

**NEUROLOGY & MOVEMENT
DISORDERS ASSOCIATES**

ADULT HEALTH QUESTIONNAIRE Date _____

PATIENT IDENTIFICATION _____

QUESTIONNAIRE FOR FAMILY MEMBER

Caregiver: _____ Relationship to Patient: _____

_____ Spouse Son Daughter Brother Sister Other

_____ Caregiver age

Address _____

City State Zip Home Phone Cell Phone or other

Do you provide: Part-time Care (how many hours/day?) _____) Full-time Care (24 hrs) Other _____