PATIENT HISTORY FORM
HEAD INJURY QUESTIONNAIRE

Patient Name:_____ Date:_____ Birth date:_____ Height_____ Weight:_____

CAUSE & DESCRIPTION OF SYMPTOMS

General reason for Office Visit (briefly explain):_____
Injury/Date of Injury _____ Illness/Date Illness Began_____
Symptoms/Date symptoms began_____

Is this a Second Opinion ☐no ☐yes - specify details: _____

Please describe what happened – event(s) that caused your current head symptoms. Please be detailed.
_____
_____
_____
_____
_____
_____

What caused your pain? ☐ Motor vehicle accident ☐ Job Injury ☐ Slip/Fall ☐ Other_____

DID YOU HAVE A MAJOR IMPACT INJURY AFFECTING YOUR HEAD? Y☐ N☐

☐ Were you injured in a motor vehicle related impact
☐ Truck vs Car Accident ☐ Car vs Car Accident ☐ Motorcycle vs Car/Truck
☐ Were you a driver or passenger in the vehicle? ☐ Driver/ ☐ Passenger/ Passenger ☐ Back Seat Passenger
Was Seat belt worn? ☐ no ☐ yes
Location of impact ? ☐ Front ended ☐ Rear ended ☐ T-Boned ☐ Hit from side ☐ From the front
☐ Pedestrian struck by vehicle
☐ Can you can give an estimate or guess the speed of the impact _____
What type of vehicle where you driving? (Make/model/year/purpose)_____
What type of vehicle impacted you? (Make/model/year/purpose)_____

What do you believe was the speed of impact
☐ 0-5 mph ☐ 5 to 10 mph ☐ 10 to 25 mph ☐ 25 to 40 mph ☐ Greater than 40 mph
☐ If you were in a vehicle, did airbags deploy?
☐ If you were in a vehicle, did you have a seat belt on?
☐ Did you hit your head on part of the vehicle during the accident
• If yes, what did you hit your head on? _____
Please provide details: _____
_____
_____
_____

☐ You were struck by another person
☐ Injured in a fight ☐ Domestic violence ☐ Victim of an assault ☐ Struck by police
Please provide details: _____

☐ There was an EXPLOSION nearby _____ feet/yards away that injured you
What exploded? _____
☐ There were multiple explosions
Please provide details: _____

☐ You were injured in a SPORTS related impact
☐ Soccer ☐ Football ☐ Rugby ☐ Baseball ☐ Basketball ☐ Boxing ☐ Martial Arts

☐ Track and Field ☐ Other _____

Check Any Box on this Page that Applies to Your Situation

☐ You were injured when your head struck a non-moving object
☐ Your head impacted a wall or the floor
☐ Slip or Trip and Fall
☐ Blacked out for some other reason and collapsed, hitting your head as you fell
☐ Walked into pole, door or building (e.g., while texting or otherwise distracted)
☐ Pulled on an object that broke loose and impacted your head
Please provide details: _____

☐ Injury while you were in a public place (for instance – a box fell on you at a store)?

☐ Injury at Work

AFTER THE EVENT THAT CAUSED THE TRAUMA:	**Yes/No**
Were you taken into Emergency Department immediately after the trauma?	Y☐ N☐
• Were you told you had bleeding or a "hematoma" in your brain?	Y☐ N☐
• Did you lose consciousness (black out) at the time of injury?	Y☐ N☐
• When did you lose consciousness? _____	
- How long did you lose consciousness for? 30 seconds ☐ 5 mins☐ 30 mins☐ 30+ mins☐ Not sure☐	
• When did you regain consciousness? _____ (ex. at hospital, in ambulance etc.)	
• Did someone else tell you that you had a period of loss of consciousness?	Y☐ N☐ Not sure ☐
• Were you initially dazed or confused?	Y☐ N☐ Not sure ☐
• Was there a cut on your scalp?	Y☐ N☐
• Was there a bruise on your scalp?	Y☐ N☐
• Did you develop a bulge or bump on your head?	Y☐ N☐
• Did you find out you have a new skull fracture from the injury?	Y☐ N☐
** If a fracture or brain bleeding occurred – are there scans or X-rays?	Y☐ N☐

