NPBTC
Neurology, Psychiatry and Balance Therapy Center, LLC

Patient History Form Page One

Patient Name_____ Date_____

What medical concerns can we assist with today?

_____

_____

Primary care physician:_____ Primary's phone #_____
Referring provider: _____ Provider's phone #_____
Pharmacy Name/Address_____ Pharmacy phone #_____

Are you currently receiving physical therapy? (Y/N)
Handedness? (Right/Left)

Are you allergic to any medications? ϒ Yes ϒ No
If yes, to which medications and what type of reaction?_____
Are you allergic to any foods? ϒ Yes ϒ No
If yes, to which foods, and what type of reaction?_____
Do you have any environmental allergies? ϒ Yes ϒ No
If yes, to what and what type?_____

Current Medications

Medication	Dose (mg/mcg)	Number of times taken daily

Family History

	Living	List Illnesses:
Mother	❑ Yes ❑ No	
Father	❑ Yes ❑ No	
Sisters	❑ Yes ❑ No	
Brothers	❑ Yes ❑ No	
Children	❑ Yes ❑ No	
Other Family Member:	❑ Yes ❑ No	
Other Family Member	❑ Yes ❑ No	

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Patient History Form Page Two

Patient initials_____

Social History

Do you currently smoke or chew tobacco? ϒ Yes ϒ No
If yes, how many packs per day? _____ How many years have you been smoking?_____
If no, have you in the past? ϒ Yes ϒ No How many years did you smoke?_____
Do you drink alcohol, beer, or wine? ϒ Yes ϒ No
If yes, how many years have you or did you drink?_____
If no, have you in the past? ϒ Yes ϒ No How many drinks per week? _____
Have you ever used an illicit drug? ϒ Yes ϒ No If yes, what have you used? _____
_____
If you still use, do you feel this is a problem ϒ Yes ϒ No
Do you currently drink coffee, pop, tea, or energy drinks? ϒ Yes ϒ No
Do you exercise daily/weekly? ϒ Yes ϒ No
Do you feel you have social support ϒ Yes ϒ No
What is the highest education level you have completed?_____
What do you do for a living?_____
What are your domestic responsibilities?_____
What are your hobbies/recreational activities? _____
_____

Please list your past surgeries
_____
_____
_____

Check Yes or No to the following diagnoses if you have ever been diagnosed with them:

ADD/ADHD	Yes	No	Developmental or Behavioral disorders	Yes	No	Nasal Polyps	Yes	No
AIDS/HIV	Yes	No	Diabetes	Yes	No	Other mental health conditions	Yes	No
Amnesia	Yes	No	Difficulty Swallowing	Yes	No	Schizophrenia	Yes	No
Anxiety	Yes	No	Eating Disorder	Yes	No	Seizures	Yes	No
Asthma	Yes	No	Fibromyalgia	Yes	No	Sleep Apnea	Yes	No
Auditory Hallucinations	Yes	No	GERD/Reflux	Yes	No	Stroke	Yes	No
Brain Injury	Yes	No	GI Problems	Yes	No	Thyroid disease	Yes	No
COPD	Yes	No	Headaches/Migraines	Yes	No	Tourette syndrome	Yes	No
Cancer	Yes	No	Heart Problems	Yes	No	Vision problem	Yes	No
Chronic Ear Infections	Yes	No	Hospitalizations	Yes	No	Visual Hallucinations	Yes	No
Depression	Yes	No	Learning Disorders	Yes	No		Yes	No

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Patient History Form Page Three

Patient initials_____

Circle any symptoms you have experienced in the last 2 WEEKS ONLY (current symptoms only):

Difficulty Hearing	Chills	Weight Gain	Weight Loss	Dry Eyes	Vision Changes	Eye Irritation	Blurry Vision
Double Vision	Fever	Trouble Swallowing	Frequent nose bleeds	Dental concerns	Chest Pain	Palpitations	Known Heart Murmur
Hallucinations	Wheezing	Shortness of Breath	Coughing up blood	Abdominal pain	Vomiting	Diarrhea	Blood in stool
Urinary frequency	Pain with urinating	Incontinence	Blood in urine	Muscle Aches	Joint Pain	Joint Swelling	Rashes
Recent loss of consciousness	Headache/ Migraine	Tremor	Seizure	Cough	Fatigue	Depression	Anxiety
Panic Attacks	Self-Harm	Thoughts of Suicide	Thoughts of harming others	Sleep disturbances	Restless sleep	Dizziness	Feeling unsafe in relationships

Is there anything else you would like us to know regarding your medical history?

_____

What are your main goals with coming to see us?

_____