



EMERY NEUROSCIENCE CENTER

Patient Name:				Chart #:	
DOB:		Age:		Date:	

PATIENT INFORMATION

(Name and Birth Date is only necessary if the information on the header above is not correct):

Patient's last name:	First:	Middle:	Patient Birth Date:
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Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status (circle one) Single / Married / Divorced / Separated / Widowed		
Primary Care Physician:			Office Phone: ()
Referring Physician:			Office Phone: ()
Street address:	Social Security Number:	Home Phone: ()	
City:	State:	Zip Code:	Cell Phone: ()
Occupation:	Employer:	Employer Phone: ()	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home Phone: ()	Work Phone: ()
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Allergies, X-rays, Surgeries

Are you allergic to:						
Medicine			Medicine			Any Foods:
Penicillin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Antitoxin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Sulfa Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mycins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other Antibiotics	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Codeine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Adhesive Tape	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Morphine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any Other Drugs:			
Tetanus	<input type="checkbox"/> Yes	<input type="checkbox"/> No				

Have you ever had X-rays, MRI scans, CAT scans, or other radiological studies of your:		
	Date:	Findings:
Skull/Head		
Back		
Neck		
Chest		
Extremities		
Other Area(s)		

If you have had surgery to the following areas, please enter date/name of hospital in space provided:		
Focus Operation:	Date:	Hospital
Tonsils		
Ovary(ies)		
Gall Bladder		
Uterus		
Appendix		
Hemorrhoids		
Other Operations		
Have you had a transfusion?		<input type="checkbox"/> Blood <input type="checkbox"/> Plasma
Any other illnesses or hospitalizations:		Date: _____ Hospital: _____



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Emotions

<i>Prior to your neurological symptoms, have you felt/or have you been treated for:</i>			
Emotion/Action	Response	Emotion/Action	Response
Depressed		Jumpy	
Irritable		Jittery	
Anxious		Difficulty Concentrating	

<i>Since the onset of your current neurological symptoms, have you felt:</i>			
Emotion/Action	Response	Emotion/Action	Response
Depressed		Jumpy	
Irritable		Jittery	
Anxious		Difficulty Concentrating	

Have you ever been treated for the <i>same</i> or <i>similar</i> condition for which you are currently seeking treatment?
Please Explain:

Have you ever been treated by a neurologist before?
Why? :

Have you ever been treated by a neurosurgeon before?
Why? :

Have you ever been treated by a chiropractor before?
Why? :

<i>Previous</i> car accidents/work related accidents/slip-and-fall accidents leading to medical treatment, emergency room visit, etc:
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<i>Prior to your current complaints</i> have you ever had any of these medical problems?	
Head Injury:	
Neck Injury:	
Middle Back Injury:	
Lower Back Injury:	
Arm/leg Injury:	



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Have you ever had:		When?	Since Injury?
Chest Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Angina	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spitting up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Night Sweats	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
At night	<input type="checkbox"/> Yes <input type="checkbox"/> No		
With exertion	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Palpitations	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fluttering Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of hands	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of feet	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Swelling of ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Extreme tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Extreme weakness	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Stones	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Problems w/urination	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal thirst	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Prostate trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Indigestion	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Gas	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Belching	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Rectal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Parasites/Worms	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No



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Review of System

Have you ever had:		When?	Since Injury?
Eye Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Eye Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Impaired Sight	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Impaired Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with nose	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with sinuses	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Trouble with throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting spells	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Severe	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Enlarged Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Overactive	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Under active	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Chronic	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Appendicitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Gall Bladder Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No



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Social History

1.	Do you smoke?	<input type="checkbox"/> Cigarettes	PPD
2.	Do you drink alcohol?	<input type="checkbox"/> Cigars	<input type="checkbox"/> Pipe
3.	Do you drink caffeine?	<input type="checkbox"/> Coffee	<input type="checkbox"/> Tobacco
4.	Do you exercise?	<input type="checkbox"/> Snuff	
5.	Do you like your work?	Ounces per week	
6.	Do you work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7.	Do you watch TV?	How? Please Explain:	
8.	Do you read?	<input type="checkbox"/> Inside	<input type="checkbox"/> Outside
9.	Do you take vacations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10.	Have you ever been treated for drug abuse?	How many hours of work per day?	
11.	Have you ever been treated for alcoholism?	Hours per day	
12.	Change in appetite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13.	Change in eating habits?	Hours per day	
14.	Change in bowel movements?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15.	Change in stools?	Weeks per year	
16.	Do you take thyroid medicine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17.	Do you take insulin?	Explain:	
18.	Do you take sedatives?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
19.	Do you take tranquilizers?	Explain:	
20.	Do you take sleeping pills?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
21.	Do you take aspirin?	Explain:	
22.	Do you take cortisone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
23.	Do you take laxatives?	Explain:	
24.	Do you take vitamins?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
25.	Do you take oral contraceptives?	Explain:	
26.	Do you take hormone therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Height:		Feet	Inches
Current Weight:		Pounds	
Weight 1 year ago:		Pounds	
Maximum Weight:		Pounds	When:



