



NEUROLOGY QUESTIONNAIRE

Date of first appointment _____ First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: Male Female If female, are you pregnant? Yes No

Handedness: Right Left Ambidextrous

Main reason for your visit: _____

Describe briefly your present symptoms (quality, location, timing, other problems): _____

Please list the names of other health care providers you have seen for this problem: _____

Date symptoms began (approximate) _____ Diagnosis given? _____

Previous treatment for this problem (include physical therapy, surgery, and medications) _____

PAST MEDICAL HISTORY: (please check all that apply and state when the problem started)

Yes No Headaches _____ Yes No Chronic Pain Syndrome _____ Yes No Depression _____

Yes No Seizures _____ Yes No Atrial Fibrillation/Flutter _____ Yes No Drug Addiction _____

Yes No Back or Joint Problems _____ Yes No Anxiety _____ Yes No Alcohol Addiction _____

Other significant illnesses or infections: _____

FAMILY HISTORY: Has any member of your family (not to include spouse or in-laws) ever had the following conditions. If yes, indicate family member.

		<u>Family Member</u>			<u>Family Member</u>		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Anxiety	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polyneuropathy	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dementia	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Depression	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Restless Leg Syndrome	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke or TIA	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tremor	_____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Obstructive Sleep Apnea	_____				

Other conditions: _____

SLEEP HISTORY:

- Yes No Do you have trouble sleeping?
- Yes No Do you have insomnia?
- Yes No Do you snore?
- Yes No Have you ever been told you stop breathing while you sleep?
- Yes No Do you have a headache when you wake up in the morning?
- Yes No Are you tired when you wake in the morning?
- Yes No Do you get sleepy during the day when things are quiet?
- Yes No Do you get sleepy during the day when sitting or reading?
- Yes No Do you get sleepy when watching television?
- Yes No Do you get sleepy while driving?
- Yes No Do you have heartburn at night?
- Yes No Do you have a crawling, uncomfortable, restless feeling in your legs when you lay down or rest?
- Yes No Does it go way if you move your feet or get up and walk?

Please mark on these drawings the present location of your symptoms using the following key:



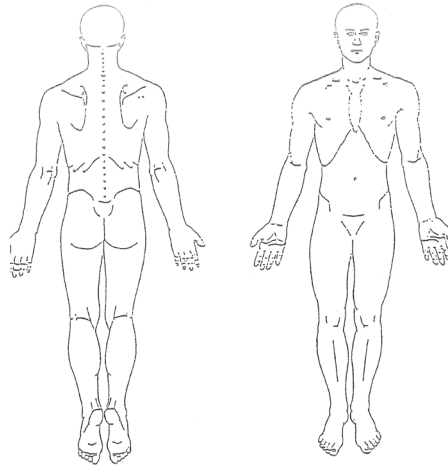
Pain



Pins & Needles



Numbness



If you missed work, what was your last day worked? _____

Using a scale from 1-10, with 0=No Pain and 10=the most pain you have ever experienced, please answer the following questions:

What is your current level of pain? 1 2 3 4 5 6 7 8 9 10

What is the worst this pain has been? 1 2 3 4 5 6 7 8 9 10

What is the best this pain has been? 1 2 3 4 5 6 7 8 9 10

What makes your pain better? Rest Heat Ice Medicine Hot Bath Exercise Massage Manipulation

What medications have you used? _____

What activity would you like to do, but cannot because of pain? _____

When do you notice most of your pain? Morning Afternoon Evening Night

What aggravates your pain? Sitting Standing Walking Lying Down Putting on Shoes Light
 Bending Driving Coughing Straining Riding in a Car Sound

Other: _____

REVIEW OF SYSTEMS: Please check any new symptoms you have experienced in the last MONTH.

Constitutional/General

- Yes No Fever
- Yes No Chills
- Yes No Heavy Sweating/
Night Sweats
- Yes No Loss of Appetite
- Yes No Sleep Disturbances
- Yes No Unexplained Weight
Loss/Gain

Other: _____

Eyes

- Yes No Blurry Vision
- Yes No Double Vision
- Yes No Wear Glasses
- Other: _____

Ear/Nose/Throat

- Yes No Sore Throat
- Yes No Mouth Sores
- Yes No Nasal Congestion/
Sinus Issues
- Yes No Hearing Loss
- Other: _____

Respiratory

- Yes No Cough
- Yes No COPD
- Yes No Wheezing
- Yes No Recurrent Respiratory
Infections
- Yes No Shortness of Breath
- Other: _____

Cardiovascular

- Yes No Chest Pain or Discomfort
- Yes No Swelling Feet, Ankles, Legs
- Yes No Irregular Heartbeat
- Yes No Heart Attack
- Yes No Palpitations
- Yes No Varicose Veins
- Other: _____

Gastrointestinal

- Yes No Abdominal Pain
- Yes No Nausea/Vomiting
- Yes No Indigestion/Heartburn
- Yes No Blood in Stools
- Yes No Change in Bowel Habits
- Yes No Rectal Bleeding
- Yes No Diarrhea
- Yes No Constipation
- Yes No Swallowing Difficulties
- Other: _____

Psychological

- Yes No Depression
- Yes No Anxiety
- Other: _____

Genitourinary

- Yes No Painful urination
- Yes No Urinary Frequency
- Yes No Loss of Urinary Control
- Yes No Enlarged Prostate
- Yes No Difficulty Urinating
- Other: _____

Skin

- Yes No Skin Rash
- Yes No Itching
- Yes No Discoloration
- Yes No Lumps or Masses
- Other: _____

Musculoskeletal

- Yes No Joint Pain
- Yes No Joint Swelling
- Yes No Back Pain
- Yes No Limitation of Motion
- Yes No Neck Pain
- Yes No Pain with Walking
- Other: _____

Endocrine

- Yes No Excessive Thirst/
Fluid Intake
- Yes No Temperature Intolerance
- Yes No Feeling Tired (Fatigue)
- Yes No Hot Flashes
- Other: _____

Hematologic/Lymphatic

- Yes No Swollen Glands
- Yes No Blood Clotting Problem
- Yes No Easy Bruising
- Yes No Bleeding Tendencies
- Other: _____

Neurological

- Yes No Tremors
- Yes No Dizzy Spells
- Yes No Numbness/Tingling
- Yes No Headache
- Yes No Unsteady Gait
- Yes No Feeling Weak
- Yes No Convulsions/Seizures
- Other: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____