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 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: _____

III. GENERAL MEDICAL HISTORY

PLEASE LIST ALL CURRENT MEDICAL CONDITIONS:

_____

_____

PLEASE LIST ALL ALLERGIES TO MEDICATIONS:

_____

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
			○	○	Blood Disorder/Lymphoma
○	○	Congestive Heart Failure	○	○	Hepatitus
○	○	Active Infection	○	○	Immunosuppression
○	○	Bleeding Disorder	○	○	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.