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Family History

Age (if living):			
Father:	Mother:	Spouse:	Brother(s):
Sister(s):		Children:	

Age of death:			
Father:	Cause of death:	Mother:	Cause of death:
Relationship:	Age at death:	Relationship:	Age at death:
Other Members Family			
Relationship:	Age at death:	Relationship:	Age at death:
Relationship:	Age at death:	Relationship:	Age at death:
Relationship:	Age at death:	Relationship:	Age at death:

Does anyone in your family currently have or had the following illnesses?		
		Relationship to Patient
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nervous Breakdown	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hay Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	



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Past Medical History

(PLEASE LIST ONLY IF YOU HAD BEFORE YOUR CURRENT COMPLAINTS OR INJURY)

Have you had:	Age:	Date:	Have you had:	Age:	Date:	
Scarlet Fever			Diabetes			
Scarlatina			Hay Fever			
Diphtheria			Asthma			
Rheumatic Fever			Hives			
Pneumonia			Eczema			
Pleurisy			High Blood Pressure			
Fever Fluctuation			Low Blood Pressure			
Arthritis			Frequent Infections			
Rheumatism			Concussion			
Bone Disease			Head Injury			
Joint Disease			Underactive Thyroid			
Neuritis			Overactive Thyroid			
Neuralgia			Food Poisoning			
Bursitis			Tuberculosis			
Sciatica			Heart Attack			
Polio			Other Heart Problems			
Meningitis			Epilepsy			
Gonorrhea			High Cholesterol			
Syphilis			Cancer			
Anemia			Migraine Headaches			
Jaundice			Other Headaches			
Drug Poisoning	Age	Date	Explain			
Broken Bones	Age	Date	Which Bone(s)			
Deliveries	Age	Date	# of Deliveries			
Tested for HIV?	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	T-Cell Count	Viral Load

Other Disease / Medical Problems not listed	Date:



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Neurological Evaluation P/M Patient's History

Records Available			
<input type="checkbox"/> Brought by patient	<input type="checkbox"/> Sent by doctor's office	<input type="checkbox"/> Sent by attorney's office	<input type="checkbox"/> Sent by W/C
Patient referred by:			
<input type="checkbox"/> Patient has been seen previously in this office:		Date of previous NEO:	
Reasons for previous neurological treatment (chief complaints):			
Date last seen:		Diagnosis:	
Work Status			
Place of Employment		Occupation:	
<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Light-duty	<input type="checkbox"/> Full-duty
<input type="checkbox"/> Disability			
<input type="checkbox"/> Not working Date last Worked:		<input type="checkbox"/> Patient has been seen previously in this office for:	
Age	<input type="checkbox"/> Right		<input type="checkbox"/> Left-handed
<input type="checkbox"/> married	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<input type="checkbox"/> Separated
<input type="checkbox"/> Widowed			
<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Black
<input type="checkbox"/> Other:			
<input type="checkbox"/> Male		<input type="checkbox"/> Female	
Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Creole <input type="checkbox"/> French <input type="checkbox"/> Italian <input type="checkbox"/> German <input type="checkbox"/> Other:			
Seen With:		<input type="checkbox"/> Interpreter <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Description of symptoms:			
Other Notes:			

