

**Patient Information:**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No.: \_\_\_\_\_ Cell No.: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Phone No.: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Contact Phone No.: \_\_\_\_\_

Name of Caregiver / Guardian: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Which of the following languages can you speak and/or understand? Please circle:

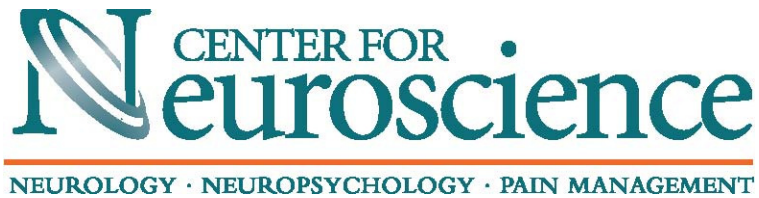
English      Spanish      Creole      French      Portuguese      Hindi/Urdu

**Purpose of Visit (please circle):**

Neurological Evaluation      Physical Rehabilitation      Chiropractic Care

Neuropsychological Evaluation and/or Psychological Therapy

Diagnostics      Other: \_\_\_\_\_



**Referring Physician Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Insurance Information:**

Name of Insurance Company: \_\_\_\_\_

Policy and or Claim Number: \_\_\_\_\_

Date of Accident or Injury (if applicable): \_\_\_\_\_

Insurance Company's Address: \_\_\_\_\_

Deductible Amount: \_\_\_\_\_ Has your deductible been met? Yes No

Do you have Medicare? Yes No Medicare Number: \_\_\_\_\_

If your visit is accident or injury related, have you done the following?

1. Reported the accident to your insurance company? Yes No
2. Has your claim been set up? Yes No
3. Do you have an attorney? Yes No

If you answered yes to question #3, name of your attorney: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature

**HISTORY OF PRESENT ILLNESS:**

Please describe your main problem or reason for making an appointment \_\_\_\_\_  
\_\_\_\_\_

When did symptoms begin? \_\_\_\_\_

Have you been treated for this problem before?      Yes      No

If yes, please describe the treatment you received including dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PAST MEDICAL/ FAMILY HISTORY**

Please list any serious illness or ongoing medical problems since childhood. Include any surgical procedures:

Conditions	Self	Father	Mother	Siblings	G-parent	Other
Asthma						
High blood pressure						
Diabetes						
Heart disease						
Arrhythmia						
Cancer						
High cholesterol						
Stroke/ TIA						
COPD						
Chronic bronchitis						
Emphysema						
Seizures						
Dementia						
Alzheimer's disease						
Parkinson disease						
Huntington's disease						
Gastritis						
Ulcers						
Thyroid disease						
Liver disease/ Hepatitis						
HIV/ AIDS						
Sinusitis						
Kidney disease						
Head/ Brain injury						
STD						
Reflux Esophagitis						

Glaucoma						
Macular Degeneration						
Cataracts						
Headaches/ Migraine						
Miscarriages/ stillbirth						
Vertigo						
Tremors						
Multiple Sclerosis						
Birth/ Developmental Problems						
Hypoxia						
Depression						
Anxiety Disorder						
Schizophrenia						
Bipolar Disorder (Manic Depression)						
Obsessive Compulsive Disorder						
ADD/ADHD						
Learning Disability						
Post Traumatic Stress Disorder						
Other:						

**PAST SURGICAL HISTORY** (Please list)

<b>Surgery</b>	<b>Year</b>
_____	_____
_____	_____
_____	_____
_____	_____

Please list all psychiatric medicines you have been prescribed in the past (including anti-depressants, anti-anxiety, anti-psychotics or medications used to help you sleep).

<u>Medication Name</u>	<u>Dates</u>	<u>How long you took it</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been hospitalized for a mental/ psychiatric illness? If so, please list dates and hospital:

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**CURRENT MEDICATIONS:**

Please list all medications you are currently taking: (include non-prescription and occasionally used medicines).

**Current medication**

**Dosage/ Time taken**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**ALLERGIES** ( List any medication, food or other allergies):

Do you have a pacemaker?      Yes      No

**PAST MEDICAL HISTORY**

Please list any serious illness or ongoing medical problems since childhood. Include any surgical procedures.

**DATE**

**PROBLEM**

_____	_____
_____	_____
_____	_____
_____	_____

**FAMILY HISTORY:**

Please use the space below to list all of your immediate family (parents, siblings, and children).