** Where were the images done (which hospital/imaging center) and when: _____
_____

What prior injuries have you had to your Head/Brain?
_____

Did you have any **PREVIOUS** head injury **BEFORE** the **CURRENT** injury that we are focused on Y☐ N☐
If yes please give the date of any **PREVIOUS** significant head injury (approximate is OK),

- what happened to cause the previous injury,
- how severe were the symptoms,
- were you completely better before the new **CURRENT** injury:

_____
_____
_____

MEDICAL CAUSE OF BRAIN SYMPTOMS	**Yes/No**
a. Did you experience a lack of oxygen?	Y☐ N☐
b. Did you experience a stroke?	Y☐ N☐
c. Do you have a Brain Tumor?	Y☐ N☐
d. Did you have a Seizure?	Y☐ N☐
e. Did you get poisoned?	Y☐ N☐

f. Other: _____

OTHER POSSIBLE CAUSES OF YOUR BRAIN SYMPTOMS	**Yes/No**
a. Are you concerned about effects of aging causing you new memory problems?	Y☐ N☐
b. Are you concerned about effects on your brain from some other disease?	Y☐ N☐

c. List any other causes/diseases/events you think might be affecting you: _____

_____

_____

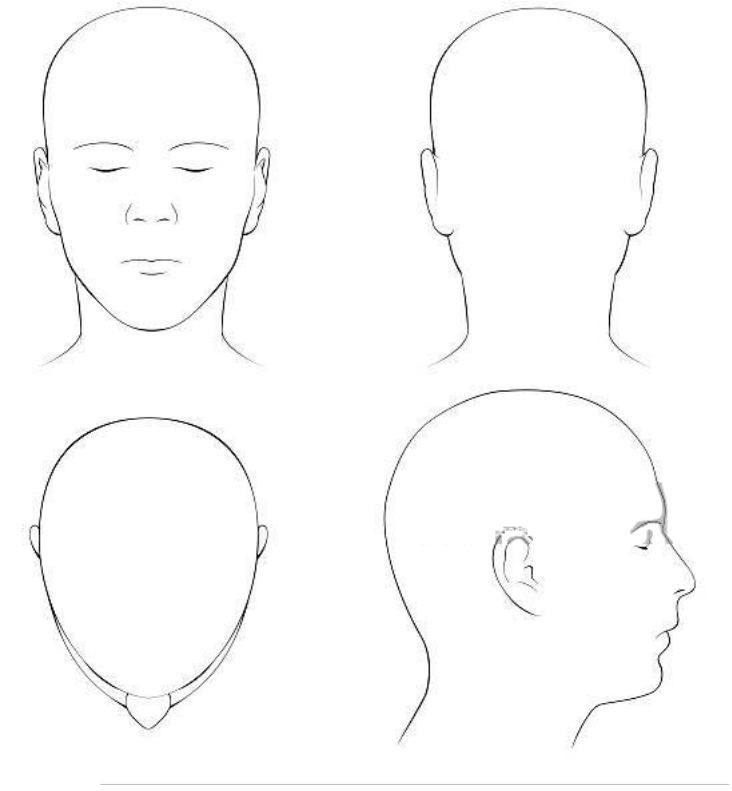
_____

HEADACHES

Are you experiencing any headaches:	Y☐ N☐
Did the headaches start or worsen after the accident/incident described above:	Y☐ N☐
Were the headaches cased by the above accident?	Y☐ N☐
When did the headaches start?	Date:_____
When did the headaches get worse?	Date:_____

Where are the headaches located? ☐ In the front ☐ in the back ☐ on the sides (temples) ☐ on the top on ☐ the left side ☐ on the right side ☐ behind the left eye ☐ behind the right eye ☐ all over the head

Please complete the following pain diagram indicating where your current headaches and/or head pains are:



Pain location caused by accident _____

Headaches occurs with the following frequency ☐ occasionally ☐ on and off ☐ all the time

☐ throughout the day ☐ at night ☐ no difference

Each episode of headache usually lasts: _____

☐ seconds ☐ minutes ☐ hours ☐ days ☐ week

Headaches feels like: ☐ a dull aching ☐ sharp ☐ stabbing ☐ burning ☐ cramping ☐ throbbing ☐ pressure

☐ squeezing ☐ dull ☐Other:_____

Intensity of headache (scale of 1-10: 1 –2 –3 –4 –5 –6 –7 – 8 – 9 – 10)

