FAX THIS COMPLETED QUESTIONNAIRE TO:

(321) 441-1559

**THOROUGHLY** complete this questionnaire. We know that it is a lot of writing, but it will help the doctor to better diagnose and provide you the appropriate care.

Your appointment is \_\_\_/­\_\_\_/ 2019 @ \_\_\_\_am / pm

**OUR ADDRESS IS:**

Downtown Location:

801 N. Orange Ave Ste 535, Orlando, FL 32801

PHONE: (407) 644-0101

**Primary Care Physician (name and address):**

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Personal Information:

### Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_

Age\_\_\_\_\_ Male\_\_\_\_\_ Female\_\_\_\_\_ Right handed\_\_\_\_\_ Left handed\_\_\_\_\_

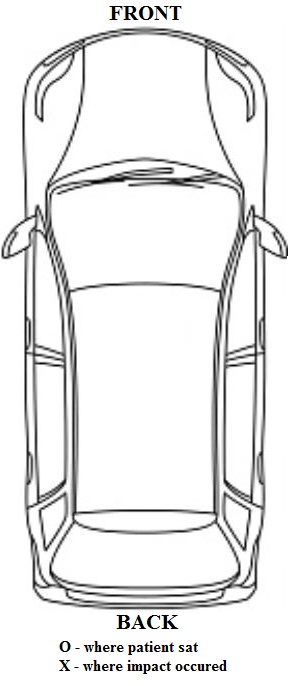
Single\_\_\_\_ Married\_\_\_\_ Divorced\_\_\_\_ Separated\_\_\_\_ Widowed\_\_\_\_

Highest Education\_\_\_\_\_\_\_\_\_\_\_ Occupation /Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Accident Information** **Date of Injury:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Type of Case**: Automobile Fall Motorcycle Pedestrian Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe how the accident happened**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Were you the Driver**? Yes or No Passenger? Yes or No

**Were you sitting in the** front seat or rear seat ?

**Total Damage to you vehicle** $ \_\_\_\_\_\_\_\_\_\_\_\_

**Year/Make/Model of you vehicle:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was your vehicle?** Moving or Stopped

**Seat Belt:** Yes or No

**Did your airbags deploy**? Yes or No

**Where was you vehicle struck**?

Rear-end or Passenger side or Driver side

**During Impact:**  Did you brace with arms on?

Steering Wheel - Dashboard - Seat

Did you brace with legs on?

Floor - Brakes

**Was your head**? Straight or Turned Right or Turned Left

**Did you strike any part of your body**? Yes or No **If yes against what**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Was anyone in the vehicle with you**? Yes or No **If yes who**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**After collision:** Did you experience Loss of consciousness? Yes or No If so, how many minutes? \_\_\_\_\_

Did you feel: Stunned Nervous Scared Dizzy Disoriented Lightheaded Confused

Immediate Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subsequent Symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Were you evaluated by paramedics**? Yes or No