Under illnesses, please list serious illnesses or diseases, especially psychiatric/mental illness.

**RELATIONSHIP**

**AGE**

**ILLNESS/ CAUSE OF DEATH**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**CHILDREN:**

_____	_____	_____
_____	_____	_____
_____	_____	_____

**SOCIAL HISTORY:**

Birth state and where you were raised: \_\_\_\_\_

Years of education: \_\_\_\_\_

Degrees: \_\_\_\_\_

Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Occupation (s) prior to retiring: \_\_\_\_\_

Smoking number of years: \_\_\_\_\_

History of alcohol abuse or addiction: \_\_\_\_\_

Alcohol: approximate drinks per week: \_\_\_\_\_

Exercise: type: \_\_\_\_\_ frequency: \_\_\_\_\_

Hobbies, interests: \_\_\_\_\_

Are you currently driving ? \_\_\_\_\_

With whom do you live? \_\_\_\_\_

\_\_\_\_\_ Home

\_\_\_\_\_ Assisted living

\_\_\_\_\_ Nursing home

Is there any other information you want to make us aware of? \_\_\_\_\_

**REVIEW OF SYMPTOMS:**

Please check any of the following that pertain to you. Give dates, duration of symptoms and details when applicable.

- Depression , persistent sadness or feeling blue \_\_\_\_\_
- Loss of pleasure in life \_\_\_\_\_
- Crying Spells \_\_\_\_\_
- Lack of energy or fatigue \_\_\_\_\_
- Loss of appetite \_\_\_\_\_
- Difficulty sleeping \_\_\_\_\_
  - Awake early and can not return to sleep
  - Have trouble falling asleep
- Difficulty concentrating \_\_\_\_\_
- Anxious, restless ,or irritable \_\_\_\_\_
- Feelings of hopelessness or worthlessness \_\_\_\_\_
- Thoughts of suicide \_\_\_\_\_
- Thoughts of hurting someone else \_\_\_\_\_
- Hallucinations of hearing voices \_\_\_\_\_
- Paranoia \_\_\_\_\_

**HEART DISEASE:**

- Chest pain \_\_\_\_\_
  - At rest \_\_\_\_\_
  - With activity \_\_\_\_\_
- Swollen ankles \_\_\_\_\_
- Become short of breath when walking or with activity \_\_\_\_\_
- Palpitations or heart racing \_\_\_\_\_
- High blood pressure \_\_\_\_\_
- High cholesterol \_\_\_\_\_
- Dizziness or fainting \_\_\_\_\_

**NEUROLOGICAL:**

- Head trauma \_\_\_\_\_
- Seizure or fits \_\_\_\_\_
- Headaches or migraines \_\_\_\_\_
- Recent fall or falls frequency \_\_\_\_\_
- Problem with balance \_\_\_\_\_
- Feels dizzy when stands up \_\_\_\_\_
- Tremor or difficulty writing \_\_\_\_\_
- Sleep problems such as loud snoring, gasping for breath, morning headaches,  
daytime sleepiness or leg jerking \_\_\_\_\_
- Numbness or tingling in toes and fingers \_\_\_\_\_
- Forgetfulness \_\_\_\_\_
- Confusion \_\_\_\_\_
- Difficulty speaking \_\_\_\_\_
- Difficulty finding your way \_\_\_\_\_
- Difficulty managing finances \_\_\_\_\_
- Difficulty maintaining home \_\_\_\_\_

**SENSATIONS:**

- Problems with sense of smell \_\_\_\_\_
- Problems with taste \_\_\_\_\_
- Problems with hearing \_\_\_\_\_
- Uses hearing aid \_\_\_\_\_
- Eye pain \_\_\_\_\_
- Blurred or double vision \_\_\_\_\_
- Sensitive to glare \_\_\_\_\_

**GASTROINTESTINAL:**

- Problems swallowing \_\_\_\_\_
- Burning in chest or stomach after meals or when lying down \_\_\_\_\_
- Constipation \_\_\_\_\_
- Diarrhea \_\_\_\_\_
- Change in color of stool/ black or tarry stools? \_\_\_\_\_

