Patient Name: _____ Today's Date: _____

Birthdate: _____

Neurological Symptoms

On a scale of 1-10 (10 being the worst), what is your current level of pain? _____

Reason for visit: (Please provide a brief history of your symptoms)

_____

_____

_____

_____

This visit is an:

□ Initial Consult □ Second Opinion (treatment has already been recommended by another provider)

Have you seen any other providers related to this condition (Neurologist, Oncologist, Ophthalmologist, ENT, etc.)? □ Yes □ No

If yes, provider/clinic name _____

Were you referred to us by a specific provider? □ Yes □ No

If yes, please list provider name and clinic: _____

Check any symptoms you have been experiencing: □ None

□ Dizziness □ Lightheaded □ Vision Changes □ Hearing Changes □ Speech Changes

□ Headache □ Numbness □ Tingling □ Loss of Balance □ Facial Paralysis

□ Seizures □ Confusion □ Disorientation

Are your symptoms: □ Recurring □ Improving □ Worsening

What is the severity of your symptoms: □ Mild □ Moderate □ Severe □ Incapacitating

□ Other _____

How often do your symptoms occur: □ Constantly □ Daily □ Weekly □ Randomly

□ Other _____