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Neurology Patient Questionnaire

Date of Service: _____ Time: _____ am / pm (office use: time _____)

Please provide 24 hour cancellation notice to avoid charges for missed appointments. Where appropriate, please have an observer of your problem help you complete this prior to your appointment. Completed by: _____

Name: _____ Birthdate: _____ Age: _____ Handedness: R L Both Gender: _____

Referring provider (a copy will be sent): _____

If self referred, do you have a primary physician? _____

Copies of this evaluation to other providers? _____

Very briefly, what is the main problem & when it began?

Do you have **pain**? No If yes, when did it begin?

Was onset gradual or sudden?

List any injuries, dates & if work related:

Describe the pain quality (e.g., burning, sharp, dull, etc.):

Is it constant? Yes If not (i.e., intermittent): How frequent is it?

How long does it last (without meds)?

Where is your pain?

Head / Face: Right / Left / Both sides

Have you had "muscle tension", "migraines", "sinus", or "cluster" headaches? No Yes

Teeth clenching while awake or grinding during sleep? No If yes, have you used a mouth guard? No Yes

Have you been told you have TMJ syndrome? No Yes

Are headaches accompanied by: Sensitivity to: Light? No Yes Sound? No Yes Smell? No Yes

Flashing lights, dark or light spots? No If yes, Right / Left / Both eyes

Nausea or vomiting? No Yes

Are they worse with: Foods (e.g., chocolate, cheese, baked goods...)? No Yes

Alcohol (e.g., red wine, ales)? No Yes

Caffeine withdrawal (& better with caffeine ingestion)? No Yes

Menstrual cycle? No Yes

Family history of migraines? No If yes, who?

Neck Right / Left / Both sides

Back Right / Left / Both sides Whole / Upper / Mid / Low

Arms / Hands Right / Left / Both

Legs / Feet Right / Left / Both

Rate the pain severity below, at its worst?

No Pain	0	1	2	3	4	5	6	7	8	9	10	Constant Maximal Pain
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Does the pain worsen when you cough, sneeze, or go to the bathroom? No Yes

Does it interfere with sleep? No Yes

Have you had constant **numbness** or intermittent **tingling**? No If yes, when did this begin?

Was onset gradual or sudden?

Where? Head / Face Right / Left / Both sides

Neck Right / Left / Both sides

Trunk Right / Left / Both sides Front / Back / Both Front & Back

Arms / Hands Right / Left / Both

Legs / Feet Right / Left / Both

Have you had muscle **weakness** (i.e., decreased strength, not fatigue)? No If yes, when did this begin?

Was onset gradual or sudden?

Where? Face Right / Left / Both sides Forehead? Eye lid? Mouth?

Arms / Hands Right / Left / Both

Legs / Feet Right / Left / Both

Do you have fatigue (low energy), sleepiness during your major wake period, or insomnia (difficulty sleeping despite given the opportunity)? No Yes

Have you had uncontrollable sleep attacks, near or complete loss of consciousness, convulsions / seizures? No If yes, when did this begin & describe?

Have you had dizziness, light headedness, imbalance, spinning (vertigo)? No If yes, when did this begin & describe?

Have you had hearing loss? No If yes, when did this begin? Both ears / Right / Left

Have you had tinnitus (e.g., ringing, buzzing)? No If yes, when did this begin? Both ears / Right / Left

Have you had difficulty swallowing, drooling, choking, episodic nausea or vomiting? No If yes, when did this begin & describe?

Have you had problems with coordination, walking, tremor, tics...? No If yes, when did this begin & describe?

Have you had blurred or double vision or loss? No If yes, when did this begin & describe? Both eyes / Right / Left

Have you had problems with thinking, attention, concentration, memory, speech, comprehension, reading or writing? No If yes, when did this begin & describe?

Have you had bowel or bladder incontinence, urgency, frequency, hesitancy or erectile dysfunction? No If yes, when did this begin & describe?

Depression? No If yes, when did this begin & rate below? Is it seasonal? No Yes

Normal Mood	0	1	2	3	4	5	6	7	8	9	10	Suicide precautions
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Anxiety / Panic? No If yes, when did this begin & rate below?

Sustained Calm	0	1	2	3	4	5	6	7	8	9	10	Sustained panic
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Irritability / Hypomania / Mania / Obsessive-Compulsive Behavior? No If yes, when did this begin?