**RESPIRATORY:**

- Cough \_\_\_\_\_
- Asthma or wheezing \_\_\_\_\_

**GENITAL/ URINARY:**

- Loss of interest in sex \_\_\_\_\_
- Difficulty maintaining an erection \_\_\_\_\_
- Delayed ejaculation \_\_\_\_\_
- Pain with intercourse \_\_\_\_\_
- Difficulty urinating \_\_\_\_\_
- Difficulty holding in urine \_\_\_\_\_
- Trouble starting stream, dribbling or reduced stream \_\_\_\_\_
- Pain when urinating \_\_\_\_\_
- Need to urinate more frequently \_\_\_\_\_
- Frequent urinary tract infections \_\_\_\_\_

**MUSCULOSKELETAL:**

- Difficulty standing up from sitting \_\_\_\_\_
- Stiffness or pain in joints \_\_\_\_\_
- Pain greater in the morning and decreases with activity \_\_\_\_\_
- Back or neck pain \_\_\_\_\_
- Other pain \_\_\_\_\_

**HEMATOLOGICAL:**

- Anemia or low blood sugar \_\_\_\_\_
- Excessive bruising or bleeding \_\_\_\_\_
- Recurrent infections or infections that will not go away \_\_\_\_\_

**ENDOCRINE:**

- Thyroid disease \_\_\_\_\_
- Weight gain or loss \_\_\_\_\_
- Dry Skin \_\_\_\_\_
- Hair loss or coarse hair \_\_\_\_\_
- Hoarse Voice \_\_\_\_\_
- Cold or heat intolerance \_\_\_\_\_

**If you are female, please read the following carefully:**

Are you pregnant or planning to become pregnant? (circle one)      YES                              NO

Please be advised that as part of your consultation/evaluation and treatment you are responsible to avoid an accidental pregnancy. Various medications, X-rays, CAT/MRI scans are contraindicated for pregnant women and may be very dangerous.

In complete understanding of the above and certifying that all information is true to the best of your knowledge, please sign below.

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Patient Signature

Print Name

Thank you for taking time to complete this form. All of the information is important to us in caring for you.

**ACTIVITIES OF DAILY LIVING**

**IF THERE ARE NO PROBLEMS WITH ACTIVITIES OF DAILY LIVING PLEASE SKIP TO PAGE 11**

**PLEASE DESCRIBE HOW MUCH HELP IF ANY YOU NEED WITH EACH OF THE FOLLOWING ACTIVITIES, CHECK THE MOST APPROPRIATE ANSWER BELOW:**

**EATING:**

- Eat without assistance (plans meals, cooks, feeds self, cleans) \_\_\_\_\_
- Eat with minor assistance at meal times (e.g. preparing food) \_\_\_\_\_
- Eat with moderate assistance (e.g. planning and cooking) \_\_\_\_\_
- Need extensive assistance for all meals \_\_\_\_\_
- Cannot feed self at all \_\_\_\_\_

**DRESSING:**

- Dresses/ undresses and selects clothes without assistance \_\_\_\_\_
- Dresses/ undresses with minor assistance \_\_\_\_\_
- Needs moderate assistance in dressing or selection of clothes \_\_\_\_\_
- Needs major assistance in dressing \_\_\_\_\_
- Completely unable to dress and resists help \_\_\_\_\_

**GROOMING: (combing hair, shaving)**

- Always neatly dressed and well groomed without assistance \_\_\_\_\_
- Grooms adequately with occasional minor assistance \_\_\_\_\_
- Needs moderate and regular assistance or supervision \_\_\_\_\_
- Needs total grooming care but remains well-groomed after getting help \_\_\_\_\_
- Resists efforts to help maintain grooming \_\_\_\_\_

**BATHING:**

- Bathes in tub/shower or takes sponge bath without assistance \_\_\_\_\_
- Bathes self but needs help getting in and out of tub/shower \_\_\_\_\_
- Washes face/hands but cannot bathe rest of body \_\_\_\_\_
- Does not wash self but is cooperative with help \_\_\_\_\_
- Does not try to wash self and resists help \_\_\_\_\_

**TOILETING:**

- Cares for self at the toilet completely and no incontinence \_\_\_\_\_
- Needs reminders or help cleaning self or may have rare accidents \_\_\_\_\_
- Soils or wets clothes while asleep \_\_\_\_\_
- Soils or wets clothes while awake \_\_\_\_\_
- Has little or no control over bladder or bowels \_\_\_\_\_

