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 #_____

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

Current Medications

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

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

Social History

Do you currently smoke or chew tobacco? □ Yes □ No
If yes, how many packs per day? _____ How many years have you been smoking?_____
If no, have you in the past? □ Yes □ No How many years did you smoke?_____
Do you drink alcohol, beer, or wine? □ Yes □ No
If yes, how many years have you or did you drink?_____
If no, have you in the past? □ Yes □ No How many drinks per week? _____
Have you ever used an illicit drug? □ Yes □ No If yes, what have you used? _____
_____
If you still use, do you feel this is a problem □ Yes □ No
Do you currently drink coffee, pop, tea, or energy drinks? □ Yes □ No
Do you exercise daily/weekly? □ Yes □ No
Do you feel you have social support □ Yes □ 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? _____
_____

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Patient History Form Page Two

Patient initials_____

What are your goals for treatment or what activities would you like to be able to do that you have trouble doing now because of your condition? (Please list 2-3) _____

_____

_____

Have you have had any of these symptoms recently? (Please circle)

Cough	Change in vision	Sinus pain	Leg cramps
Shortness of breath	Swollen/painful joints	Allergy symptoms	Heartburn
Thoughts of suicide	Headache	Breathing problems	Diarrhea
Light sensitivity	Dizziness	Chest pain	Nausea/vomiting
Decreased hearing	Fainting	Palpitations	Rash
Abdominal pain	Sound sensitivity	Pain with urination	Urinating frequently
Back pain	Difficulty urinating	Constipation	Memory difficulty
Neck pain	Foot/ankle pain	Numbness	Trouble sleeping/snoring
Sore Throat	Swollen lymph nodes	Weakness	Recent Weight Loss/Gain
Fatigue	Sexual dysfunction	Hoarseness	Tingling
Depression	Anxiety	Loss of taste	Walking difficulty
Double vision	Swallowing difficulty	Ringing in the ears	Loss of consciousness
Speech difficulty	Loss of smell		

Females: Gynecological History

Are you pregnant? (Y/N)
Do you get any symptoms that seem to occur regularly with your period (Y/N)
If yes, please explain_____

Which of the following medical conditions do you have or have had in the past?

☐ Heart problems	☐ Blood pressure problems	☐ Stroke/TIA
☐ Breathing problems	☐ Diabetes	☐ Cancer
☐ Depression/anxiety	☐ Migraines	☐ Head/neck trauma

Please describe any current or past medical conditions not listed above:

_____
_____
_____

Please list your past surgeries

_____
_____
_____

Family History

	Living	Age(s) (or age at death)	List illnesses
Mother	☐ Yes ☐ No	_____	_____
Father	☐ Yes ☐ No	_____	_____
Sisters	☐ Yes ☐ No	_____	_____
Brothers	☐ Yes ☐ No	_____	_____
List other family members and their illnesses			
_____	☐ Yes ☐ No	_____	_____
_____	☐ Yes ☐ No	_____	_____