NeuLine
HEALTH

BRAIN WELLNESS INTAKE FORM

Patient Name ______________________________ Date__________________

If you answered yes to a question that has a follow-up question, please give your best answer.

Y	N	
☐	☐	1. Have you been diagnosed with COVID-19 within the last nine months?
☐	☐	2. Have you received one or more doses of the COVID-19 vaccine?

WITHIN THE PAST 12 MONTHS:

Y	N	
☐	☐	1. Have you lost consciousness or fainted at any point?
☐	☐	2. Have you experienced memory loss? If so, for what length of time? __________
☐	☐	3. Have you experienced any seizures?
☐	☐	4. Have you experienced any convulsions (e.g., body muscles contract and relax rapidly and/or repeatedly)?
☐	☐	5. Have you experienced any periods of dizziness or vertigo? If so, what time of day? ______________
☐	☐	6. Have you found yourself disoriented?
☐	☐	7. Have you experienced any moments of an altered mental state of mind?
☐	☐	8. Do you suffer from any type of post-traumatic stress (PTSD)?
☐	☐	9. Would you be willing to undergo a quick 20-minute brain scan?

HISTORY:

Y	N	
☐	☐	1. Have you ever had a brain scan/test?
☐	☐	2. Have you ever been admitted into the hospital for any neurological-related condition?

VER EL REVERSO PARA ESPAÑOL