE		TELEPHONE (Include Area Code) ( )			ZIP CODE		TELEPHONE (INCLUDE AREA CODE) ( )					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER			a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>				
b. OTHER INSURED'S DATE OF BIRTH MM DD YY			b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME						
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>					
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>												
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.					13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.							
SIGNED _____ DATE _____					SIGNED _____							
14. DATE OF CURRENT: MM DD YY			15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY							
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE			17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY							
19. RESERVED FOR LOCAL USE					20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)					22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.							
1. _____ 3. _____					23. PRIOR AUTHORIZATION NUMBER							
2. _____ 4. _____												
24. A DATE(S) OF SERVICE To		B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
From MM DD YY To MM DD YY												
1												
2												
3												
4												
5												
6												
25. FEDERAL TAX I.D. NUMBER SSN EIN			26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part hereof.)			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)			33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #						
SIGNED _____ DATE _____			PIN# _____ GRP# _____									

STATE OF CALIFORNIA  
DEPARTMENT OF INDUSTRIAL RELATIONS  
WORKERS COMPENSATION APPEALS BOARD

Notice and Request for Allowance of Lien

I.D./Case Number \_\_\_\_\_

\_\_\_\_\_  
Injured Workers Name Address

Date of Injury \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Date of Birth \_\_\_\_\_

\_\_\_\_\_  
Attorney for Injured Worker Address

\_\_\_\_\_  
Employer Address

\_\_\_\_\_  
Insurance Carrier Address

\_\_\_\_\_  
Adjusting Agency Address

\_\_\_\_\_  
Attorney for Employer/Carrier Address

\_\_\_\_\_  
Lien Claimant Address Phone Number

\_\_\_\_\_  
Attorney for Lien Claimant Address Phone Number

The lien claimant hereby requests the Workers' Compensation Appeals Board to determine and allow as a lien the sum of

\_\_\_\_\_ Dollars (\$ \_\_\_\_\_ . \_\_\_\_\_) against my amount now due or which may hereafter become payable as compensation to the above named worker on account of the above named claimed injury.

This request and claim for lien is for (Mark appropriate box):

- The reasonable expense incurred by or on behalf of said worker for medical treatment to cure or relieve from the effects of said injury; or
- The reasonable medical expenses incurred to prove a contested claim; or
- The reasonable value of living expenses of said worker or of his or her dependents, subsequent to the injury; or
- The reasonable living expenses of the spouse or minor children, or both, of said worker, subsequent to the date of injury, where such worker has deserted or is neglecting his or her family; or
- The reasonable fee for interpreter's services to be performed on \_\_\_\_\_, 20\_\_\_\_\_

**Note: ITEMS STATED JUSTIFYING THE LIEN MUST BE ATTACHED**

For injuries occurring on or after January 1, 1990, for which the lien claimant does not have a WCAB identification number, the lien claimant declares under penalty of perjury that:

A copy of the original completed Employee's Claim for Workers' Compensation Benefits (DWC Form 1) is attached, or the lien claimant does not have a copy of the claim form, but made the following efforts to secure one: A copy of the lien claim and supporting documents was served by mail or delivered to each of the above named parties.

\_\_\_\_\_  
Signature of Attorney for Lien Claimant

\_\_\_\_\_  
Signature of Lien Claimant Date

\_\_\_\_\_  
Signature of Attorney for Injured Worker

\_\_\_\_\_  
Signature of Injured Worker

# Neurology Medical Center

26932 Oso Parkway, Suite #240; Mission Viejo, CA 92692  
# (949) 348-8880; Fax # (949) 348-8881

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## AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

### **I hereby authorize:**

Provider Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### **To disclose the following information from the health records of:**

Patient Name (Last, First, Middle): \_\_\_\_\_

Previous Name (Last, First, Middle): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ S.S. #: \_\_\_\_\_

D.O.B.: \_\_\_\_\_

### **To be disclosed to:**

Provider Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

### **Information to be disclosed:**

- All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- All of my health information described above except for the following: \_\_\_\_\_

Only the following records or types of health information: (Insert dates of treatment, types of treatment and/or other designation): \_\_\_\_\_

**For the purpose of:** \_\_\_\_\_

I understand that I am entitled to a copy of this authorization upon my request.

I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases, AIDS, or HIV Infection, alcohol and/or drug abuse and mental health conditions

I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization or as specifically required or permitted by law.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and may not be protected by federal or state confidentiality laws.