**WALKING:**

- Walks around neighborhood or city alone \_\_\_\_\_
- Ambulates in home or within one block from home alone \_\_\_\_\_
- Ambulates well with assistance of another person, or alone using \_\_\_\_\_
- Railing, cane, walker, wheelchair \_\_\_\_\_
- Sits unsupported in chair or wheelchair, but can't ambulate without help \_\_\_\_\_
- Bedridden more than half the time \_\_\_\_\_

**TRAVELING:**

- Travel independently on public transport or drives own car \_\_\_\_\_
- Arranges own travel by taxi but does not use public transportation \_\_\_\_\_
- Travels using public transportation when assistance of another person \_\_\_\_\_

**FINANCES:**

- Manages financial matters independently \_\_\_\_\_
- Manages day-to-day purchases but needs help with banking \_\_\_\_\_
- Or major purchases \_\_\_\_\_
- Incapable of handling money \_\_\_\_\_
- Does not apply \_\_\_\_\_

**TELEPHONE:**

- Operates the telephone on own initiative \_\_\_\_\_
- Dials only a few well know numbers \_\_\_\_\_
- Answers telephone and takes messages but doesn't dial \_\_\_\_\_
- Answers telephone but cannot take messages and does not dial \_\_\_\_\_
- Does not apply \_\_\_\_\_

**FOOD PREPERATION:**

- Plans, prepares, and serves adequate meals independently \_\_\_\_\_
- Prepares adequate meals if supplied with ingredients \_\_\_\_\_
- Heats and serves prepared meal or prepares simple meals but \_\_\_\_\_
- Does not maintain an adequate diet \_\_\_\_\_
- Needs to have meals prepared and served \_\_\_\_\_
- Does not apply \_\_\_\_\_

**HOUSEKEEPING:**

- Maintains own house alone or with occasional assistance \_\_\_\_\_
- Performs only light daily tasks \_\_\_\_\_
- Performs light daily tasks but cannot maintain an acceptable \_\_\_\_\_
- Level of cleanliness \_\_\_\_\_
- Does not participate in any housekeeping tasks \_\_\_\_\_
- Does not apply \_\_\_\_\_

**SHOPPING:**

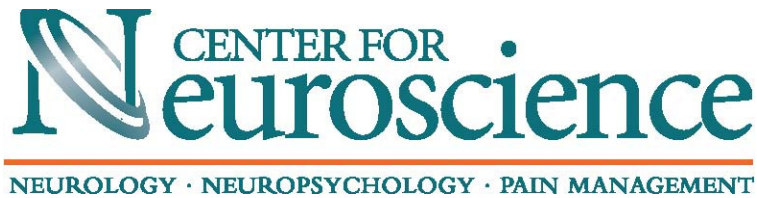
- Takes care of all shopping needs independently \_\_\_\_\_
- Shops independently for small purchases \_\_\_\_\_
- Needs to be accompanied on any shopping trip \_\_\_\_\_
- Completely unable to shop \_\_\_\_\_
- Does not apply \_\_\_\_\_

**MEDICATIONS:**

- Independently takes medication correctly \_\_\_\_\_
- Takes responsibility for taking medications if prepared in \_\_\_\_\_
- Advance in separate doses \_\_\_\_\_
- Not capable of dispensing own medication \_\_\_\_\_
- Does not apply \_\_\_\_\_

**DRIVING:**

- Drives alone safely \_\_\_\_\_
- Drives alone but has had one or more recent accidents \_\_\_\_\_
- Drives alone but has gotten lost \_\_\_\_\_
- Drives only with someone else in the car \_\_\_\_\_
- No longer drives \_\_\_\_\_
- Never drove/ does not apply \_\_\_\_\_



## Authorization for Medical Records and Reports

Date: \_\_\_\_\_

To: \_\_\_\_\_

You, and any person associated with you, are hereby authorized to give to Center for Neuroscience or any representative thereof any and all information which may be requested regarding my physical condition and treatment rendered by you thereof, and if necessary to allow them, or any physician appointed by them, to examine and X-Ray pictures/ CT or MRI scans/ electro-diagnostics of me, or records which may have information regarding my condition or treatment.