**Were you taken to hospital**? Yes or No **By ambulance**? Yes or No

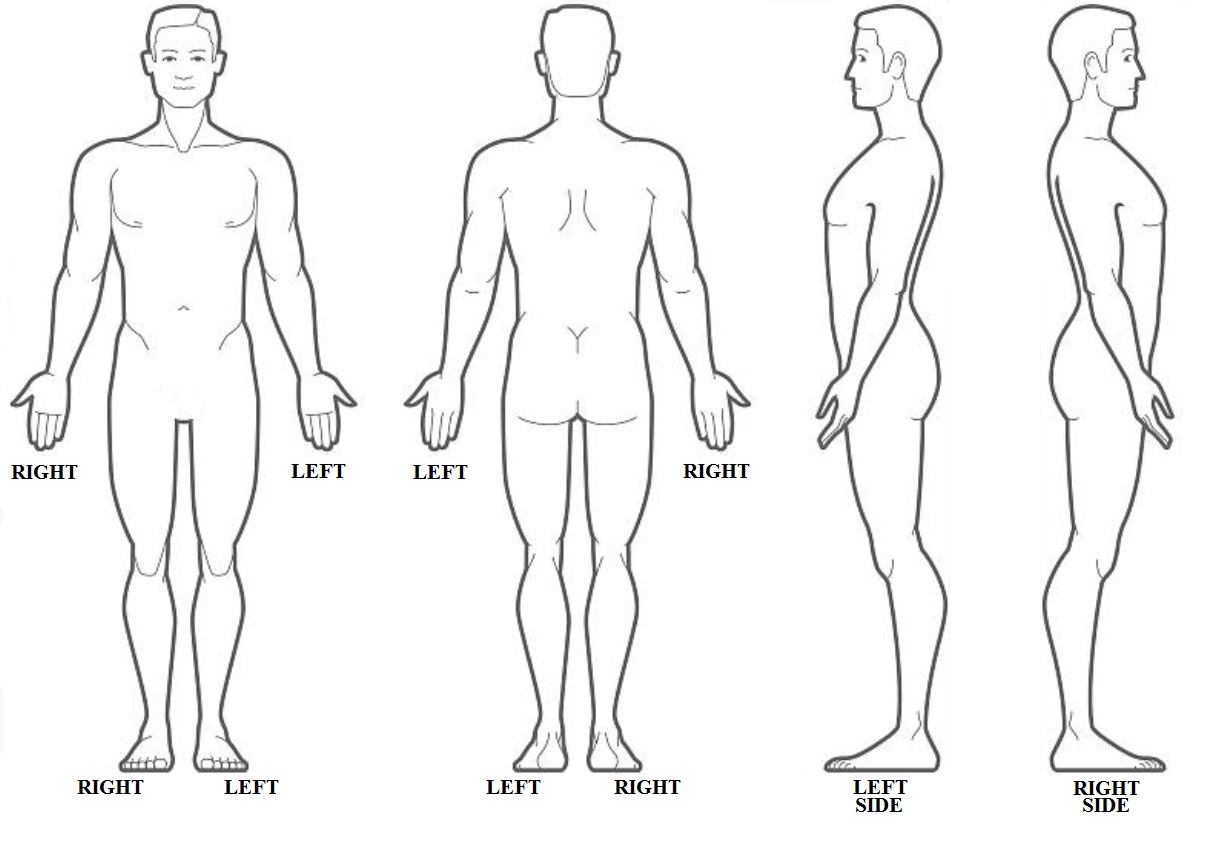
**Hospital Treatment**? Yes or No **Did they do**? X-rays - CT Scans – MRIs

2

**Pain Assessment:** Mark the area(s) where you feel your symptoms/pain

/////= Stabbing 0000= Tingling XXXX= Burning AAAA= Aching

TTTT= Throbbing SSSS=Shooting DDDD=Dull NNNN= Numb



*How often do your symptoms affect you?*

Occasionally\_\_\_(0-33% of the day) Frequently\_\_\_(33-66%) Constant\_\_\_(66-100%)

*What time of the day your pain is most severe or frequent? (average)*

Wake up by the pain \_\_\_, when arrive to work\_\_\_, by noon\_\_\_, mid-afternoon\_\_\_, late in the evening\_\_, when lying down to sleep\_\_\_, Anytime\_\_\_, I haven’t noticed\_\_\_

**After Hospital Treatment**:

Dr. Name & Specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### Previous treatment for this injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MRI, CT, X-rays for this injury:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3**

**Current Main / Primary Complaint**

Location of your pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe pain: \_\_\_sharp, \_\_\_stabbing, \_\_\_\_dull, \_\_\_\_aching, \_\_\_\_burning, \_\_\_throbbing

Intensity: (from 1-10, if 10 is like cutting your arm off with no anesthesia) \_\_\_\_\_\_\_\_\_\_\_\_

When do you experience the pain worst? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequently do you experience the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain less? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Secondary Complaint**

Location of your pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe pain: \_\_\_sharp, \_\_\_stabbing, \_\_\_\_dull, \_\_\_\_aching, \_\_\_\_burning, \_\_\_throbbing

Intensity: (from 1-10, if 10 is like cutting your arm off with no anesthesia) \_\_\_\_\_\_\_\_\_\_\_\_

When do you experience the pain worst? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequently do you experience the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain less? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Third Complaint**

Location of your pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe pain: \_\_\_sharp, \_\_\_stabbing, \_\_\_\_dull, \_\_\_\_aching, \_\_\_\_burning, \_\_\_throbbing

Intensity: (from 1-10 , if 10 is like cutting your arm off with no anesthesia \_\_\_\_\_\_\_\_\_\_\_\_

When do you experience the pain worst? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequently do you experience the pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain less? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anything else? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Daily Functions:**

**S*leeping difficulties*?** No/Yes

* difficulty getting to sleep
* awakens from pain
* easily awakens (cannot sleep through the night)
* early awakening (before expected)
* awake tired (not rested)

