New Patient Initial Consult

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Dear New Patient and Family, Please fill in, or, circle the most appropriate item. Feel free to leave any item blank. Feel free to add additional detail to the right of the item. Thank you!

Name _____
Preferred title Mr. Ms. Mrs. Dr. Other _____

Who referred you to us? (or self) _____

Date of Birth and **Age** _____ _____
Dominant Hand and **Foot** Right Left Ambidextrous Other _____
Social Security ID _____

Home Address _____
City _____
State _____
Zip Code _____

Race White Black Hispanic Asian Indigenous Other _____
Gender Identity Male Female Transgender Other _____
Sexual Orientation Straight Lesbian Gay Bisexual Other _____

Marital Status Single Married Separated Divorced Widowed Other _____

Education Elementary Middle School High School Technical School College Graduate School Other _____ Other _____ Other _____

Primary Language English Spanish Other _____

I Live In My own home An Independent Living (IL) setting An Assisted Living (AL) setting A Memory Care (MC) setting Other setting _____
I Live With Spouse Sibling Adult Child Friend Caregiver Alone Other _____

At my initial consult I will be joined by Spouse Sibling Adult Child Grandchild Friend Caregiver Alone Other _____ Other _____ Other _____

Home phone _____
Okay to call at this number? Yes No
Okay to leave messages? Yes No

Cell phone _____
Okay to call at this number? Yes No
Okay to leave messages? Yes No

Email address (for administrative only) _____

Occupational History (circle all, additional detail welcome)

Administrative	Management	Skilled
Clerical	Military	Technical
Craft	Professional	Other _____
Executive	Sales	Other _____
Machine	Service	Other _____

My Children (name, gender, age, location)

1. _____
2. _____
3. _____
4. _____
5. _____

Permission to speak with children if needed? Yes No *(if yes, release form)*

I have a Best Friend who is (first name, gender, location)
_____

Daily Interpersonal Contact includes Spouse Children Sibling Extended Family Friends Other _____ Other _____ Other _____

I receive help in my home from Spouse Children Sibling Extended Family Friends Caregiver Other _____ Other _____ Other _____
Number of hours per week _____ Is this sufficient? Yes No Not Sure

My Primary Care Provider (PCP) is _____
How long have you been his/her patient? _____

My current Specialty Care Providers include *(please note name)*

Bariatrics	Neurology	Psychology
Cardiology	Nursing	Pulmonary
Colon and Rectal	Occupational Therapy	Rheumatology
Endocrinology	Oncology	Speech Language
Gastroenterology	Otolaryngology (ENT)	Pathology
Geriatric Medicine	Pain Management	Social Work
Gynecology	Palliative Care	Urology
Hematology	Physical Medicine	Other _____
Immunology	Physical Therapy	
Nephrology	Psychiatry	

Neurologic Studies I have had include *(important, bring or forward records)*

CAT scan
EEG study
EMG study
fMRI imaging
MRI imaging
Neuropsychological testing
PET scan
Sleep Study
SPECT scan
Other _____
Other _____
Other _____
Other _____
Other _____

My Personal Health History includes *(important, indicate "Prior or Current")*

AFib
Alzheimer's
Anemia
Angina
Anxiety
Appetite change
Back pain
Bladder incontinence
Bleeding
Blood clots
Bowel changes
Bowel incontinence
Cancer
Chest pain or tightness
Chills
Cirrhosis
Constipation
Cough
Deafness
Dementia
Dental problems
Depression
Diabetes
Diarrhea
Difficulty swallowing
Difficulties in thinking
Dizziness
Dry eyes
Easy bruising
Epilepsy
Excessive thirst
Fainting
Falls
Feeling too hot or too cold
Fevers
Gastric problems
Glaucoma
Gout
Hallucinations
Head injury
Headache
Heart Disease
Hernia
High blood pressure
High Cholesterol
Hypertension
Irritable Bowel
Joint pain
Leg pain
Loss of consciousness
Memory problems
Microvascular changes
Migraine
Neurologic changes
Neuropathies
Paralysis
Parkinson's
PTSD
Pulmonary disease
Rapid heart beat
Rash
Seizures
Sexual function
Shortness of breath
Sinus problems
Sleep problems
Sore throat
Sores
Stroke
Sweats
Swelling of feet
Thyroid
Tremor
Ulcers
Urinary tract infections
Weight gain
Weight loss
Word Finding
Wheezing