☐ no pain (0) ☐ mild pain (1-2) ☐ moderate pain (3-4) ☐ severe pain (5-6)

☐ very severe pain (7-8) ☐ worst possible pain (9-10)

There is associated pain or tension in the neck: Y☐ N☐

Mark the body position and /or activities that make headaches better or worse:

Stress	☐ better	☐ worse	At night	☐ better	☐ worse
Bright Lights	☐ better	☐ worse	Laying Down	☐ better	☐ worse
Loud Noises	☐ better	☐ worse	No activity	☐ better	☐ worse
Sleep Deprivation	☐ better	☐ worse	Sleeping	☐ better	☐ worse
Consuming Alcohol	☐ better	☐ worse	Medications	☐ better	☐ worse
Menses	☐ better	☐ worse	Heat	☐ better	☐ worse
Straining	☐ better	☐ worse	Cold	☐ better	☐ worse
Coughing, Sneezing	☐ better	☐ worse	Shower	☐ better	☐ worse
Movement	☐ better	☐ worse	Rest	☐ better	☐ worse
Sitting	☐ better	☐ worse	Massage	☐ better	☐ worse
Standing	☐ better	☐ worse	Hot Baths	☐ better	☐ worse
Walking	☐ better	☐ worse	Reducing Stimulation	☐ better	☐ worse
During the day	☐ better	☐ worse			

What associated symptoms do you experience with your headaches?

General: ☐nausea, ☐vomiting ☐dizziness

Provide details:_____

Vision: ☐blind spots ☐sensitivity to light ☐blurred vision

Provide details:_____

Sensory: ☐head pain ☐head numbness ☐head tingling ☐sensitivity to sound ☐loss of sense of taste ☐loss of senses of smell ☐arm or leg numbness ☐arm or leg tingling ☐insomnia ☐drowsiness

Provide details:_____

Cognitive: ☐memory difficulties ☐concentration problems ☐mental fogginess ☐learning disabilities

Provide details:_____

Psychological: ☐irritability ☐depression ☐anxiety ☐mood changes ☐attention deficit ☐hyperactivity ☐anger

Provide details:_____

Any urinary or fecal incontinence? ☐No ☐Yes

Provide details:_____

Do you have an aura before your headache? ☐No ☐Yes

An aura is a warning sign of migraine that usually occurs before the headache and can last 5-60 minutes, usually about 20 minutes. Most commonly, auras consist of visual symptoms such as flashing lights, zigzag lines or blind spots in your vision.

Provide details:_____

Tests completed so far:

☐MRI ☐ brain ☐ other – specify and provide date(s) _____ _____

location (name of facility) _____ Do you have the CD of the MRI ☐no ☐yes

☐CT Scan ☐ brain ☐ other – specify and provide - date(s) _____ _____

location (name of facility) _____ Do you have the CD of the CT scan ☐no ☐yes

Other scans/ images

☐ X-rays ☐ DTI scan ☐other (specify)_____

Treatment done so far:

☐ Medications

☐ Over the counter medications
Name of medication(s):_____ _____ For how long:_____
Start date:_____ End date:_____ On-going: ☐no ☐yes
Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

☐ Pain medications
Name of medication(s):_____ _____ For how long:_____
Start date:_____ End date:_____ On-going: ☐no ☐yes
Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

☐ Muscle relaxants
Name of medication(s):_____ _____ For how long:_____
Start date:_____ End date:_____ On-going: ☐no ☐yes
Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

☐ Anti-inflammatory ☐non-steroidals ☐Steroids
Name of medication(s):_____ _____ For how long:_____
Start date:_____ End date:_____ On-going: ☐no ☐yes
Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

☐ Nerve altering medications (e.g. antidepressants or antiepileptics)
Name of medication(s):_____ _____ For how long:_____
Start date:_____ End date:_____ On-going: ☐no ☐yes
Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

☐ Headache/ migraine specific medications (e.g. triptans):_____
Name of medication(s):_____ _____ For how long:_____
Start date:_____ End date:_____ On-going: ☐no ☐yes
Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

☐ Other medications: _____
Name of medication(s):_____ _____ For how long:_____
Start date:_____ End date:_____ On-going: ☐no ☐yes
Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

☐ Chiropractic treatments

Name of chiropractor/ facility name:_____

How many visits:_____ For how long: _____ ☐Weeks ☐Months ☐Years
When did you start going there? _____ When did you stop going there? _____

Is your treatment still on-going? ☐no ☐yes

Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief
What modalities were used to treat you?