***Thirsty frequently***? No\_\_ Yes\_\_ (how many glasses a day?\_\_\_ )

***Appetite*** greater than usual? No\_\_ Yes\_\_

***Urinate*** frequently? No\_\_ Yes\_\_ Every \_\_hours

***Bowel movements***: Daily\_\_ every 2 days\_\_ 3-5 days\_\_ 6-7 days\_\_

**Current Medications:** List ALL Medications, if there are more than you can list, bring a separate list with you.

Name of Medication Strength (mg) How Many Per Day? Were you taking Medication before your Accident?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes or No

**Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Habits:**

***Important!!! These substances have serious adverse side effects if combined with medications, so help the physician to decide what medicine is safe for you!***

Smoke tobacco: Yes or No. If yes, packs /day? \_\_\_\_\_\_\_, how many years? \_\_\_\_\_\_

Quit? (Yes or No) When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Drink Coffee / caffeine: No\_\_/Yes\_\_, how many cups/mugs/cans a day\_\_\_\_\_\_

Drink Alcohol: No\_\_/Yes\_\_. How many glasses liquor or beers a day\_\_\_\_ week\_\_\_\_

Drug Use: No\_\_/Yes\_\_\_, Are you in a methadone program? No\_\_/Yes\_\_

Detail type of substance and frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Issues:**

Is this work-related: Yes / No Date of injury: \_\_\_\_\_\_\_\_\_\_

Was your supervisor notified? Yes\_\_ or No\_\_

Is there any ongoing litigation? Yes\_\_ or No\_\_

Have you been awarded/ assessed an IMPAIRMENT or DISABILITY RATING for before? No / Yes, What was the rating percentage? \_\_\_\_\_

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#### REVIEW OF SYSTEMS:

Please check **ONLY** those you had **“BEFORE THIS INJURY”**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL:**

□yes □no Unexplained changes in weight

□yes □no Fever

□yes □no Chills

□yes □no Night sweats

**NEUROLOGICAL:**

□yes □no Unusual change in voice

□yes □no Seizures

□yes □no Loss of consciousness

□yes □no Memory difficulties

□yes □no Disorientation

□yes □no Difficulty with speaking

□yes □no Difficulty with writing

□yes □no Difficulty with reading

□yes □no Dysphagia

□yes □no Double vision

□yes □no Loss of vision

□yes □no Tremors

□yes □no Difficulty walking

□yes □no Weakness

□yes □no Numbness

□yes □no Changes in sensation

□yes □no Tingling

**HEAD:**

□yes □no Headache

□yes □no History of head contusions

□yes □no Hearing

□yes □no Auditory problems

□yes □no Dizziness

□yes □no Ear buzzing

□yes □no Sinus (stuffy nose)

□yes □no Ear pain

□yes □no Dental problems

□yes □no Metal implants

□yes □no Bleeding gums

**CARDIOLOGY/PULMONARY:**

□yes □no Chest pain

□yes □no Palpitations

□yes □no Murmur

□yes □no Swollen feet legs worse at the end of the

day.

□yes □no Cough

□yes □no Wheezing

□yes □no Shortness of breath walking up one flight

Stairs.

**GASTROINTESTINAL:**

□yes □no Digestion problems

□yes □no Bloating

□yes □no Nausea

□yes □no Heartburn

□yes □no Vomiting

□yes □no Constipation

□yes □no Unexplained diarrhea

□yes □no Abdominal pain

□yes □no Sour mouth sensation after sleeping.

**GENITAL/URINARY:**

□yes □no Difficulty urinating

□yes □no Urge urinating

□yes □no Pain urinating

□yes □no Painful intercourse

□yes □no Vaginal secretions

□yes □no Bladder incontinence

□yes □no Kidney stones

□yes □no Kidney infections

**MUSCULAR/SKELETAL:**

□yes □no Diffuse muscle aching

□yes □no Fibromyalgia

□yes □no Legs or joint swelling

□yes □no Stiffness

□yes □no Painful foot sole or arch “*first steps in the*

*morning*”.

