403 Gilead Road, Suite B
Huntersville NC, 28078
(P) 704.464.1509
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Email: info@ncneuro.com

Date: _____

Patient Name _____ DOB_____

REASON FOR VISIT: _____

PATIENT'S CONCERNS: **Check all that apply**

- ☐ Abdominal pains
- ☐ Anxiety
- ☐ Chills
- ☐ Cough
- ☐ Easy bruising
- ☐ Fever
- ☐ Poor appetite
- ☐ Neck pain
- ☐ Behavior Problems
- ☐ Skin rash
- ☐ Trouble hearing
- ☐ Vomiting
- ☐ Abnormal growth
- ☐ Asthma
- ☐ Chokes easily
- ☐ Daydreaming
- ☐ Excessively sleepy
- ☐ Frequent falls
- ☐ Insomnia
- ☐ Numbness or tingling
- ☐ Shortness of breath
- ☐ Speech problems
- ☐ Trouble learning
- ☐ Weakness
- ☐ Aggressive
- ☐ Back pain
- ☐ Clumsy/poor coordination
- ☐ Depression
- ☐ Fainting or passing out
- ☐ Headache
- ☐ Joint pain or swelling
- ☐ Pain in arms or legs
- ☐ Reactive Airway Disease
- ☐ Stares off into space
- ☐ Trouble seeing
- ☐ Weight change
- ☐ Allergies
- ☐ Birthmark
- ☐ Diarrhea
- ☐ Hostile/Angry
- ☐ Shy
- ☐ Heart murmur
- ☐ Nasal congestion
- ☐ Pain with urination
- ☐ Tremor
- ☐ Trouble sleeping
- ☐ Wets self during the day
- ☐ Wets self during sleep
- ☐ Anemia
- ☐ Chest pain
- ☐ Constipation
- ☐ Dizziness
- ☐ Fatigue

BIRTH HISTORY: **Check all that apply**

Problems with pregnancy: ☐ Infection ☐ Fever ☐ High blood pressure ☐ Drank alcohol ☐ Used recreational drugs
Delivery: ☐ Vaginal ☐ Cesarean (C-Section)
Problems with delivery? ☐ No ☐ Yes ☐ Other _____
Birth was: ☐ Full term ☐ Late ☐ Early (how many wks? _____) Birth Weight: _____
Problems as newborn: ☐ Jaundice ☐ Breathing ☐ Infection ☐ Seizure ☐ Heart
☐ NICU stay ☐ Feeding

☐ Other Birth Issues: _____

MEDICAL HISTORY: Check or fill in as indicated

Hospitalizations: ☐ No ☐ Yes, for what?: _____

Surgery: ☐ No ☐ Yes, for what?: _____

Past medical problems / illnesses: _____

Immunizations up to date: ☐ No ☐ Yes

Tests performed: ☐ MRI ☐ CT scan ☐ Spinal tap ☐ Genetics ☐ EEG/Brain wave test

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Allergies to medications: _____

Current medications and doses: _____

FAMILY MEDICAL HISTORY: Check all that apply and write in relationship of family member to patient to whom it applies.

☐ Headaches _____ ☐ Learning difficulties/Developmental Delay _____

☐ Behavior (Psychiatric) problems _____ ☐ Speech problems _____

☐ Inflammation (lupus, sarcoid, etc.) _____ ☐ Muscle problems _____

☐ Other medical illnesses not listed that run in the patient's family? (i.e. young heart attack/stroke, blindness, deafness, tremors, tics): _____

SOCIAL HISTORY:
Members of household: _____

Current grade placement _____ Name of School: _____

OFFICE NOTES ONLY:

HT		WT	
BP		HR	
POX		TEMP	

Doctor Reviewed with family: _____Date_____