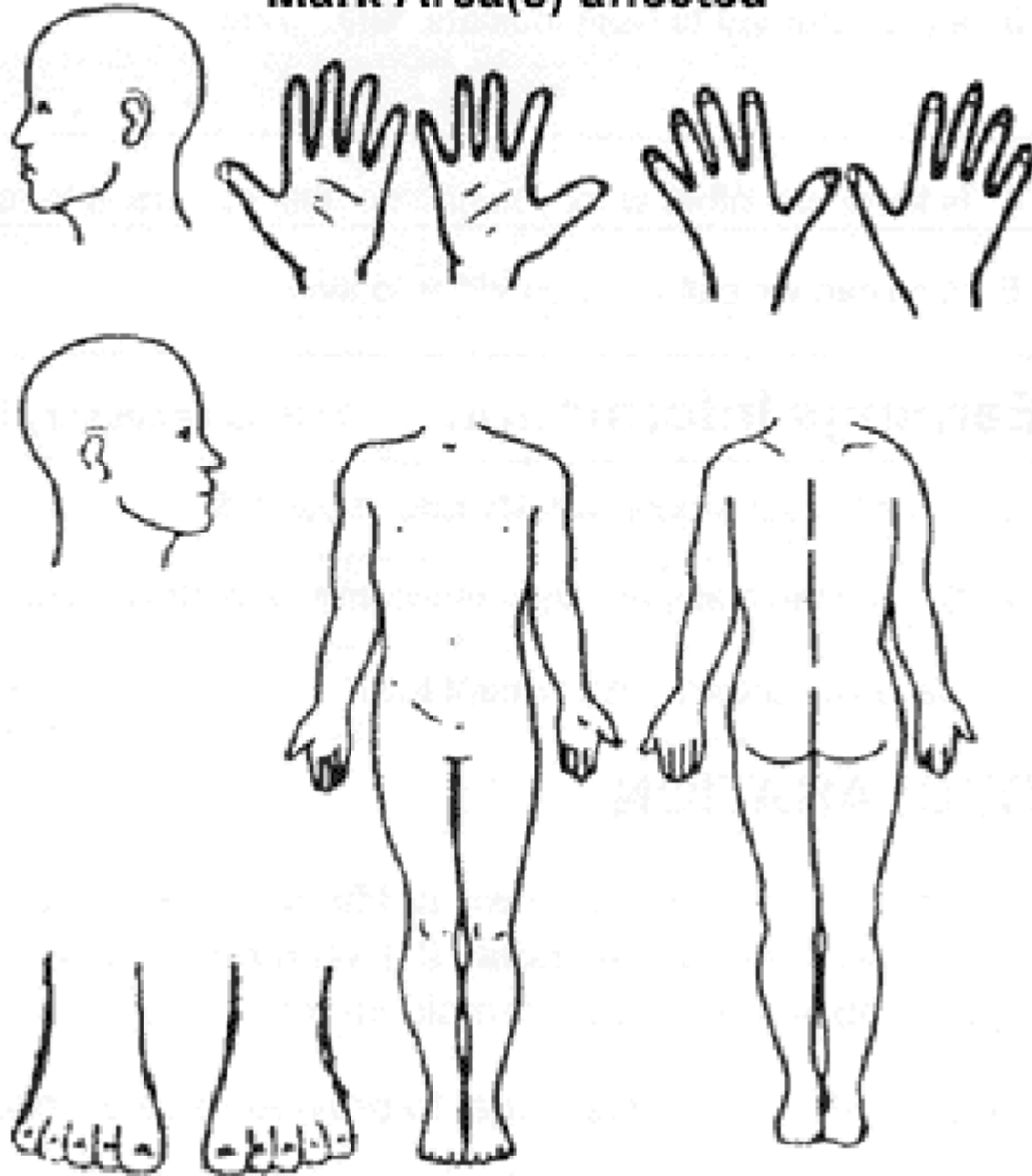
The patient has a previous history of accident / injuries:			
1.	Dated:	Injuries:	
<input type="checkbox"/> Workmen's Compensation		<input type="checkbox"/> Auto Accident	Other:
Diagnosis(es):			
2.	Dated:	Injuries:	
<input type="checkbox"/> Workmen's Compensation		<input type="checkbox"/> Auto Accident	Other:
Diagnosis(es):			
3.	Dated:	Injuries:	
<input type="checkbox"/> Workmen's Compensation		<input type="checkbox"/> Auto Accident	Other:
Diagnosis(es):			
Other Notes:			



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Mark Area(s) affected





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		Date:	

Neurological Symptom Checklist

Please check ***ONLY*** the areas where you are having neurological problems that you would like Dr. Emery to evaluate. A questionnaire for each area you check will then be given to you which you are to bring into the examining room with you so that Dr. Emery will evaluate your specific neurological symptoms.

