SELKIRK NEUROLOGY
610 S. Sherman St. #201
Spokane, WA 99202
Phone: 509-473-0885
Fax: 509-795-0895

Patient Name:

_____

Date of Birth: _____

Handedness: RIGHT or LEFT (circle)

PCP Name: _____

Most bothersome symptoms you wish to address:

_____

_____

_____

_____

Goals for your care:

_____

_____

_____

Other significant or active medical problems:

_____

_____

_____

_____

Recent hospitalizations or ER visits:

(year, name of hospital, reason)

_____

_____

_____

_____

_____

Description and year of brain or spine surgeries:

_____

_____

_____

Please write medication name, dose, and when you take medication (or attach a list). If you complete this list you do not need to bring in your medications

_____

_____

_____

_____

_____

_____

_____

Previous Treatments tried for your symptoms

(benefits or side effects):

_____

_____

_____

_____

_____

_____

Physical, Occupational, and/or Speech Therapy:

_____

_____

_____

_____

_____

_____

Allergies (to what and what happens):

_____

_____

_____

List Recent or most significant other surgeries or procedures:

_____

_____

_____

Brain or Spine MRI or Head CT in last 4 years?

(list type of scan and facility where it was done):

_____

_____

_____

EMG/Nerve testing (location, year, doctor, arms or legs)

_____

_____

_____

EEG (brain wave recording)? When and Where?

_____

_____

Spinal Tap? When and Where?

_____

_____

Smoking: Yes / No

If "Yes," how many years? _____

Alcohol: Yes / No

If "Yes," how many drinks per day? _____

Single / Married (circle)

Living Situation (circle):

Home: Alone or Home with Family

Assisted Living Name:

_____

Nursing Home Name:

_____

Types (or prior types) of work: _____

_____

Highest Education level:

_____

Health problems in family members:

Mother: _____

_____

Father: _____

_____

Siblings: _____

_____

How many siblings: _____

Children's health problems: _____

_____

_____

Circle Symptoms:

- Sleep, appetite, weight changes
- Vision changes or pain
- Ear problems, speech, or swallowing problems
- Chest pain or palpitations
- Constipation or diarrhea
- Bladder frequency, urgency or incontinence
- Muscle aches or pains
- Skin problems
- Anxiety or depression

Please write below symptoms that best describe your problem(s). Include location and severity of symptoms (mild/moderate/severe):

_____

_____

_____

_____