Please Provide the Names and Phone Numbers of your physicians that you would like to have your records forwarded :

PRIMARY CARE \_\_\_\_\_

INTERNIST \_\_\_\_\_

CARDIOLOGIST \_\_\_\_\_

PODIATRIST \_\_\_\_\_

OTHER \_\_\_\_\_

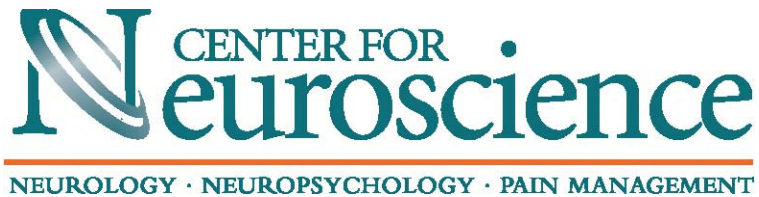
Patient's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

DOB: \_\_\_\_\_

SS #: \_\_\_\_\_

Witness' Signature: \_\_\_\_\_



## Authorization for Release of Insurance Information

Date: \_\_\_\_\_

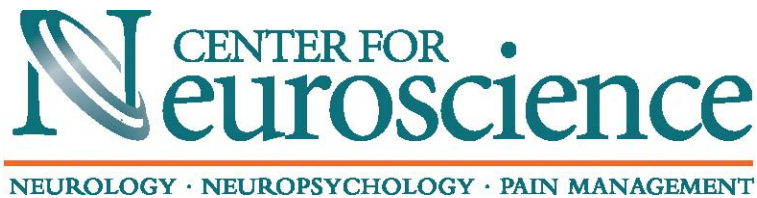
To: \_\_\_\_\_

You, and any person associated with you, are hereby authorized to give to The Center For NeuroScience or any representative thereof any and all information which may be requested regarding insurance claim information for your clients P.I.P. claim. Clients name in order to process any foregoing claims acquired by the patient.

Patient's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness' Signature: \_\_\_\_\_



## Conditions for Admission

**Medical Consent:** The undersigned consents to any X-Ray, examinations, and/or medical services rendered to the patient under the general and special instructions given by the physician.

**Minors:** If the patient is a minor or an incapacitated person, the undersigned hereby consents for any medical procedure on his/her behalf which the physician may consider necessary in the treatment of his/her care.

**Liability:** The patient is under the care of the Center for NeuroScience. Neither Dr. Siddiqui nor Dr. Essig is liable for any act or omission in following the instructions given by Dr. Siddiqui or Dr. Essig.

**Personal Valuables:** It is agreed and understood that the medical practice of the Center for NeuroScience shall not be liable for the loss of and/or damage to any personal property items (i.e. money, jewelry, dentures, documents, garments etc.).

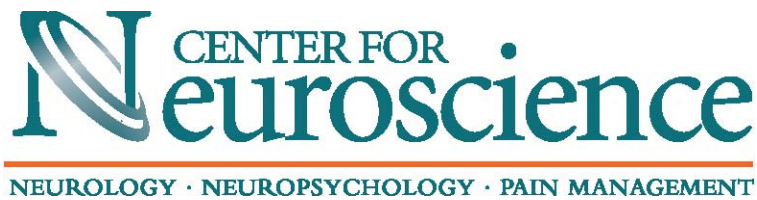
**Payment:** The undersigned agrees that to the extent necessary to determine liability for payment and to obtain reimbursement, the Center for NeuroScience may disclose portions of patient's medical records, to any person or corporation which is or may be liable for all or any portion of the charges for services provided the Center for NeuroScience. **If your account is delinquent at 60 days, 25% collection fee, will be added to the amount due.**

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**Patient's Signature**

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**Printed Name**



## Direction of Payment

I authorize the Center for NeuroScience to release any information acquired in the course of my examination to my insurance company. I hereby authorize payment directly to the Center for NeuroScience of the medical benefits, if any, otherwise payable to the provider for services not to exceed the provider's usual and customary fee. I also authorize the refund of over paid insurance benefits where my coverage is subject to a coordination of benefits. I recognize, understand and accept that I am financially responsible to the provider for all charges for any unpaid balance or fee not covered, In the event that I have no insurance or my insurance coverage is rejected. The undersigned agrees to pay all costs of collection, including a reasonable attorney's fee, and agrees to pay the legal rate of interest on the account until paid in full and hereby waive all rights of exemption under the constitution and the laws of the State of Florida.

I agree that the Center for NeuroScience be given Power of Attorney to endorse/sign my name on any and all checks for payment of my doctor's bills when sent directly to their office.