**SKIN/HAIR:**

□yes □no Changes in skin moles

□yes □no Non-healing ulcers

□yes □no Dry skin

□yes □no Itching

□yes □no Nail fungus

**ENDOCRINE/HEMATOLOGICAL/IMMUNE:**

□yes □no HIV positive

□yes □no Hepatitis

□yes □no Fainting

□yes □no Swollen armpit

□yes □no Swollen groin glands,

□yes □no Pale color

□yes □no Bleeding disorders

□yes □no Recurrent infection

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**PAST MEDICAL HISTORY** - **UNRELATED TO THIS INJURY !!!** - **(Only what was prior to this injury)**

If diagnosed by physician check “X”. if probably, write **a** “P”

Specify when first started, in years (ie. 6 months)

### Arthritis \_\_\_\_\_\_\_\_ Osteoarthritis \_\_\_\_\_\_\_\_

Neck pain \_\_\_\_\_\_\_\_ Heart attack \_\_\_\_\_\_\_\_

Back pain \_\_\_\_\_\_\_\_ Angina/ arrhythmias \_\_\_\_\_\_\_\_

Bleeding or blood clots \_\_\_\_\_\_\_\_ Hypertension /low pressure \_\_\_\_\_\_\_\_

Cholesterol \_\_\_\_\_\_\_\_ Osteoporosis \_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_Type I ( ) or Type II ( ) Osteopenia \_\_\_\_\_\_\_\_

Depression \_\_\_\_\_\_\_ Thyroid problems \_\_\_\_\_\_\_\_

Gastritis or peptic ulcer disease \_\_\_\_\_\_ HIV positive \_\_\_\_\_\_\_\_

Hepatitis \_\_\_\_\_\_\_\_ Syphilis \_\_\_\_\_\_\_\_

Deep vein thrombosis \_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there significant stress at work? Yes\_\_ No\_\_\_

How does this make your pain worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Any Food intolerance or allergy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Imaging Studies (Before this Injury):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Past Surgical History** **or prolonged hospitalizations** you have had in the past:

Operation Month/Year Hospital/City Doctor

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family Medical History**

**Father**: alive? Yes\_\_/No\_\_ cause and age died \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If alive, age\_\_\_ and medical problems\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mothe**r: alive? Yes\_\_/No\_\_, cause and age died\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

if alive, age: \_\_\_\_\_, diseases \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Number of Brothers\_\_\_\_\_\_\_\_Number of Sisters\_\_\_\_\_\_\_\_**

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**Functional History:**

**Previous Level:** check **(‘x”)** if you have a problem;

( ) Walking: independent\_\_\_, use a cane\_\_\_/brace\_\_\_\_

( ) Climbing: upstairs independent?

( ) Driving: Independent?

( ) Transfers (get up, bed to chair, sitting to standing)

( ) Dressing oneself (shirt, pants, shoelaces)

( ) Eating/ drinking (cooking)

( ) Self care (urinating, defecating,) and personal

( ) Hygiene (bathing, brushing, combing, etc)

**Social History:**

I live in a House /Apartment / Other\_\_\_\_\_\_\_\_\_

How many steps/stairs to your room?\_\_\_\_\_\_\_\_

Do you live alone? Yes\_\_ / No\_\_, with whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If you have a home attendant, #hours/day\_\_\_\_\_/\_\_\_\_\_

**Educational Background**: (circle you answer)

What was your highest level of Schooling?

High school, Technical school, Associates, College

Did you have any learning disabilities prior to the accident? Yes / No

Were you ever held or left back a grade in school? Yes / No

Have you had any history of ADHD prior to the accident? Yes / No

Did you have any need for Special Education Classes prior to the accident?? Yes / No

Did you ever require tutoring prior to the accident? Yes / No

On average what were your grades? A’s, B’s, C’s, D’s, F’s

##### **Functional Work Demands:**

Current occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary activities you do at work: Sitting ( ), standing ( ), kneeling ( ), bending forward ( ) bending backward ( ) rotating the trunk ( ) squatting ( ) reaching ( )

What is the maximum weight you can tolerate lifting without provoking pain? \_\_\_\_\_\_lbs

How many hours spend sitting? \_\_\_\_\_ How many hours using the computer? \_\_\_\_\_

How many hours standing? \_\_\_\_\_\_\_\_

**Recreational History:**

Practice Sports or exercise? No\_\_ /Yes\_\_. If yes, how many times a week?\_\_\_\_\_\_\_\_\_\_\_\_ What kind of sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### I enjoy (movies/ theater / listen music /dancing, racing, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Complete Boxes Below ONLY if you have had any Prior Motor Vehicle Collisions**

**with Injuries?**

Date of **PRIOR** MVA: \_\_\_\_\_\_\_\_\_\_\_Type of Collision: □ Head-on

□ Rear-ended

□ Side-impact

Driver’s side impact

Passenger side impact

Area of Body Injured:

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Property Damage Amount: $\_\_\_\_\_\_\_\_\_\_.00

