



Adult New Patient History and Demographics

Demographics: Date: ___/___/___

Last Name:		First Name:		Preferred Name:		
Date of Birth: ___/___/___		Age:	Handedness:	Right	Left	Both
Street Address:						
City:		State:		Zip Code:		County:
Is this a residential facility? Yes No			Name of Facility and Contact:			
Home Phone:		Cell Phone:		Work Phone:		
Preferred Contact Method: (Circle):		Home	Cell	Work		

Race:

American Indian	Alaskan Native	African American/Black	
Native Hawaiian	Pacific islander	Asian	
Hispanic	White Caucasian	Other/Prefer not to Identify	

Country of Origin: _____ Languages Spoken: _____

Legal Custody: Self: Other: (If other, please list under guardianship information)

Guardianship Information:

Last Name:		First Name:			
Street Address:					
City:		State:		Zip Code:	County:
Home Phone:		Cell Phone:		Work Phone:	
Preferred Contact Method: (Circle):		Home	Cell	Work	

Emergency Contact:

Last Name:		First Name:			
Street Address:					
City:		State:		Zip Code:	County:
Home Phone:		Cell Phone:		Work Phone:	



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Family Medical History:

Relation:	Age:	Seizure/Epilepsy History?	Other Health Issues:	Deceased?	Cause of Death:
Mother:					
Father:					
Sisters					
Brothers:					
Maternal Grandfather:					
Maternal Grandmother:					
Paternal Grandfather:					
Paternal Grandmother:					
Additional:					

