Tampa Neurology Associates

New Patient Questionnaire

Name: _____ Age: _____ Date of Visit: _____

Date of Birth: _____ Referring Physician: _____

Primary Care Physician: _____

Main Reason for Visit Today: _____

Email Address: _____ Phone Number: _____

Have you been admitted/hospitalized at Tampa General Hospital, Memorial Hospital, or St. Joseph's Hospital in the last 3 years? Yes _____ No _____

Do you have history of the following?

	Yes	No	Date
Arthritis			
Cancer			
Cholesterol problems			
Depression			
Diabetes			
Heart Rhythm Problem			
Heart Attack			
High Blood Pressure			
HIV/AIDS			
Falls			
Multiple Sclerosis			
Memory Loss			
Meningitis			
Migraine Headaches			
Neuropathy			
Seizure			
Stroke			
Syncope			
Other:			

Current Medications:

Name	Dose	Frequency

Allergies:

_____

_____

_____

Social History:

Martial status: S/M/D/W
Occupation: _____
Children: Yes/No
Tobacco: Yes/No Quit? Yes/No When? _____
Alcohol: Yes/No Frequency? _____
Drug use? Yes/No
Do you have a living will? Yes/No
Do you have an advanced care plan? Yes/No
Do you have a power of attorney? Yes/No
Name of Surrogate Decision Maker: _____ Relationship: _____

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Past Surgeries	Date

Preferred Pharmacy Name:

_____

Address:

_____

Preferred Lab:
LabCorp/Quest/Other: _____

Did you get the flu shot in 2019 or 2020?
Yes/No

Family Medical History:

	Alive/Dead	Cause of Death/Illnesses
Mother		
Father		
Sister(s)		
Brother(s)		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Other:		

Do you have any of the following conditions?

		Yes	No		Yes	No
General	Fatigue			Fever		
	Weight Loss			Weight gain		
	Memory Loss			**Gastrointestinal**		
Skin	Rash			Loss of appetite		
	Skin Cancer			Nausea		
Head/Neck	Headaches			Vomiting		
	Head injury			Blood in stool		
	Neck pain			Changes in bowel habits		
	Blurred vision			Ulcers		
	Double vision			**Gynecological**		
	Hearing loss			Irregular menses		
	Ears ringing			Abnormal vaginal bleeding		
	Vertigo or dizziness			Pregnancy		
	Hoarseness			Contraceptive use		

	Difficulty swallowing			Post-menopausal		
Respiratory	Cough			**Behavioral**		
	Asthma			Drug abuse		
	Shortness of breath			STD		
	Pneumonia			Insomnia		
	Tuberculosis			**Hematological**		
Cardiac	Angina/chest pain			Transfusions		
	Irregular heart beat			Anemia		
	Heart failure			Cancer/malignancy		
	Rheumatic fever			Clotting disorder		
Renal/Urinary	Kidney devices			**Endocrine/Metabolic**		
	Change in bladder function			Diabetes		
	Blood in urine			Thyroid problems		
	Kidney stones			**Bone/Joints**		
Emotional/ Psychiatric	Depression			Pain		
	Anxiety			Swelling		
	Suicidal thoughts			Injury		
	Previous psychological counseling					

What is your primary concern to discuss with your neurologist at your appointment?

_____

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Name: _____ Date of Birth: _____ Gender: _____

Home Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Email: _____

Employer: _____ Address: _____

Business Phone: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Primary Insurance:
Insurance Company: _____
Address: _____
City: _____ State: _____
Zip Code: _____
Policy Holder Name: _____
Subscriber Name: _____
Group Number: _____

Supplemental Insurance:
Insurance Company: _____
Address: _____
City: _____ State: _____
Zip Code: _____
Policy Holder Name: _____
Subscriber Name: _____
Group Number: _____

Workmen's Compensation: Were you injured on the job? Yes ____ No ____ Date:_____

Employer: _____ Insurance Company Responsible for Claim: _____

Adjustor's Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Public Liability: Is this the result of an accident? Yes ____ No ____ Date:_____

Attorney's Name: _____ **Phone Number**: _____

Insurance Company Responsible for Claim: _____

Name of Insured: _____ Address of Insurance Company: _____

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Patient Consent and Authorization Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I acknowledge receipt of notice of privacy and authorize you to use and disclose my protected health information to, and inclusive of:

Disclose the patient's personal health information, treatment, billing, and payment. Disclose the patient's diagnosis for related lab and diagnostic centers where treatment is rendered as requested by Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment and health operations, but that Tampa Neurology Associates, LLC is not required to agree to the restrictions. However, if Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP agree, you are then bound to comply with this restriction.

If I revoke this consent, Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP does not have to provide any further healthcare services to the patient.

My signature below indicates that I have been given the chance to review a current copy of the Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP Notice of Privacy Practices. This can be found at www.fcneurology.net or can be provided upon request. My signature indicates that I agree to follow Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP to use and disclose my personal health information to carry out treatment, payment and healthcare operations.

Print Patient Name: _____ **Relationship to Patient**: _____

Signature: _____ **Date**: _____

Financial Agreement/Assignment of Benefits:

I hereby authorize payment to be made directly to Tampa Neurology Associates, LLC/Neuroscience Consultants, LLP of benefits due to me from my insurance company. The responsible parties agree to pay for all fees, services and treatment incurred by the patient. If there is a fee that is not covered by insurance, this is payable by the patient. The patient also agrees to pay for all deductibles, co-payments and non-covered services. After receipt of a statement, if payment is not received by the next billing cycle, it is subject to a monthly finance charge. If an account is referred to an outside agency for collection, the patient agrees to pay for all such action. An account will be referred to a collection service if no payment has been received within 90 days of service.

Signature: _____ **Date**: _____

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Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last two weeks, how often have you been bothered by any of the following problems? Use an "X" to indicate your answers.

	Not at All (0)	Several Days (1)	More than Half the Days (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself or that you are a failure, or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or hurting yourself in some way				

Total Score:

Interpretation of Total Score for Depression Severity:

- **1-4: Minimal depression**
- **5-9: Mild depression**
- **10-14: Moderate depression**
- **15-19: Moderately severe depression**
- **20-27: Severe depression**

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