Last Treatment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of other **PRIOR** MVA: \_\_\_\_\_\_\_\_\_\_\_Type of Collision: □ Head-on

□ Rear-ended

□ Side-impact (T-Bone):

Driver’s side impact

Passenger side impact

Area of Body Injured:

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_4) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Property Damage Amount:$\_\_\_\_\_\_\_\_\_\_.00

Last Treatment Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**BECK Inventory Questionnaire:**

This group of questions will help your doctor understand how pain has changed your outlook on life. In each group, pick out one statement that best describes how you have been feeling the past week, including today:

1. 0. I do not feel sad 2. 0. I have not lost interest in other people

1. I feel sad sometimes 1. I am less interested in other people than

1. I am sad all of the time I used to be
2. I am so sad/unhappy that I can’t stand it 2. I have lost most of my interest in other
3. I have lost all interest in other people people

3. 0. I am not particularly discouraged about 4. 0. I make decisions about as well as I ever

the future could

1. I feel discouraged about the future 1. I put off making decisions more than I
2. I feel I have nothing to look forward to used to
3. I feel the future is hopeless and things 2. I have greater difficulty in making

cannot improve decisions than before

3 I can’t make decisions at all anymore

5. 0. I do not feel like a failure 6. 0. I don’t feel I look any worse than I used

1. I feel I have failed more than the average to

person 1. I am worried that I am looking old or

1. As I look back on my life, all I see is a lot unattractive

of failure 2. I feel that there are permanent changes in

1. I feel I am a complete failure as a person my appearance

3 I believe that I look ugly

7. 0. I get as much satisfaction out of things as 8. 0. I can work about as well as before

I used to 1. It takes an extra effort to get started at

1. I don’t enjoy things like I used to doing something
2. I don’t get real satisfaction out of 2. I have to push myself very hard to do

anything anymore anything

1. I am dissatisfied or bored with 3. I can’t do any work at all

Everything

9. 0. I don’t feel particularly guilty 10. 0. I can sleep as well as usual

1. I feel guilty a good part of the time 1. I don’t sleep as well as I used to
2. I feel quite guilty most of the time 2. I wake up 1-2 hours earlier than usual
3. I feel guilty all of the time and find it hard to get back to sleep

3 I wake up several hours earlier than I

used to & cannot get back to sleep

11. 0. I don’t feel that I am being punished 12. 0. I don’t get more tired than usual

1. I feel I may be being punished 1. I get tired more easily than I used to

2. I expect to be punished 2. I get tired from doing anything

3. I feel I am being punished 3. I am too tired to do anything

13. 0. I don’t feel disappointed in myself 14. 0. I don’t feel that I am worse than

1. I am disappointed in myself Anyone else
2. I am disgusted with myself 1. I am critical of myself for my
3. I hate myself weaknesses and mistakes

2. I blame myself all of the time for my

faults

3. I blame myself for everything bad that

Happens

-10-

**BECK Inventory Questionnaire (Continued):**

15. 0. I am not more irritated now than I ever 16. 0. I haven’t lost much weight, if any, lately

1. I get annoyed to irritated more easily 1. I have lost more than 5 pounds

than I used to 2. I have lost more than 10 pounds

1. I feel irritated all of the time now 3. I have lost more than 15 pounds
2. I don’t get irritated at all by things that

used to irritate me

17. 0. I don’t have thoughts of killing myself 18. 0. I am more worried about my health than

1. I have thoughts of killing myself, but I usual

would not carry them out 1. I am worried about my physical problems

2. I would like to kill myself such as aches and pains, upset stomach,

3. I would kill myself if I had the chance constipation.

2. I am very worried about my physical

Problems and it’s hard to think of much else

3. I am so worried about my physical

problems that I can’t think of much else

19. 0. I don’t cry anymore than usual 20. 0. I have not noticed any recent change in my

1. I cry more than I used to interest in sex

1. I cry all of the time now 1. I am less interested in sex
2. I used to be able to cry, but now I can’t 2. I am much less interested in sex

cry even though I want to 3. I have lost interest in sex completely

21. 0. My appetite is not worse than usual

1. My appetite is not as good as it used

to be

1. My appetite is much worse now
2. I have no appetite at all

OFFICE USE ONLY

11-16 ml \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17-26 MO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

>26s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11

**Neurobehavioral Symptom Inventory (NSI)**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please rate the following symptoms to how much they have disturbed you **IN THE LAST TWO WEEKS.** Rate each symptom from 0 to 4, as based on the following definitions.

0 = None – Rarely if ever present; not a problem at all.