Other _____
Other _____
Other _____

My Family Health History includes

AFib
Alzheimer's
Anxiety
Back pain
Bladder incontinence
Blood clots
Bowel changes
Bowel incontinence
Cancer
Chest pain or tightness
Cirrhosis
Constipation
Cough
Deafness
Dementia
Depression
Diabetes
Difficulty swallowing
Difficulties in thinking
Dizziness
Easy bruising
Epilepsy
Excessive thirst
Fainting
Falls
Feeling too hot or too cold
Frontotemporal disorder
Gastric problems
Hallucinations
Head injury
Headache
Heart disease
Hernia
High blood pressure
High cholesterol
Hypertension
Irritable bowel
Joint pain
Leg pain
Memory problems
Migraine
Neurologic changes
Neuropathies
Paralysis
Parkinson's disease
PTSD
Pulmonary disease
Seizures
Shortness of breath
Sleep problems
Stroke
Swelling of feet
Thyroid
Tremor
Ulcers
Urinary tract infections
Weight gain
Weight loss

Other _____
Other _____
Other _____

My Major Surgeries *(please include year)*

Cataracts	Hip repair due to fracture	Other _____
Defibrillator	Hip replacement(s)	Other _____
Heart bypass	Knee replacement(s)	Other _____
Heart stent	Pacemaker	Other _____
Heart valve replacement	Other _____	

My Past Twelve (12) Months Hospitalizations include *(please provide detail)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Past twelve (12) months I have had *(please indicate results)*

Bone Density (DXA) exam	Hearing exam
Colonoscopy	Other _____
Dental exam	Other _____
Eye exam	Other _____

I have had a Fall in the Past Year (PY) Yes No Other _____
I am afraid of Falling Yes No Maybe
I use a Cane Walker Wheelchair None Other _____

I have Sensory Challenges related to *(please provide detail)*

Visual (eyes)
Auditory (ears)
Olfactory (smell)
Gustatory (taste)
Tactile (touch)

I engage in the following exercises or activities

Aerobics	Hiking	Walking
Aquatics	Jogging	Weights
Bicycle (stationary or road)	Pilates	Yoga
Bowling	Running	Other _____
Dancing	Table Tennis	Other _____
Golf	Tennis	Other _____

Days per Week _____ Amount of Time per Day _____

My Current Prescribed (Rx) Medications include (mg, dosing, other detail)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

My Over the Counter (OTC, Natural and Other) include (mg, dosing, other detail)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Prescription (Rx) Drug Allergies or Negative Events? *(important, please detail)*

Over the Counter (OTC) Allergies or Negative Events? *(important, please detail)*

I have a History of Substance Abuse or Chemical Dependency
Yes No Not Sure

My Alcohol Consumption None Less than once a week A few days a week Daily
Other _____
Has anyone been concerned per your drinking?
Yes No Not Sure

My Tobacco Consumption None Less than once a week A few days a week Daily
Other _____

Do you own firearms? Yes No
Firearms currently in the home? Yes No

My Medico-Legal and Advanced Care Planning includes *(please circle all relevant, please bring copy for your chart)*

A Living Will
A Power of Attorney (Type of POA, Person Who Holds) _____
Advanced Directives (resuscitation, intubation, tube feeding, palliative care)
A Conservatorship and/or Guardianship
Other _____

If I was sick and unable to speak to my needs, I would want you to talk to (full name and relationship) _____

I consider my Strengths to be

1. _____
2. _____
3. _____

I consider my Limitations to be

1. _____
2. _____
3. _____

Opportunities I have, include

1. _____
2. _____
3. _____

Obstacles I have to consider, include

1. _____
2. _____
3. _____

What matters to me most is . . .

1. _____
2. _____
3. _____

Compared to my peers, I consider my health to be
Excellent Good Fair Poor Other _____

The concerns I have today and would like to talk to the doctor about

1. _____
2. _____
3. _____

The complaints I have today and would like to talk to the doctor about

1. _____
2. _____
3. _____

Names of person(s) completing this questionnaire

_____

_____

The ColoNeuroGero Team Cares About Your Health. Thank you for taking the time to complete the above information!

Our practice goal is to provide you and your family ease of access and availability, a friendly and supportive staff, high levels of communication (administration, billing, clinical), outstanding bedside manner, clear discussion of benefits versus burdens, and the time you need to tell us everything important to you.

If we ever disappoint you, please let us know by scheduling a consult, emailing, calling or writing. We're interested and we will help. We look forward to being in touch!

Printed name _____

Patient Signature (no proxy permitted) _____

Today's Date _____

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