I request that payment of authorized medical benefits be made on my behalf to the Center for NeuroScience for any services furnished to me by the physician or his employee. I authorize any holder of medical information about me to release to my insurance company any information needed to determine these benefits payable for related services.

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Name of Insurance Company

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Name of Insured

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Insurance Claim Number

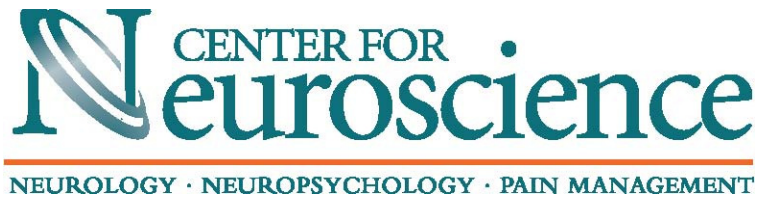
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Patient's Full Name Printed

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Patient's Signature (Parent or legal guardian if patient is a minor)

16244 S. Military Trail, Suite 150, Delray Beach, FL., 33484  
10189 W. Sunrise Blvd. Plantation, FL., 33322  
1633 North Hiatus Road, Pembroke, FL., 33026  
561-638-8872 FAX 561-638-8874



**Center for NeuroScience Policy Regarding No-Shows**

It is the policy of Center for NeuroScience that patients who do not attend a scheduled appointment (or fail to cancel within one full business day prior to the scheduled appointment) will be charged a no-show fee of \$25.00 for each hour scheduled.

DR. Patricia M. Joyce Ph.D.  
Director, Center for NeuroScience

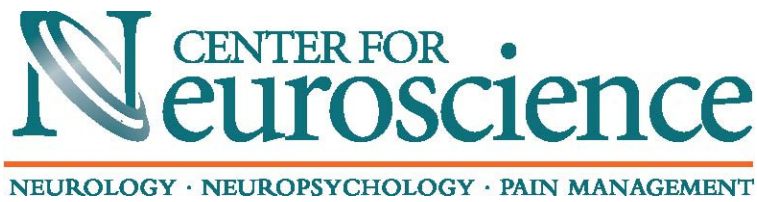
M. Farhan Siddiqui, MD, MPH  
President, Center for NeuroScience

I agree to pay a no-show fee of \$25.00 for every scheduled hour with Dr Joyce and Dr. Siddiqui that I failed to attend or cancel within one full business day prior to the appointment. I give express permission to the Center for NeuroScience to charge my credit card, on file, for the appropriate amount.

\_\_\_\_\_  
Patient's Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



### Release of Liability

I agree to disclose in writing my physical and medical conditions and limitations and sensitivities; and hereby release and hold the Center for NeuroScience, its agents and employees harmless from any liability, claims, conditions, limitations or sensitivities. I expressly agree that utilization of the facilities and equipment shall be undertaken at my own risk, and I represent that I am physically and medically able to participate in the physical therapy conditioning program.

- Herniated Discs
- Spondylolisthesis
- Joint Replacement
- Dislocating Joint
- Joint Pain
- Cardiac Surgery or rhythm disturbances
- Pulmonary/Breathing problems
- Recent Fracture
- Pregnancy
- Nerve Pain

Other physical or medical condition or limitations: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NOTICE of PRIVACY PRACTICES

I, \_\_\_\_\_ acknowledge that I have received the  
Notice of Privacy Practices.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

**Claim No:** \_\_\_\_\_

**Adjuster:** \_\_\_\_\_

The undersigned patient hereby assigns the benefits of insurance under the applicable automobile policy

to: Doctors' name: \_\_\_\_\_ at

the **Center For Neuroscience** for service rendered to the undersigned patient and covered by Personal Injury Protection (PIP) coverage under the policy issued to:

(Insured's' Name): \_\_\_\_\_

and in accordance with Florida Statute 627.736 (5)

The undersigned patient further agrees to pay any co-payment and/or deductible not covered by the aforementioned PIP coverage.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Print name here: \_\_\_\_\_

The undersigned hereby accepts assignments of insurance benefits for service rendered to:

(Patient's Name): \_\_\_\_\_

with such benefits to be paid directly to me under:

(Insured's Name): \_\_\_\_\_'s

Personal Injury Protection coverage with \_\_\_\_\_ and in

Accordance with Florida Statute 627.336(5)

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

Print Name here: \_\_\_\_\_