1 = Mild – Occasionally present, but it does not disrupt my activities; I can usually continue what I’m doing and it

does not concern me.

2= Moderate – Often present, occasionally disrupts my activities; I can usually continue what I’m doing with some

effort; I feel somewhat concerned.

3= Severe – Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort;

I feel I need help.

4= Very Severe- Almost always present and I have been unable to perform at work, school or home due to this problem;

I probably cannot function without help.

|  |  |  |
| --- | --- | --- |
| **Number** | **Symptom Description** | |
| 1 | Feeling dizzy | 0 1 2 3 4 |
| 2 | Loss of balance | 0 1 2 3 4 |
| 3 | Poor coordination, clumsy | 0 1 2 3 4 |

**Vestibular Total:**

|  |  |  |
| --- | --- | --- |
| **Number** | **Symptom Description** | |
| **4** | Headaches | 0 1 2 3 4 |
| **5** | Nausea | 0 1 2 3 4 |
| **6** | Vision problems, blurring, trouble seeing | 0 1 2 3 4 |
| **7** | Sensitivity to light | 0 1 2 3 4 |
| **8** | Hearing difficulty | 0 1 2 3 4 |
| **9** | Sensitivity to noise | 0 1 2 3 4 |
| **10** | Numbness or tingling on parts of my body | 0 1 2 3 4 |
| **11** | Change in taste and/or smell | 0 1 2 3 4 |

**Somatosensory Total:**

|  |  |  |
| --- | --- | --- |
| **Number** | **Symptom Description** | |
| **12** | Loss of appetite or increased appetite | 0 1 2 3 4 |
| **13** | Poor concentration, can’t pay attention, easily distracted | 0 1 2 3 4 |
| **14** | Forgetfulness, can’t remember things | 0 1 2 3 4 |
| **15** | Difficulty making decisions | 0 1 2 3 4 |
| **16** | Slowed thinking, difficulty getting organized, can’t find things | 0 1 2 3 4 |

**Cognitive Total:**

|  |  |  |
| --- | --- | --- |
| **Number** | **Symptom Description** | |
| **17** | Fatigue, loss of energy, getting tired easily | 0 1 2 3 4 |
| **18** | Difficulty falling asleep or staying asleep | 0 1 2 3 4 |
| **19** | Feeling anxious or tense | 0 1 2 3 4 |
| **20** | Feeling depressed or sad | 0 1 2 3 4 |
| **21** | Irritability, easily annoyed | 0 1 2 3 4 |
| **22** | Poor frustration tolerance, feeling easily overwhelmed by things | 0 1 2 3 4 |

**Affective Total:**

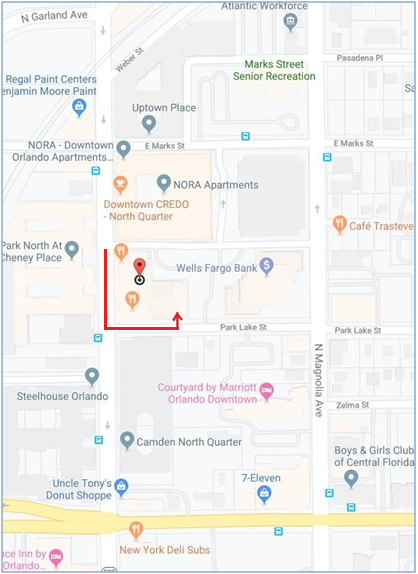
**-12- TOTAL: \_\_\_\_\_\_\_\_\_\_\_\_\_**

Directions to Downtown location:

**When traveling west on I-4:**

Exit Ivanhoe Blvd, at the bottom of the offramp turn left (east) onto Lakeview. Stay in the far right lane on Lakeview as it turns to the right, it will become Orange Avenue. The Sixth Street on your left will be Park Lake, Turn Left. The second driveway on your left is the driveway to the parking garage for the 801 building. Drive up to the 4th floor and turn right at the elevator, our reserved spots are straight ahead marked MD Diagnostics.

**When traveling east on I-4:**

 Exit the Amelia street exit. Stay in the middle lane and continue straight onto Garland Avenue. After you pass through Colonial, continue straight for approx. 2 blocks. Turn right onto Marks street and another right on Orange Ave. Merge to the far left lane, 2 streets on your left will be Park Lake, Turn Left (See red arrow on map below). The second driveway on your left is the driveway to the parking garage for the 801 building. Drive up to the 4th floor and turn right at the elevator, our reserved spots are straight ahead marked MD Diagnostics.

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