

## Intake Form: General Neurology

Briefly describe what brings you in for today's visit

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Date symptoms began: \_\_\_\_\_

Have you been given a diagnosis for these symptoms? If so, what diagnosis was given?

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What tests have been performed to evaluate this problem (i.e. MRI, lab tests, etc.)? *Please note when and where these tests were completed*

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

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List other physicians you have seen for this problem:

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Would you be interested in participating if a research study were available? (circle one) **Yes** **No** **Maybe**

**Surgical History**  No prior surgeries or procedures

Procedure	Date (MM/YYYY)	Complications?