The primary reason for your visit is for a Brain Consultation:(please circle) **YES or NO**

If you circled no, please contact our office so we can get the correct packet to you.

Please check all that apply and indicate how long these symptoms have been occurring:

☐Seizures _____

☐Headaches _____

☐Blackouts _____

☐Dizziness_____

☐Paralysis or weakness of limb(s) _____

☐Nervousness _____

☐Difficulty in going to sleep _____

☐Loss of sensation _____

☐Loss of balance _____

☐Loss of coordination _____

☐Double vision _____

☐Difficulty in speaking _____

☐Depression _____

☐Early morning awakening _____

☐Difficulty with memory for past events _____

☐Difficulty with memory for recent events _____

☐Difficulty with thinking or problem solving _____

☐Excessive Nasal Drainage _____

Please list any/all other symptoms that you are having:

_____

_____

_____

Is the current problem a result of: (circle all that apply)

Approximate date of injury:_____/_____/_____

Work Injury / Auto Accident / Sports Injury / Lifting / Bending / Falling / No apparent cause / Other: _____

Is there any litigation pending? (circle all that apply)

Lawsuit / Auto Claim / Worker's Comp / Disability Claim / Social Security Claim / None
CLAIM #_____

Do you have any trouble controlling your bladder? YES or NO

Do you have any trouble controlling your bowels? YES or NO

Have you had any of the following?

Imaging: EMG / X-Ray / CT Scan / Myelogram / MRI /Angiogram / Other: _____

_____

Procedures: Shunt Placement / Coiling / Clipping /

Other (s):_____

Have you seen the follow specialties?

Endocrinologist (Name):_____

Ophthalmologist (Name):_____