Are your neurological symptoms a result of an accident of any kind?	
<input type="checkbox"/> YES	<input type="checkbox"/> NO

If your symptom is a result of an accident then please specify:	
<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Slip and Fall
<input type="checkbox"/> Workmen's Compensation	
<input type="checkbox"/> Other	Describe:

<input type="checkbox"/>	HEADACHES
<input type="checkbox"/>	NECK PAIN
<input type="checkbox"/>	MIDDLE BACK PAIN
<input type="checkbox"/>	LOW BACK PAIN
<input type="checkbox"/>	VISION PROBLEMS
<input type="checkbox"/>	VERTIGO OR DIZZINESS
<input type="checkbox"/>	WALKING PROBLEMS
<input type="checkbox"/>	NUMBNESS OR WEAKNESS OF FACE
<input type="checkbox"/>	NUMBNESS OR WEAKNESS OF ARMS/HANDS
<input type="checkbox"/>	NUMBNESS OR WEAKNESS OF LEGS/FEET
<input type="checkbox"/>	MEMORY DISTURBANCE
<input type="checkbox"/>	DEPRESSION
<input type="checkbox"/>	ANXIETY
<input type="checkbox"/>	TREMOR
<input type="checkbox"/>	SEIZURE OR SPELLS OF LOSS OF CONSCIOUSNESS
<input type="checkbox"/>	SPEECH DIFFICULTY
<input type="checkbox"/>	SLEEP DISTURBANCE



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Patient Consent Form

<input type="checkbox"/>	I consent to have my medical records provided to my other active treating physicians.
<input type="checkbox"/>	I consent to have my medical records provided to physicians whom Dr. Emery refers me to for additional treatment or whom Dr. Emery wants a second opinion, e.g., a Professor of Neurology.
<input type="checkbox"/>	I consent to have my medical records provided to Social Security Disability (should the need ever arise.)
<input type="checkbox"/>	I consent to have my medical records provided to any attorney who represents me either in civil litigation (personal injury) or in a Workman's Compensation claim. I understand that in a Workmen's Compensation claim a Defense Attorney (the attorney representing the company you work for) as well as adjustors, nurse case managers, secretaries, or any other personnel working for the Insurance Company have the right to my medical records as well as the right to talk with Dr. Emery <u>without my permission</u> , according to Florida State Law.
<input type="checkbox"/>	I consent to have my medical records provided to any and all of my family members if requested.
<input type="checkbox"/>	I consent to have my medical records provided to my insurance company should they request them for billing purposes or should they request them prior to authorizing a test or tests that Dr. Emery has recommended.
<input type="checkbox"/>	I consent to have my medical records provided to any Law Enforcement agency should a situation arise in which Dr. Emery feels it would be in <u>my</u> best interest to do so, e.g. I get involved in a bad accident and a law enforcement agency wants to know what my Neurological condition is or what medicines I am taking.
<input type="checkbox"/>	I consent to being Video taped if Dr. Emery orders a Video EEG.
<input type="checkbox"/>	None of These options

Signature

Date



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PATIENT CONTRACT PM

The undersigned, whether he/she signs as guardian, agent or as patient, agrees that in consideration of the service to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Waden E. Emery III, M.D., P.A.. Should the account be referred to an attorney or collection agency, the undersigned shall pay all reasonable attorneys' fees and collections expense.

This authorization or photocopy thereof will authorize the release of full and complete medical records when necessary to authorized physicians, hospitals, medical attendants, attorneys and/or insurance companies.

If the insured's policy prohibits direct payment to the physician, then the insured person/persons hereby instructs and directs the insurance company to make the payment out to the insured person/persons as patient and mail payment to the insured person/persons as follows:

**c/o Waden E. Emery III, M.D., P.A.
5340 North Federal Highway
Suite 205
Lighthouse Point, Florida 33064**

- The undersigned agrees that assignment of each medical claim to any insurance or agent will be taken by **Waden E. Emery III, M.D., P.A.** and the undersigned is responsible for any difference, between the amount charged.
- The undersigned agrees that the total amount for each visit is due and payable at the time of service.
- The undersigned agrees telephone calls to this office requiring medical or medical staff attention will be subject to the appropriate levels of service charge.
- The undersigned agrees that a disruption fee will be charged if, at least, 24 hour notice of cancellation of an appointment is not given.

Waden E. Emery III, M.D., P.A. contracts with numerous insurance companies. In the event Waden E. Emery III, M.D., PA. contracts with your insurance company, Waden E. Emery III, M.D., PA's contract with your insurance company will supersede this contract.

I/We have read, understood and agree to the above.

Print: Patient's Legal Name	Print: Agent or Guardian's Legal Name
_____	_____
Patient's Signature	Agent or Guardian's Signature
_____	_____
Date	Date