

PATIENT DOB: _____ / _____ / _____
MONTH DAY YEAR

PATIENT NAME: _____
LAST FIRST MI

Patient Medical History: Please mark all that apply

<input type="checkbox"/> Abnormal Heartbeat	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Anemia	<input type="checkbox"/> Problems with Anesthesia
<input type="checkbox"/> Anxiety/Panic Attacks	<input type="checkbox"/> Asthma	<input type="checkbox"/> Autism/Asperger's	<input type="checkbox"/> Autoimmune Disorders
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Blindness	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Constipation/Encopresis	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Deafness	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema	<input type="checkbox"/> Epilepsy/Seizure	<input type="checkbox"/> Fainting/Blackout
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Genetic Disorders	<input type="checkbox"/> Headache	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Defect	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> IBS	<input type="checkbox"/> Kidney/Urinary Tract Disorders	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Muscle Disease	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Nystagmus
<input type="checkbox"/> OCD	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> SIDS/Crib Death
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Stomach/Digestion Disorders	<input type="checkbox"/> Sexually Transmitted Diseases	<input type="checkbox"/> Strabismus
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Tic/Tourette Syndrome	<input type="checkbox"/> Tremor
<input type="checkbox"/> Other:			

Patient Surgical History: Please mark all that apply

<input type="checkbox"/> Carotid Endarterectomy	<input type="checkbox"/> Ileac/Femoral Bypass	<input type="checkbox"/> Brain Aneurysm
<input type="checkbox"/> Craniotomy	<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Cataract
<input type="checkbox"/> Cervical Spine	<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> CABG
<input type="checkbox"/> Heart Valve	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Join Replacement
<input type="checkbox"/> Lumbar Spine	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Coronary Stent	<input type="checkbox"/> Transplant	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Other Cancer:	<input type="checkbox"/> Other:	

Prior Neurodiagnostic Testing: Please mark all that apply

MRI

- Head
- Neck
- Lumbar
- Other:

Date(s): _____

Testing Facility:

- Oregon Imaging Center
- Willamette Valley Imaging
- Other:

CT

- Head
- Neck
- Lumbar
- Other:

Date(s): _____

Testing Facility:

- Sacred Heart Hospital
- McKenzie-Willamette Hospital
- Other:

NCV/EMG

Date(s): _____

Testing Facility:

EEG

Date(s): _____

Testing Facility:

- Sacred Heart Hospital
- McKenzie-Willamette Hospital
- Other:

Patient Birth History

Where was the child born?

- Sacred Heart Hospital
- McKenzie-Willamette Hospital
- Other: _____

Birth Weight: _____ lbs. _____ oz.

Apgar Score: (please circle)

1 min:	0	1	2	3	4	5	9	7	8	9	10
5 min:	0	1	2	3	4	5	9	7	8	9	10

Problems During pregnancy with this child:

- Diabetes
- Fetal Distress
- Premature labor
- Bleeding
- Hypertension
- Other: _____
- None

Problems during delivery of this child:

- C-Section
- Abnormal fetal heart rate
- Vacuum extraction
- Meconium staining
- Premature rupture of membranes
- Other: _____
- None

Developmental History

Did child develop at same age as siblings? (circle one) YES NO

At what age did the patient:

	Lift head?	Roll over?	Sit without support?	Begin walking?	Say their first word?	Make their first sentence?	Pedal a tricycle?	Become toilet-trained?
3 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23 Months	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2 Years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3 Years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4 Years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5 Years	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Unknown	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Social History

Family changes since symptoms began: (mark all that apply)

- A new child
 A marriage
 A divorce
 None
 A job change
 Serious illness
 A death

School Name: _____ Grade Level: _____

Average Grades: (circle one) A's B's C's D's C's F's

Repeated a grade? (circle one) YES NO

Social History

School days missed due to illness: (circle one) 0 1-5 6-10 10-20 > 20

How does child get along with others? (circle one) Not well As expected Very well

Discipline or behavior problems in school? (circle one) YES NO

Participates in sports: (circle one) YES NO

Child on IEP: (circle one) YES NO *If yes, for what?* _____

Drug use: (circle one) YES NO

If yes, for how many years? Less than 1 1-2 3-4 5-6 +7

Is there a history of physical and/or sexual abuse to the patient? (circle one) YES NO

Is the child adopted? (circle one) YES NO

Who has legal custody? (circle one)

Both parents Mom Dad Grandparents Court Other:

Patient writes with this hand: (circle one) RIGHT LEFT

Gynecological History: Women only

Has patient begun menstruating? (circle one) YES NO

Age at menarche: _____

LMP: _____ / _____ / _____

Is patient on birth control? (circle one) YES NO

Has patient ever been pregnant? (circle one) YES NO

Family History: (please mark all that apply)

	Father	Mother	Sibling	Grandparent	Other	If other, please specify:
Abnormal Heartbeat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ADD/ADHD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Problems with Anesthesia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Anxiety/Panic Attacks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Autism/Asperger's	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Autoimmune Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bipolar Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Birth Defects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bleeding Disorder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Family History: (please mark all that apply)

	Father	Mother	Sibling	Grandparent	Other	If other, please specify:
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Blood Clots	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cerebral Palsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Deafness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Epilepsy/Seizure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Fainting/Blackout	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Genetic Disorders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Headache	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Heart Attack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Heart Defect	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Learning Disability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Mental Retardation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Muscle Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Neuropathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Nystagmus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
OCD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Rheumatic Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Schizophrenia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
SIDS/Crib Death	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Strabismus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Tic/Tourette Syndrome	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Tremor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

SPRINGFIELD OFFICE:

1 Hayden Bridge Way, Springfield, OR 97477



Patient Profile

PATIENT INFORMATION

Name: _____

Preferred Name: _____

Date of Birth: _____ Sex: []M []F

Social Security #: _____

Address: _____

City,State,Zip: _____

Primary Phone: _____ []Home []Cell []Work

Secondary Phone: _____ []Home []Cell []Work

Referring Physican: _____

Primary Physician: _____

Employment Status:[]Employed []Retired []Unemployed

Employer: _____

Employer Phone: _____

Email: _____

SPOUSE OR PARENT INFO

Spouse or Parent: _____

Date of Birth: _____

Social Security #: _____

Address: _____

Employer: _____

Work Phone: _____

INSURANCE INFORMATION

If you would like us to bill your insurance, please bring a copy of your insurance card with you to your appointment.

Primary Insurance Company: _____

Policy/Group Number: _____

Subscriber ID: _____

Name of Subscriber: _____

Date of Birth: _____

Secondary Insurance Company: _____

Policy/Group Number: _____

Subscriber ID: _____

Name of Subscriber: _____

Date of Birth: _____

If applicable, check which applies: Work Injury (see below) Auto Injury (Date:_____) Accident (Date:_____)

WORK INJURY

Date of Injury: _____ Claim Number: _____

Employer at date of injury: _____

On-the-job Insurance Company: _____
