Intake Form: Movement Disorder

Chief Complaint

In your own words, what brings you in today?

_____

_____

History of Present Illness (HPI)

Briefly describe your present symptoms:

_____

_____

Date symptoms began? _____

Describe the frequency of the problem *(continuous, intermittent, daily, hourly etc.)*:

_____

On a scale from 0 to 10, 0 being no problem at all and 10 being severe as possible, how would you rate it? _____

What body parts are most affected? _____

Have you previously received a diagnosis for this problem? *(circle one)* **Yes** **No**

If so, what was the diagnosis:_____

Who made the diagnosis:_____

What tests have been performed to evaluate this problem *(i.e. MRI, lab tests, etc.)*?

_____

_____

What treatments have been tried for this problem *(i.e. medications, physical therapy, etc.)*?

_____

_____

What improves the problem *(medication, rest, sitting, etc.)*?

_____

_____

What worsens the problem *(exercise, poor sleep, stress, etc.)*?

_____

_____

Has your problem interfered with your activities of daily living, such as bathing, feeding, or clothing yourself, or has it impacted your occupation? If so, what?

_____

_____

Who in your family has a similar problem?

_____

Are you interested in participating in research trials? *(circle one)* **Yes** **No** **Maybe**

Surgical History ☐ No prior surgeries or procedures

Procedure	Date (MM/YYYY)	Complications?

Review of Systems

Constitutional ☐ None of the below

☐ Fever / Chills
☐ Unintentional weight gain / loss
☐ Exercise intolerance
☐ Fatigue
☐ Night sweats
☐ Inability to sleep
☐ Sleeping too much

HEENT ☐ None of the below

☐ Blurred vision / vision loss
☐ Hearing change
☐ Nosebleeds
☐ Difficulty chewing / swallowing
☐ Change in smell / taste
☐ Double vision
☐ Ringing in the ears
☐ Hoarseness / prolonged sore throat
☐ Speech changes / difficulty
☐ Snoring

Respiratory ☐ None of the below

☐ Shortness of breath
☐ Wheezing
☐ Chronic cough

Cardiovascular ☐ None of the below

☐ Chest pain / pressure / heaviness
☐ Swelling of feet / ankles
☐ Palpitations
☐ Fainting spells

Gastrointestinal ☐ None of the below

☐ Nausea / Vomiting
☐ Constipation
☐ Diarrhea
☐ Heartburn / Indigestion
☐ Abdominal pain
☐ Blood in stool

Genitourinary ☐ None of the below

☐ Pain or burning with urination
☐ Blood in urine
☐ Sexual dysfunction / impotence
☐ Frequent urination
☐ Change in menstrual cycle

Neurologic ☐ None of the below

☐ Headache
☐ Numbness / Tingling
☐ Involuntary movements / tremor / twitching / cramps
☐ Memory loss
☐ Poor balance / falls
☐ Seizures / Convulsions

Psychiatric ☐ None of the below

☐ Mood change
☐ Depression
☐ Anxiety
☐ Hallucinations
☐ Paranoia
☐ Delusions

Endocrine ☐ None of the below

☐ Heat or cold intolerance
☐ Excessive sweating
☐ Excessive thirst / urination
☐ Hair change

Hematologic/Immune ☐ None of the below

☐ Easy bruising or bleeding
☐ Swollen lymph nodes

Musculoskeletal ☐ None of the below

☐ Joint pain
☐ Neck pain +/- shooting pain into arms
☐ Low-back pain +/- shooting pain into legs

Movement Disorder Questionnaire

Handedness *(circle one)* **Left** **Right** **Both**

Do you have a tremor? *(circle one)* **Yes** **No**

If yes, where:

□ Hand □ Tongue □ Right Hand □ Right Arm □ Right Leg
□ Face □ Trunk □ Left Hand □ Left Arm □ Left Leg

When do you notice your tremor? *check all that apply*

□ At rest
□ With action (writing, eating, using a tool)
□ Holding an arm/leg outstretched

Does anything make your tremor **better**? *check all that apply*

□ Medication
□ Certain positions
□ Alcohol
□ Other_____

Does anything make your tremor **worse**? *check all that apply*

□ Stress
□ Activity/Exercise
□ Caffeine
□ Other_____

Have you tried any medications for your tremor? *check all that apply*

□ _____ **Did it help?** *(circle one)* **Yes** **No**
□ _____ **Did it help?** *(circle one)* **Yes** **No**
□ _____ **Did it help?** *(circle one)* **Yes** **No**
□ _____ **Did it help?** *(circle one)* **Yes** **No**

Do you have balance difficulty? *(circle one)* **Yes** **No**

If yes, have you fallen? *(circle one)* **Yes** **No**

If yes, how often?

□ Daily □ Weekly □ Monthly □ Yearly

Do you have sleep difficulty? *(circle one)* **Yes** **No**

If yes, check all that apply:

□ Falling asleep
□ Staying asleep
□ Vivid dreams
□ Talking/Kicking/Fighting in your sleep
□ Excessive daytime sleepiness
□ Walking up short of breath
□ Feeling of needing to move the legs and walk around

Do you have anxiety, depression, mood/personality changes? *(circle one)* **Yes** **No**

If yes, check all that apply:

□ Anxiety □ Personality change □ Depression □ Mood change

Do you have problems with memory? *(circle one)* **Yes** **No**

If yes, check all that apply:

□ Remembering short term events (events from the past week/month)
□ Remembering long term events (childhood/early adulthood memories)
□ Difficulty concentrating
□ Difficulty finding words
□ Other:_____