Mount Sinai
Barbara and Maurice Deane Center for Wellness and Cognitive Health
5 East 98th Street, 7th floor

Patient intake form

Patient:	
Full name	Phone number
Address	Date of birth:
Physician you are seeing:	
Primary care provider:	
Name	Phone number
Address	
Please list all doctors you would like the after-visit report to go to along with their address/fax number: 1._____ 2._____ 3._____	
Emergency contact:	
Name	Phone number
Address	Relationship to patient
Pharmacy:	
Name	Phone number
Address	
Person filling this form:	
Name	Phone number
Address	Relationship to patient
PLEASE BRING ALL YOUR INSURANCE CARDS TO THE APPOINTMENT	

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AUTHORIZED CONTACT(S) FORM

To assist us in protecting your privacy, please provide us with the names and contact numbers of people with whom we may discuss your care.

Name _____ Relationship to patient _____

Primary phone ◯ home ◯ mobile ◯ work _____ Secondary phone ◯ home ◯ mobile ◯ work _____

Name _____ Relationship to patient _____

Primary phone ◯ home ◯ mobile ◯ work _____ Secondary phone ◯ home ◯ mobile ◯ work _____

Name _____ Relationship to patient _____

Primary phone ◯ home ◯ mobile ◯ work _____ Secondary phone ◯ home ◯ mobile ◯ work _____

Other instructions if applicable _____

Signature of patient or authorized representative _____ Date _____

Name of authorized representative _____ Relationship to patient _____

Patient Name:_____ Date of Birth:_____

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Tell us a little bit about you:

Are you: □ Right handed □ Left handed □ Forced-right handed (changed in childhood) □ Ambidextrous (use both hands equally)	
What type of education do you have: □ High school □ Bachelor □ Masters □ PhD/MD Field of Study:_____	
Do you have any history of: □ Developmental delay □ Dyslexia □ Learning disability Other:_____	
Did you ever play: Football □ Yes □ No Boxing □ Yes □ No How long:_____	
How many languages do you speak: ____ Please specify which:_____	
Are you currently: □ Employed □ Retired (When:_____) Nature of job:_____	
Do you have: □ Short term disability □ Long term disability □ None	
Are you a Veteran? □ Yes □ No	
Living Environment: □ Private home/Apartment □ Assisted living □ Nursing Home □ Other (specify)_____ Who do you live with:_____	
Do you have an advanced directive?*	□ Yes □ No
Do you have a durable power of attorney for health?*	□ Yes □ No
Do you have a durable power of attorney for finances?*	□ Yes □ No
Do you have a MOLST form?*	□ Yes □ No
***If Yes to any, please bring a copy with you to your appointment**	
Do you drive?	□ Yes □ No
Are you having any difficulties with driving?	□ Yes □ No
Have you had any car accidents in the past 5 years?	□ Yes □ No
Do you smoke: □ Cigarettes □ Pipes □ Cigars How many packs a day: _____ For how many years:_____ Date quit:___/___/_____	
Do you drink alcohol? □ Yes □ No If yes, how many drinks per week:_____	
In the past month, have you used marijuana or other social drugs such as stimulants, hallucinogens, narcotics or sedatives? □ Yes □ No If yes, type and frequency:_____	
Do you drink coffee or tea? □ Yes □ No If yes, how many cups per day:_____ □ Check if you drink only decaffeinated coffee or tea	
Do you drink soft drinks with caffeine (Coke, Pepsi, Mountain Dew, Jolt, Dr. Pepper) □ Yes □ No If yes, how many 12 oz. cans do you drink per day:_____	
Do you regularly exercise: □ Yes □ No If yes, how many hours per week:_____ What type of exercise do you do:_____	
Tell us a little bit about the type of diet you eat:_____ _____	
Tell us about your day to day social support (families, friends, social activities you do): _____	

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Please briefly describe the reason(s) for which you are being seen:_____
_____

Check if you are having difficulties in any of the following (If yes please give a brief example):

	Since when?	Example:
□ Short term memory		
□ Planning and organizing		
□ Judgment, problem solving, troubleshooting		
□ Word finding difficulties		
□ Difficulty understanding words		
□ Difficulty navigating or getting lost		
□ Difficulty recognizing people		
□ Difficulty walking □ Falling (if yes specify how often)		
□ Tremors		
□ Difficulty swallowing		
□ Slowness of movements		
□ Loss of sense of smell		
□ Personality or behavioral changes		
□ Decreased motivation		
□ Obsessive thoughts or compulsions		
□ Changes in eating habits		
□ Hallucinations or false beliefs		
□ Feeling depressed □ Anxious □ Suicidal Thoughts		
□ Sleep difficulties □ Snoring		
□ Acting out dreams		
□ Weight loss		How much:_____

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Tell us about your **current** health, in the past month have you had any of the below:

□ Yes □ No Chest Pain	□ Yes □ No Diarrhea
□ Yes □ No Dizziness	□ Yes □ No Constipation
□ Yes □ No Fainting	□ Yes □ No Stool incontinence
□ Yes □ No Shortness of breath	□ Yes □ No Joint pain
□ Yes □ No Cough	□ Yes □ No Fever
□ Yes □ No Burning with urination	□ Yes □ No Chills
□ Yes □ No Urine incontinence	□ Yes □ No Night sweats
□ Yes □ No Muscle ache	□ Yes □ No Nausea/Vomiting
□ Yes □ No Numbness (Where_____)	□ Yes □ No Leg edema
□ Yes □ No Tingling (Where_____)	□ Yes □ No Back pain
	□ Yes □ No Other pain (Where_____)

Now tell us about your **chronic and/or previous** medical problems:

Do you have any of the following?	For how many years have you had it?
□ Yes □ No Hypertension	
□ Yes □ No Diabetes	
□ Yes □ No High Cholesterol	
□ Yes □ No Coronary artery disease	
□ Yes □ No Liver disease	
□ Yes □ No Kidney disease	
□ Yes □ No Hypothryoidism	
□ Yes □ No Seizures	
□ Yes □ No Depression	
□ Yes □ No Other psychiatric condition	
□ Yes □ No Sleep apnea	

Have you ever had a stroke? □ Yes □ No
If yes, please state when and the symptoms you had:
_____
_____

Do you have hearing loss? □ Yes □ No For how long: _____
Do you wear hearing aids? □ Yes □ No (If yes, **bring them to your appointment**)

Do you have vision problems? □ Yes □ No For how long:_____
Do you wear glasses? □ Yes □ No (If yes, please **bring them to your appointment**)

Have you ever had a trauma to your head? □ Yes □ No
If yes, please list all events, circumstances and whether you lost consciousness:
1._____
2._____
3._____

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Please list all the surgeries that you had in the past and the year it was done:

1._____Year:_____

2._____Year:_____

3._____Year:_____

4._____Year:_____

5._____Year:_____

Now please tell us about your family (add more family members as appropriate):

Relation	**Name**	**Status (alive or deceased)**	**Age of death**	**Cause of death**
Mother				
Father				
Brother				
Sister				
Son				
Daughter				
etc				

Now please tell us about any medical condition or dementia in the blood relatives (see first line for example):

Problem	**Relation**	**Age of onset**	**Description**
Eg. Dementia	*Maternal grandfather*	*75*	*Short term memory loss*

Please check if any of the following has been done before for the workup of your condition:

□ MRI (If yes, please **bring the images on a disc to your appointment**)
□ PET scan (If yes, please **bring the images on a disc to your appointment**)
□ EEG □ Blood work □ Neuropsychology testing □ Lumbar Puncture

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Now please tell us about the medications that you take (please list all medications **including prescription medications, non-prescribed over-the-counter medications, vitamins and minerals**):

Name of medication	Strength of each pill	How often is it taken?	How long have you been taking it?	What is it taken for?

(If there is not enough space, please continue on backside of form)

Who administers your medications: □ Self □ Other (Family member/caregiver) How are medications organized: □ Multi-dose vials □ Mediset/Pillbox □ Not sure
How many doses of medications were missed last week: □ None □ 1-2 doses □ 3-4 doses □ more than 4 doses
In the past week, have you taken any medications prescribed for someone else? □ Yes □ No If yes, specify which medication:_____

Now tell us about herbal or alternative medicines you are taking (include all **home remedies, herbal teas, herbal pills, amino acids, and nutritional supplements**):

Name of herbal medicine (brand and generic if available)	List active ingredients (often found on back of bottle of box)

Where were these herbal medications purchased (check all that apply): □ Pharmacy □ Health food store □ Herbal store □ Herbalist □ Mail order □ I grow my own herbs □ Other (please name):_____
Did any of these products improve memory: □ Yes □ No or mood: □ Yes □ No If yes, which product:_____
Please bring these herbal medications and other medications to your first visit.

Patient Name:_____ Date of Birth:_____

Now tell us about any allergies:

Have you ever had a bad reaction to any medication or experienced any allergy to:
Reaction:_____ Date: _____
Reaction:_____ Date: _____
Reaction:_____ Date: _____
Reaction:_____ Date: _____
Reaction:_____ Date: _____
Did any of the above reactions require treatment? □ Yes □ No What was the treatment: _____

Now tell us how well you are able to do the below on a daily basis:

	Completely independent	Needs some help	Unable, or needs major assistance
Bathing/Showering			
Dressing			
Toileting			
Transferring			
Continence			
Feeding/Eating			
Ability to Use Telephone			
Shopping			
Preparing food			
Housekeeping			
Doing Laundry			
Transportation (driving or using public transport)			
Manage your own Medications			
Handling Finances			
Do you have a hired health aide or companion: □ Yes □ No Who:_____			

Thank you for completing this form. We look forward to meeting you and helping you with your medical condition. If you have any questions, please contact the practice at the following number: (212) 241-7076