NEW JERSEY
BRAIN AND SPINE

Elana Clar, MD
Board Certified Neurologist
Movement Disorders Specialist

Movement Disorders New Patient Questionnaire

Please email your completed form to rociom@NJbrainspine.com AT LEAST 1 week before your scheduled appointment

Name ______________________________________ **Date of Birth**_________________________________

Age __________ **Sex** __________ **Social Security** _______________________________

Address ____

Mobile Phone _____________________________ **Home Phone** _______________________________

Email Address(es) ____

Emergency Contact Name ____________________________ **Relationship** __________________________

Emergency Contact Number(s) ____

Referring Patient or Physician ____

Address ____

Phone Number(s) ____

Do you wish us to send a consultation note to your referring physician? **Yes** ________ **No**_________

680 Kinderkamack Road, Suite 300 Oradell, NJ 07649 | 20 Prospect Avenue, Suite 907 Hackensack, NJ 07601
Phone: 201.342.2550 | Fax: 201.342.7171 | www.njbrainspine.com

Pharmacy Name ____________________________ **Pharmacy Number**____________________________

Pharmacy Address ____

HISTORY OF PRESENT ILLNESS

Please explain the main reason(s) you are seeking a movement disorders consultation:

1) ____
2) ____
3) ____

Reconstruct, as best as possible, the story of your illness. Include the first symptoms you or others noticed. What happened next? Did you have further progression of your symptoms? Did this occur acutely or gradually? Are there certain things prior to your illness you used to do easily but can no longer do now?

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Are you interested in Deep Brain Stimulation (DBS)? **YES _____________** **NO ______________**

Please list any health care providers you have previously seen for this issue:

Date **Provider Name** **Provider Specialty** **Treatment Provided (if any)**

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Have you ever had one of the following tests? If so, please provide brief details:

	Date	Where Obtained?	Result?
CT of Head			
CT of Spine			
MRI of Brain			
MRI of Spine			
EEG			
EMG/NCS			
Spinal Tap			
Other			

Do you have any drug allergies? Yes _________ No ___________

If yes, please list the drug and what allergic reaction you get:

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List all your CURRENT MEDICATIONS:

Name of Medication	Dose (mg)	Number of Times a Day (list times if necessary)

List all your PRIOR MEDICATIONS tried for this particular illness:

Name of Medication	Dose (mg)	Number of Times a Day

PAST MEDICAL/SURGICAL HISTORY

Please list any of your chronic medical conditions (even if you are not on medications for it) and any prior surgeries/hospitalizations (with the date):

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PERSONAL HISTORY

Are you right-handed or left-handed? ____

Current height: ________________________ **Current weight:** ________________________

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Are you presently employed?____________ **Present/Former Occupation: _____________________**

Marital Status (Please Circle): Single / Married / Divorced / Widowed

How many children do you have? ____________________

Who currently lives with you at home? ____

SOCIAL HISTORY

Do you get any exercise on a regular basis? _________ If so, what do you like to do? ___________________

____

SMOKING HISTORY (IF YOU HAVE NEVER SMOKED, PLACE “0” IN ALL THE ANSWERS):

Year Stopped: _________ **Number of Packs/Day __________** **Number of Years Smoked: _____________**

DRINKING HISTORY (IF YOU DO NOT DRINK, PLACE A “0” IN THE BLANK):

Number of beers or glasses of wine per week: __________________

RECREATIONAL DRUG HISTORY (IF YOU HAVE NEVER TRIED DRUGS, PLACE “0” IN ALL THE ANSWERS):

Marijuana ___________ **Cocaine _____________** **Heroin _____________** **Other ________________**

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FAMILY MEDICAL HISTORY

	If Alive, Current Age	If Alive, List Medical Issues	If Dead, Age at Death	Medical History or Cause of Death
Mother				
Father				
Brother				
Sister				
Other Sibling				
Son				
Daughter				
Other Child				

Is there any other information that you would like to share for the purposes of this consultation?

____

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*****PLEASE OBTAIN ANY PERTINENT MEDICAL RECORDS (INCLUDING PHYSICIAN NOTES, IMAGING REPORTS, IMAGING DISCS AND BLOODWORK) OVER THE PAST YEAR, AND BRING THIS TO YOUR 1ST APPOINTMENT*****