PATIENT INFORMATION/HISTORY FORM

INSTITUTE OF NEUROLOGICAL RECOVERY®
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PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. ALL INFORMATION WILL REMAIN CONFIDENTIAL. **(Potential patient or caregiver may fill this form out.)**

I. POTENTIAL PATIENT INFORMATION

Today's Date: ____________________

Name: First: ______________________ Mid. Init.: ________ Last: ______________________

Home Address: ____

City/State/Zip: ____

Date of Birth: ______________ **Age**: __________ **Social Security No.**: ______________

Email Address: ______________________ **Occupation:** ______________________

Phone: Home: ______________ Cell: ______________ Work: ______________

Primary Caregiver: ______________________ **Relationship to Patient**: ______________

Drive time to office: ______________ **How did you hear about us?**: ______________________

PLEASE CHECK "YES" OR "NO":

YES	NO	
○	○	Does the patient live with the caregiver? If the answer is NO, please describe the current living arrangement of the patient: ______________________
○	○	Can the patient walk? If yes, is it: ○ With a Walker/Cane OR ○ Without assistance
○	○	Is the caregiver/legal representative committed and able to accompany the patient to weekly office visits for an indefinite period of time?
○	○	Does the patient have residual pain resulting from the stroke?

II. DIAGNOSIS/PATIENT CARE

Please check the correct diagnosis: ○ Ischemic Stroke ○ Hemorrhagic ○ Other ______________

Date of Stroke: ______________________

NEUROLOGIST WHO DIAGNOSED STROKE CONTACT INFORMATION:

NAME: ______________________ LOCATION: ______________________

TELEPHONE: ______________________ SPECIALTY: ______________________

PRIMARY MD CONTACT INFORMATION:

NAME: ______________________ LOCATION: ______________________

TELEPHONE: ______________________

PHYSICAL THERAPIST CONTACT INFORMATION:

NAME: ______________________ LOCATION: ______________________

TELEPHONE: ______________________

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III. GENERAL MEDICAL HISTORY

PLEASE LIST ALL CURRENT MEDICAL CONDITIONS:

____

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PLEASE LIST ALL ALLERGIES TO MEDICATIONS:

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PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGES:

Name of Medication	Dosage	How Many Pills Per Day?	Date Started?
________________________	__________	_____________	_____/_____/_____
________________________	__________	_____________	_____/_____/_____
________________________	__________	_____________	_____/_____/_____
________________________	__________	_____________	_____/_____/_____
________________________	__________	_____________	_____/_____/_____
________________________	__________	_____________	_____/_____/_____
________________________	__________	_____________	_____/_____/_____

V. SPECIFIC MEDICAL HISTORY: DOES THE PATIENT HAVE A HISTORY OF ANY OF THE FOLLOWING? Please check Yes or No.

No	Yes		No	Yes	
○	○	Multiple Sclerosis	○	○	Uncontrolled Diabetes Mellitus
○	○	Other demyelinating disease (i.e. optic neuritis)	○	○	HIV
○	○	Congestive Heart Failure	○	○	Blood Disorder/Lymphoma
○	○	Active Infection	○	○	Hepatitus
○	○	Bleeding Disorder	○	○	Immunosuppression
			○	○	Tuberculosis or Positive PPD Test

POTENTIAL PATIENT'S SIGNATURE: ____________________________ DATE: ______________

CAREGIVER'S SIGNATURE: ____________________________________ DATE: ______________

For Physician's Use Only: **I have reviewed the above information and believe this patient is a candidate for medical evaluation to determine and discuss his/her suitability for anti-TNF treatment for his/her individual condition.**

YES **NO** PHYSICIAN SIGNATURE: ____________________________________ **DATE:** ____________________

Directions:
Please fill out the above information by typing directly into this form on your computer, or printing the form and then filling it out by hand. Then please send this form to the INR by one of the following methods:

1. Please click the **Submit Form** button at the top upper right of the form. You may then e-mail the form using your e-mail application, or attach it using web-based e-mail, to inrpatient@gmail.com;
2. Please fax this document, without a cover sheet, to (310) 824-6196.

If you need help with this form please contact the Institute at (310) 824-6199.

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