Restorative Neurology and Headache Center

7730 W Boynton Beach Blvd, # 4
Boynton Beach, FL
Phone: (813)482-5515
Fax: (813)537-8752

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Dear Sir/Madame,

Please, complete each page of this form and return it to us, preferably prior to your appointment. If available, also have with you at the time of your appointment all laboratory results for the past 2 years, imaging (CT scan or MRI of the brain and spine), carotid doppler, EEG, nerve conduction tests, hospitalization records and other medical records that may be relevant to your health concerns.

We ask you to bring the following to your initial consultation:

1) Photo ID
2) Insurance Card
3) List of all medications and supplements. It is preferable to bring supplements with you so that we see the exact composition.

Please, arrive in time for your appointment to maximize your time with the doctor.

If you are unable to keep your appointment, please notify us in advance to cancel or reschedule.

Thank you for allowing us to be part of your health care team. We look forward to meeting with you and helping you to regain your health!

Nina Tsakadze, MD, PhD
RNHC Founder and Medical Director

WHAT TO EXPECT

Be treated with courtesy, respect and protection of privacy.

Receive impartial in–depth assessment and review, with the diagnosis, planned course of further evaluation and treatment, risks and prognosis provided to you after your appointment.

Restorative Neurology and Headache Center works with Medicare, but is not contracted with any commercial insurance companies or Medicaid.

Understand that Restorative Neurology and Headache Center is a specialty care clinic and the services we provide are not meant to take place of your primary care provider.

Understand that as a specialty care clinic we do not offer emergency or urgent care. If you experience medical emergency, please, call 911 and go to the nearest emergency room or urgent care facility.

Prompt and reasonable response to non-urgent questions and requests outside of the appointment is provided to our patients within 48 hours.

DEMOGRAPHIC PROFILE

Date_____

Name_____

Date of Birth _____ Sex _____Ht_____Wt_____

Address_____City_____State_____Zip_____

Phone _____ Alternative phone_____

Email_____

Name of Insurance_____Insurance Policy#_____

Primary Care Provider_____Phone_____Fax_____

Alternative Providers_____Phone_____

Preferred Pharmacy_____Phone_____

Race/Ethnicity_____

Preferred Language_____

Employment Status and Occupation_____

Referring provider (if applicable)_____

How did you hear about us?_____

HISTORY OF PRESENT ILLNESS

List your complaints below, prioritize and score severity on a scale from 0-10 with 10 being the worst imaginable.

| | Description | Score | When did it start? |
|---|---|---|---|
| | Example: Headache | 7 | June 2017 |
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |
| 9 | | | |
| 10 | | | |
| 11 | | | |
| 12 | | | |

PAST MEDICAL HISTORY

| | | | | | |
|---|---|---|---|---|---|
| | Alzheimer's | | Dysmenorrhea | | Neck /Back Injury |
| | Anemia | | Reflux | | Skin problems/Rash |
| | Anxiety/Depression | | Headache/Migraine | | Seizures |
| | Arthritis | | Heart disease/CAD | | Sinusitis |
| | Asthma | | HIV/AIDS | | Stroke |
| | Cancer | | High blood pressure | | TBI/Concussion |
| | COPD/Bronchitis | | Irritable Bowel Syndrome | | Thyroid disease |
| | Celiac disease | | Kidney disease | | Urinary tract infection |
| | Constipation | | Liver disease | | Other |
| | Diabetes | | Multiple sclerosis | | |

PAST SURGICAL HISTORY

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ALLEGIES
Foods_____

Drugs_____

Please, list examples of your typical MEALS:

Breakfast_____

Lunch_____

Dinner_____

How were you delivered as a baby? Vaginal Delivery_____C-section_____

Were you breastfed as a child for over 6 months? Yes _____ No _____

Have you taken numerous rounds of antibiotics? Yes_____No_____

For what reason and for how long?_____

Have you had exposure to water damaged buildings/mold? _____

Have you had history of tick/insect bites? _____

Have you had Adverse Childhood Experiences (Physical abuse, Sexual abuse, Verbal abuse, Physical Neglect, Emotional Neglect, Family member with depression or mental disease, Family member addicted to alcohol or drugs, Family member in prison, Witnessing a mother being abused, Parents divorced/separated
_____

Rate your level of STRESS from 1 to10? _____

METAL DENTAL FILLINGS (amalgam, silver, gold) Yes _____ No _____

SLEEP
Hours per night? _____ Snoring? Yes _____ No _____

CURRENT MEDICATIONS

| Medication | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

CURRENT SUPPLEMENTS

| Supplement | Dose | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

SOCIAL HISTORY

Smoking _____Married_____Employed_____
Alcohol _____ Live alone_____Unemployed_____
Marijuana_____ Divorced_____Retired_____
Other drugs_____ Occupation_____Disabled_____

Caffeine (servings per day)_____

Exercise hours/week _____

Occupational exposures_____

Chemical exposures_____

FAMILY HISTORY

Azheimer's disease _____
Autoimmune disease _____
Cancer_____
Diabetes _____
Epilepsy _____
High blood pressure_____
Heart disease_____
Migraine _____
Multiple sclerosis_____
Stroke_____
Thyroid disease_____

REVIEW OF SYSTEMS (check all that apply)

**Constitutional**
Hot flashes Fevers Chills Night sweats Fatigue
Weight loss Weight Gain Sleeplessness

**Head/Eyes**
Headache Vision loss Blurry vision Double vision Light sensitivity
Dry eyes Discharge Tearing

**Ears, Nose, Throat**
Ear pain Ear drainage Nose bleeds Bleeding gums Hearing loss
Ringing in the ears Nasal congestion Nasal discharge Problem swallowing

**Cardiovascular**
Chest pain Palpitations Irregular heart beat Edema (swelling)
Fainting spells Claudication

**Respiratory**
Shortness of breath Cough Wheezing Wear oxygen CPAP

**Gastrointestinal**
Abdominal pain Constipation Diarrhea Nausea/Vomiting Ulcers
Reflux Flatulence Hemorrhoids Food intolerances Blood in stool

**Genitourinary**
Frequency Urgency Hesitancy # urinations overnight _____
Painful urination Incontinence/Leakage of urine

**Musculoskeletal**
Back pain Neck pain Joint pain Joint swelling
Muscle pain Muscle stiffness Cramps

**Dermatological**
Acne Rashes Dryness Itching Birthmarks Ulcers

**Neurological**
Headache Dizziness/Vertigo Memory loss Tremor/Involuntary movements
Seizures Weakness Nerve pain Numbness Tingling

**Endocrine**
Heat intolerance Cold intolerance Hair changes Nail changes

**Psychiatric**
Depression Anxiety Panic attacks PTSD

**Female**
Breast lumps/tenderness Vaginal dryness /discharge Pelvic pain
PMS OCPs STDs Abnormal Pap Abnormal mammogram
Pregnancy # _____ Miscarriage # _____ Decreased libido

**Male**
Testicular pain Erectile dysfunction Decreased libido Prostate problems STD

**Do you experience any PAIN?**

Location _____Severity (on the scale from 0-10)_____

Frequency (constant, frequent, occasional) _____

Thank you for completing this form.
Please, contact us to schedule your appointment.