☐Adjustments ☐stretching ☐active range of motion ☐passive range of motion

☐decompression/traction ☐activator ☐TENS/interferential unit ☐massage ☐dry needling

☐acupuncture ☐other_____

☐ Physical therapy

Name of physical therapist / facility name:_____

How many visits:_____ For how long: _____ ☐Weeks ☐Months ☐Years
When did you start going there? _____ When did you stop going there? _____

Is your treatment still on-going? ☐no ☐yes

Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief
What modalities were used to treat you?

☐stretching ☐active range of motion ☐passive range of motion ☐decompression/traction

☐TENS/interferential unit ☐massage ☐dry needling ☐acupuncture ☐ aquatic therapy

☐other_____

☐ Cognitive therapy and/or ☐ Psychotherapy

Name of therapist / facility name:_____

How many visits:_____ For how long: _____ ☐Weeks ☐Months ☐Years
When did you start going there? _____ When did you stop going there? _____

Is your treatment still on-going? ☐no ☐yes

Did it help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief
Describe your treatment progress?

_____
_____
_____

☐ Injections

Name of provider or facility where injection was done:_____

Type of injection: ☐epidural ☐facet block ☐nerve block ☐joint injection ☐median branch block

☐radiofrequency ablation ☐trigger point ☐Other pain procedure
(specify)_____

Location: ☐back of head ☐sides of head ☐cervical spine ☐other joint ☐other cranial nerves ☐other
(specify)_____
Date of injection(s)_____ _____ _____

Number of injections:_____ Did it/they help: ☐no ☐yes - ☐mild relief ☐moderate relief ☐great relief

Specifiy which injection helped and for how long:_____
_____

☐ Other treatment(s)
Specify: _____
_____
_____
_____

PROBLEMS WITH MEMORY

There are three general types of memory.
• Long term recall: (change in what you can usually recall from the past)
• New memory formation; (recall of events of the past 5 to 15 minutes)
• Immediate memory: (recall of the beginning of a sentence as you finish saying it)

Forgetting the Past? Questions Below Ask What Kind Of Memories are Affected:

A. LONG TERM MEMORY

	Yes/No	Getting wors
Do you have difficulty:		
1. Naming popular songs from years ago?	Y☐ N☐	☐
2. Remembering the words to those songs?	Y☐ N☐	☐
3. Remembering the names of artist or group?	Y☐ N☐	☐
4. Remembering major life events such as weddings, and birthdays?	Y☐ N☐	☐
5. Remembering names of family members, co-workers, students, and long-term friends?	Y☐ N☐	☐
6. Remembering names of people you were introduced to in the past week or two?	Y☐ N☐	☐
7. Remembering faces of family members, co-workers, students, long term friends?	Y☐ N☐	☐
8. Remembering faces of people you were introduced to in the past week or two?	Y☐ N☐	☐
9. Remembering places and objects? Can you visualize buildings and landmarks?	Y☐ N☐	☐
10. Remembering locations- where an event took place and name of the location?	Y☐ N☐	☐
11. Remembering time when an event occurred: For instance, weeks versus years in the past?	Y☐ N☐	☐
12. Remembering which of two recent events happened first?	Y☐ N☐	☐
13. Check the box if you had very good memory before the injury	☐	
14. Check the box <u>if you have</u> **<u>forgotten:</u>** ☐how to use a computer, ☐how to use a cell phone, or ☐how to operate a car?		