The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Expiration date or event:** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (or)

Legal Representative & Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT GENERAL HISTORY OUTLINE

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ BIRTH DATE: \_\_\_/\_\_\_/\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE: (\_\_\_) \_\_\_-\_\_\_

S.S. #: \_\_\_\_\_  
SEX: M \_\_\_ F \_\_\_ MAJOR HAND: RIGHT \_\_\_ LEFT \_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_  
\*\*\*\*\*

INTERPRETER NEEDED: YES: \_\_\_ NO: \_\_\_ PRIMARY LANGUAGE: \_\_\_\_\_

INTERPRETER'S NAME: \_\_\_\_\_

INTERPRETER'S AGENCY/COMPANY: \_\_\_\_\_

HISTORY REVIEWED WITH PATIENT BY: \_\_\_\_\_  
\*\*\*\*\*

Answer each question on this outline as completely as possible. Include exact dates and names whenever possible. Use the back of pages as necessary. Proper completion of this outline will allow the Physicians to focus their questions on the specific issues in your case. If you have any questions, please call our office between 8:30 AM and 5:30 PM, Monday through Friday at 916-924-4877.

### JOB DESCRIPTION:

EMPLOYER (at time of injury): \_\_\_\_\_

EMPLOYER'S ADDRESS: \_\_\_\_\_

EMPLOYER'S PHONE: (\_\_\_) \_\_\_-\_\_\_

JOB TITLE: \_\_\_\_\_ SUPERVISOR'S NAME: \_\_\_\_\_

HOW LONG HAD YOU WORKED THERE: \_\_\_\_\_

Hours worked per day: \_\_\_\_\_ Days worked per week: \_\_\_\_\_ Overtime per week: \_\_\_\_\_

How long have you done this or a similar type of work: \_\_\_\_\_

What were your job duties when on this job: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What percent of an average work day were you required to do the following activities:

C = Continuous or Constant / 75% - 90 % of the time

F = Frequent - 50 % - 75 % of the time

I = Infrequent - 25 % - 50 % of the time

O = Occasional - 1 % - 25 % of the time

\_\_\_\_ REACHING (above or at the shoulder level)

\_\_\_\_ STANDING

\_\_\_\_ WALKING

\_\_\_\_ CLIMBING

\_\_\_\_ LIFTING: FROM \_\_\_ TO \_\_\_ POUNDS LIFTED

\_\_\_\_ DETAILED HAND WORK

\_\_\_\_ PUSHING

\_\_\_\_ PULLING

\_\_\_\_ SITTING

\_\_\_\_ DRIVING

\_\_\_\_ BENDING

\_\_\_\_ STOOPING

Was protective equipment worn (such as gloves, goggles, ear plugs, etc.): YES: \_\_\_ NO: \_\_\_

If yes, please describe: \_\_\_\_\_

Were you exposed to excessive amounts of dust, fumes, or gases?: YES: \_\_\_ NO: \_\_\_

If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Where you required to work around moving machinery?: YES: \_\_\_\_ NO: \_\_\_\_ If yes, please list what type(s) : \_\_\_\_\_  
\_\_\_\_\_

### HISTORY OF INJURY

DATE(S) OF SPECIFIC INJURY: (1) \_\_\_\_\_ (2) \_\_\_\_\_  
(3) \_\_\_\_\_ (4) \_\_\_\_\_  
DATES OF CONTINUOUS TRAUMA: FROM: \_\_\_\_\_ TO: \_\_\_\_\_

Please explain exactly how the injury happened? (if more than one injury, please number each): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What symptoms did you have IMMEDIATELY following the injury? (if more than one injury, please number each): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### TREATMENT FOLLOWING THE INJURY

DESCRIBE WHERE YOU WENT FOLLOWING THE INJURY FOR MEDICAL CARE – in order, list the DATES and NAMES of all physicians you have seen. Please list any x-rays that were performed, medications prescribed, physical therapy, hospitalizations, surgeries, etc.: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you were taken OFF WORK or placed on WORK RESTICTION, please list when and by whom: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PRESENT COMPLAINTS

DESCRIBE YOUR PRESENT COMPLAINTS (type of pain, severity, duration, what causes the pain, what relieves the pain, etc.) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CURRENT TREATMENT

LIST THE DOCTORS THAT YOU ARE CURRENTLY SEEING FOR FOLLOW UP CARE AND WHAT TYPES OF TREATMENT YOU ARE RECEIVING (canes, crutches, physical therapy, etc.) : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**CURRENT MEDICATIONS**

LIST MEDICATION PERSCRIBED BY TREATING PHYSICIANS AS WELL AS OVER THE COUNTER MEDICATIONS:

DRUG: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ QUANTITY TAKEN: \_\_\_\_\_  
DRUG: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ QUANTITY TAKEN: \_\_\_\_\_  
DRUG: \_\_\_\_\_ DOSAGE: \_\_\_\_\_ QUANTITY TAKEN: \_\_\_\_\_

**WORK RECORD AFTER INJURY**

DATES MISSED FROM WORK DUE TO THE INJURY (or injuries): \_\_\_\_\_

ARE YOU WORKING FOR THIS EMPLOYER AT THIS TIME: YES: \_\_\_\_ NO: \_\_\_\_

If NO, please complete the following:

Date last worked: \_\_\_\_\_ Were you fired?: \_\_\_\_\_ Laid off?: \_\_\_\_\_  
On medical leave?: \_\_\_\_\_ On State Disability?: \_\_\_\_\_ Did you quit?: \_\_\_\_\_  
On Workers Compensation Temporary Disability?: \_\_\_\_\_ Other: \_\_\_\_\_  
If YES, are you having any problems?: \_\_\_\_\_

SINCE THE INJURY, HAVE YOU WORKED, OR ARE YOU WORKING FOR A DIFFERENT EMPLOYER?: YES \_\_\_\_ NO \_\_\_\_ If YES, please list whom:

Employer's Name	Dates of Employment	Job Description
_____	_____	_____
_____	_____	_____
_____	_____	_____

**WORK RECORD BEFORE INJURY**

EMPLOYER	JOB TITLE	DATES EMPLOYED
_____	_____	_____
_____	_____	_____
_____	_____	_____

**PAST MEDICAL HISTORY**

LIST PRIOR ACCIDENTS, INJURIES OR ILLNESSES INVOLVING THE SAME PART OF THE BODY OR SYSTEM AS YOUR CURRENT INJURY OR ILLNESS: (Also, list date of injury, treatment received, time missed from work, and if or when you fully recovered. If any symptoms were still present at the time of the current injury, please describe.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SINCE YOUR INJURY, HAVE YOU HAD ANY ADDITIONAL INJURIES? (If so, please describe): \_\_\_\_\_  
\_\_\_\_\_

LIST ALL PRIOR HOSPITALIZATIONS, SURGERIES, OR INCEDENTS WHICH HAVE REQUIRED HOSPITAL CARE: \_\_\_\_\_  
\_\_\_\_\_

LIST ANY ALLERGIES AND THE TYPE OF REATION YOU HAVE (medicine, food, pollen, etc.): \_\_\_\_\_  
\_\_\_\_\_

DID YOU HAVE ANY SERIOUS CHILDHOOD DISEASES? (such as scarlet fever, polio, strep throat, heart problems or murmurs, kidney problems, whooping cough, etc): \_\_\_\_\_  
\_\_\_\_\_

HAVE YOU HAD ANY SERIOUS ADULT DISEASES? (involving the heart, kidney, lungs, liver, etc. Or, do you have, or have had, high blood pressure, ulcers, tuberculosis, stroke, etc.) \_\_\_\_\_  
\_\_\_\_\_

**FAMILY AND SOCIAL HISTORY**

ARE YOU CURRENTLY: MARRIED \_\_\_\_\_ SEPERATED: \_\_\_\_\_ DIVORCED: \_\_\_\_\_  
WIDOWED \_\_\_\_\_ SINGLE: \_\_\_\_\_ LIVING WITH A SIGNIFICANT OTHER: \_\_\_\_\_

**MARITAL HISTORY:**

- 1. AGE WHEN MARRIED: \_\_\_\_\_ DURATION OF MARRIAGE: \_\_\_\_\_ CHILDREN: \_\_\_\_\_
- 2. AGE WHEN MARRIED: \_\_\_\_\_ DURATION OF MARRIAGE: \_\_\_\_\_ CHILDREN: \_\_\_\_\_
- 3. AGE WHEN MARRIED: \_\_\_\_\_ DURATION OF MARRIAGE: \_\_\_\_\_ CHILDREN: \_\_\_\_\_

TOTAL NUMBER OF CHILDREN YOU HAVE: \_\_\_\_\_ LIVING AT HOME: \_\_\_\_\_

ADDITIONAL COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any recreational activities you enjoyed prior to the injury: \_\_\_\_\_  
\_\_\_\_\_

Please list which of these activities you are unable to do since the injury: \_\_\_\_\_  
\_\_\_\_\_

RELATIONSHIP	ALIVE	DECEASED	CAUSE OF DEATH	AGE
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
SON(S)				
DAUGHTER(S)				

RELATIONSHIP	FATHER	MOTHER	BROTHER	SISTER	GRAND PARENT
DIABETES					
TUBERCULOSIS					
HIGH BLOOD PRESSURE					
HEART DISEASE					
EPILEPSY					
MENTAL ILLNESS					
ALLERGIES					
OTHER					

