PATIENT INFORMATION/HISTORY FORM

Institute of Neurological Recovery®
100 UCLA Medical Plaza, Suites 205-210, Los Angeles, CA 90095
361 Hospital Road, Suite 428, Newport Beach, CA 92663

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 SELECT "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?

II. DIAGNOSIS/PATIENT CARE

Date of Traumatic Brain Injury: ______________________

PLEASE LIST THE NAME, LOCATION, AND PHONE NUMBER OF THE <u>PHYSICIAN</u> WHO DIAGNOSED TRAUMATIC BRAIN INJURY (TBI):

NAME: ______________________ LOCATION: ______________________

TELEPHONE: ______________________ SPECIALTY: ______________________

PLEASE LIST THE NAME, LOCATION, AND PHONE NUMBER OF THE <u>PRIMARY MD</u>:

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 select "Yes" or "No" for each of the following:

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: ________________________________ DATE: ____________

CAREGIVER: ____ 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: ________________________________ **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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