# GREELEY & ASSOCIATES
## Northwest Neurological, PLLC

**Intake Questionnaire** Patient Name: Date:
Date of Birth:

**Reason for the medical visit:**

**Past Medical Problems (incl. surgeries)?**

| | Current Medication | Dose (mg) | # Per Day |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | | | |

**Family Medical History**: any family members with a history of neurological concerns? o**Yes** o**No**

**Social History**: Are you married? o**Yes** o**No**
working? o**Yes** o**No**

| **Review of Systems**: Do you **currently** have any of the following problems? | | | (if "**Yes**", please explain) |
|---|---|---|---|
| **General** (difficulty with sleep, fatigue, appetite, weight…) | o**Yes** | o**No** | |
| **Eyes** (blurry vision, double vision, glaucoma, cataracts, pain…) | o**Yes** | o**No** | |
| **Ear/Nose/Throat** (hearing loss or ringing, sinus problems, vertigo, runny nose, pain, drooling, choking…) | o**Yes** | o**No** | |
| **Heart** (high or low blood pressure, chest pain, irregular beats, swollen ankles…) | o**Yes** | o**No** | |
| **Lungs** (asthma, shortness of breath, wheezing, cough…) | o**Yes** | o**No** | |
| **Stomach/Bowels** (heartburn, nausea, constipation, diarrhea, bleeding, pain…) | o**Yes** | o**No** | |
| **Bladder/Reproductive** (frequent or urgent need to urinate, blood in urine, pain, pregnancy, impotence, prostate concerns…) | o**Yes** | o**No** | |
| **Muscles/Bones** (pain, swelling, leg cramps, osteoporosis…) | o**Yes** | o**No** | |
| **Skin/Hair** (dry skin, hair loss, rash…) | o**Yes** | o**No** | |
| **Neurology** (numbness, tingling, shaking, headache, memory loss, balance problems…) | o**Yes** | o**No** | |
| **Psychiatry** (nervous, anxious, depressed, tearful, angry, hallucinating, delusional…) | o**Yes** | o**No** | |
| **Endocrine** (hot/cold, sweating, diabetes, thyroid disorder…) | o**Yes** | o**No** | |
| **Hematologic** (bleeding, bruising…) | o**Yes** | o**No** | |
| **Allergies?** | o**Yes** | o**No** | |
| Have you had a shingles vaccine? | o**Yes** | o**No** | |
| Have you had a pneumonia vaccine? | o**Yes** | o**No** | |

507 S. Washington, #101 Spokane, WA 99204 phone: 509-458-7720 fax: 509-777-0432