ADDITIONAL COMMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATIENT PROFILE**

PLACE OF BIRTH: \_\_\_\_\_  
WHERE WERE YOU RAISED: \_\_\_\_\_  
IF FOREIGN BORN, WHEN DID YOU MOVE TO THE UNITED STATES?: \_\_\_\_\_  
EDUCATION: GRADE LEVEL REACHED \_\_\_\_\_ HIGH SCHOOL \_\_\_\_\_ COLLEGE: \_\_\_\_\_  
CERTIFICATES OR DEGREES: \_\_\_\_\_  
MILITARY SERVICE: YES \_\_\_\_\_ NO \_\_\_\_\_  
BRANCH: \_\_\_\_\_  
DATES OF SERVICE: \_\_\_\_\_

**PERSONAL HABITS**

Do you drink coffee or tea? \_\_\_\_\_ How much per day? \_\_\_\_\_  
Do you drink alcohol? \_\_\_\_\_ How often? \_\_\_\_\_ How much? \_\_\_\_\_  
Has your past use of alcohol been different? \_\_\_\_\_ If so, how much did you drink then? \_\_\_\_\_  
\_\_\_\_\_  
Have you had any problems with, or treatment for alcohol excess? \_\_\_\_\_  
If yes, when? \_\_\_\_\_  
Do you use tobacco? \_\_\_\_\_ Type: Cigarettes \_\_\_ Cigars \_\_\_ Pipe \_\_\_ Chew \_\_\_\_\_  
How much per day? \_\_\_\_\_ How long have you used it? \_\_\_\_\_  
Do you use illicit drugs? \_\_\_\_\_ How often? \_\_\_\_\_  
Type(s): \_\_\_\_\_

**FOR WOMEN ONLY:**

Number of pregnancies: \_\_\_\_\_ Number of live births: \_\_\_\_\_  
Is there any possibility that you could be pregnant at this time? \_\_\_\_\_

**SYSTEM REVIEW**

HAVE YOU HAD, OR DO YOU CURRENTLY HAVE, PROBLEMS WITH ANY OF THE FOLLOWING SYSTEMS (not caused by your injury). If NO, then write NONE.

HEENT (eyes, ears, nose and throat): \_\_\_\_\_  
\_\_\_\_\_

RESIRATORY (lungs): \_\_\_\_\_  
\_\_\_\_\_

CARDIOVASCULAR (heart): \_\_\_\_\_  
\_\_\_\_\_

GASTROENTEROLOGY (esophagus, stomach, colon): \_\_\_\_\_  
\_\_\_\_\_

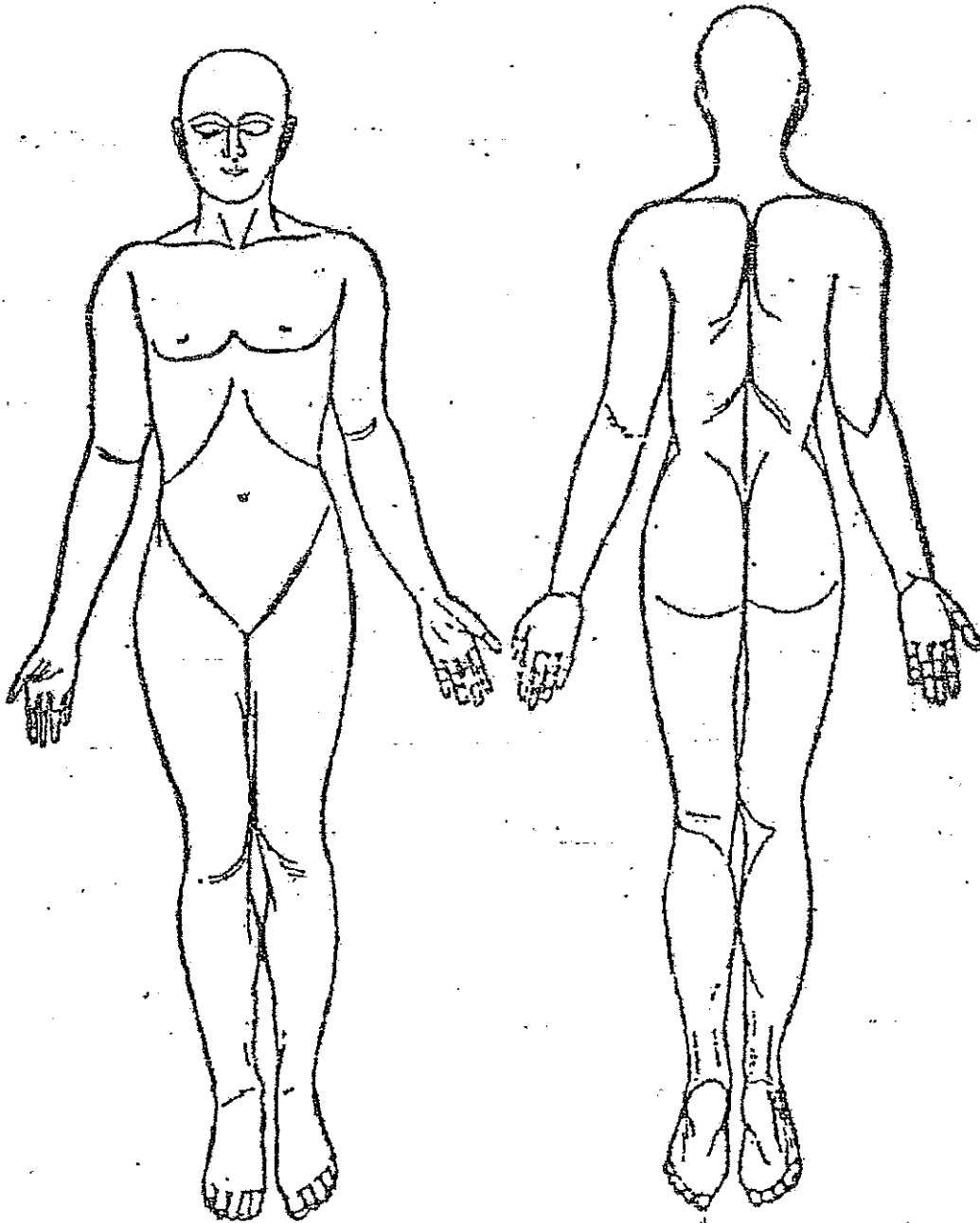
GENITOURINARY (kidneys, bladder, genitals): \_\_\_\_\_  
\_\_\_\_\_



## PAIN DIAGRAM

Indicate, with the following symbols, the kind of pain and where it is located:

- Sharp pain = XXXXXX
- Dull pain = OOOOOO
- Numbness & Tingling = //////////////





# Neurology Medical Center

M. Mike Kreidie, M.D.

Fellow of The American Academy of Neurology  
Diplomate of the American Board  
of Psychiatry and Neurology

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## ASSESSMENT OF ACTIVITIES OF DAILY LIVING (ADL)

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please CIRCLE the activity(ies) of daily living that is(are) affected by your medical condition(s).

1. Self-Care, Personal Hygiene:

- Urinating
- Defecating
- Brushing teeth
- Combing hair
- Bathing
- Dressing oneself
- Eating

2. Communication:

- Writing
- Typing
- Seeing
- Hearing
- Speaking

3. Physical activities:

- Standing
- Sitting
- Reclining
- Walking
- Climbing stairs

4. Sensory function:

- Hearing
- Seeing
- Tactile feeling

- Tasting

- Smelling

5. Non-specified hand activities:

- Lifting
- Grasping
- Tactile discrimination

6. Travel:

- Riding
- Driving
- Flying

7. Sexual function:

- Orgasm
- Ejaculation
- Lubrication
- Erection

8. Sleep:

- Restful
- Nocturnal sleep patterns

Notes:

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RATINGS DETERMINING IMPAIRMENT ASSOCIATED WITH PAIN

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

I. Pain (Self-Report of Severity)

A. Rate how severe your pain is **right now, at this moment** (circle a number):

0    1    2    3    4    5    6    7    8    9    10  
No pain Most severe pain imaginable

B. Rate how severe your pain is **at its worst** (circle a number):

0    1    2    3    4    5    6    7    8    9    10  
No pain Excruciating

C. Rate how severe your pain is **on the average** (circle a number):

0    1    2    3    4    5    6    7    8    9    10  
No pain Excruciating

D. Rate how severe your pain is **aggravated by activity** (circle a number):

0    1    2    3    4    5    6    7    8    9    10  
Activities does not Excruciating following  
aggravate pain any activity

**Sum score of Section I:**    Add A through D = Total Pain Severity/4 = \_\_\_\_\_

E. Rate how **frequently** you experience pain (circle a number):

0    1    2    3    4    5    6    7    8    9    10  
Rarely All of the time

**Add total pain severity score (items A through D/4) to score for item E = \_\_\_\_\_**

TOTAL PAIN SEVERITY SCORE (RANGE FROM 0 TO 20) =