B. MEMORY FORMATION

	Yes/No	Getting worse
15. Do you forget what was just said on a phone call right after the call ends:	Y☐ N☐	☐
16. Do you forget instructions someone just gave you:	Y☐ N☐	☐
17. Do you frequently forget what you intended to do or get when you go to another room in your home?	Y☐ N☐	☐
18. Do you forget where you left your keys just moments after placing them down?	Y☐ N☐	☐

C. IMMEDIATE MEMORY

19. Do people tell you that you keep repeating yourself?	Y☐ N☐	☐
20. When you ask a question, are you told that you just asked the same question a few moments ago?	Y☐ N☐	☐
21. Do you frequently lose track of what you are saying?	Y☐ N☐	☐
22. Do you forget what you were saying at the beginning of a sentence by the time you get to the end of the sentence:	Y☐ N☐	☐

You may provide further details about your memory problems here:

_____
_____
_____

PROBLEMS WITH SPEECH AND WORDS

A. FLOW AND CONTENT OF SPEECH

Word Finding and Word Use	`Yes/No	Getting worse
23. Do you have a difficult time finding the word you need to say?	Y☐ N☐	☐
24. Do you accidentally insert the wrong word in a sentence?	Y☐ N☐	☐
25. Do you accidentally say nonsense words	Y☐ N☐	☐
Abnormal Flow of Speech		
26. Do you find yourself speaking slow, fast, or varying speed as you talk	Y☐ N☐	☐
27. Do you say words or parts of sentences out of order so that the sentence doesn't make sense?	Y☐ N☐	☐
28. Do you have a new onset of Stuttering or Slurred Speech?	Y☐ N☐	☐
29. If you are bi-lingual, are both English and a second language affected?	Y☐ N☐	☐
B. UNDERSTANDING OF SPEECH		
30. Do you have difficulty remembering the meaning of words said to you?	Y☐ N☐	☐
31. Do you have difficulty understanding what someone is telling you?	Y☐ N☐	☐
32. Do you have difficulty understanding and/or responding to questions?	Y☐ N☐	☐
33. If you are bi-lingual are both English and a second language affected?	Y☐ N☐	☐
C. READING		
34. Do you have difficulty recognizing words when you are reading?	Y☐ N☐	☐
35. Do you have difficulty understanding a sentence when you are reading?	Y☐ N☐	☐
36. Are you unable to keep your ATTENTION on sentences so you can understand what you just read?	Y☐ N☐	☐
37. Do you have a difficult time remembering what you have just read?	Y☐ N☐	☐
38. If you are bi-lingual are both English and a second language affected?	Y☐ N☐	☐
D. WRITING		
39. Do you have a difficult time remember how to write words?	Y☐ N☐	☐
40. Are there major changes in the way your signature looks?	Y☐ N☐	☐
41. Have you lost the ability to type without looking at the keyboard?	Y☐ N☐	☐
42. If you are bi-lingual are both English and a second language affected?	Y☐ N☐	☐

You may provide further details about your speech and word finding problems here:

_____
_____
_____

THOUGHT PROCESSES/COGNITION

COGNITIVE (THINKING) SKILL	**Yes/No**	**Getting worse**
43. Multi-Step Planning: Do you have a difficult time planning multiple routine tasks, such as making a recipe or complex work tasks? For instance, get bread, peanut butter, jam, a knife and a plate so you can make a sandwich?	Y☐ N☐	☐
44. Multi-Tasking: Do you have a difficult time carrying out more than one task at the same time, and or have a difficult time keeping multiple tasks organized, or "pick	Y☐ N☐	☐

up where you left off" in a task?

45. Are you able to proficiently switch attention from one task to another? Y☐ N☐ ☐
46. Are you able to work on more than one task at a time? Y☐ N☐ ☐
47. Attention: Are you able to maintain focus on a multi-step process? For instance, making a sandwich, writing out instructions, reading the paper, watching a movie, and listening to what someone is trying to tell you? Y☐ N☐ ☐
48. Poor Concentration: Do you find that you can't focus your mind on a single task? Y☐ N☐ ☐
49. Mental Fog: Do you feel that your thoughts are cloudy or slowed? Y☐ N☐ ☐

NAVIGATION

50. Map Based Planning: Are you having difficulty figuring out what turns you will need to make to travel a familiar route (such as from home to your usual grocery store) Y☐ N☐ ☐
51. Are you having difficulty getting from one place to another without using a navigation app on your phone? Y☐ N☐ ☐
52. Do you have a difficult time remembering which aisle things are at your local grocery store that you always go to? Y☐ N☐ ☐

SIMPLE MATH

53. Since the accident, have you started to have a difficult time calculating a tip? Y☐ N☐ ☐
54. Since the accident, have you started to have difficulty calculating the cost of Items that you are picking up at the grocery store? Y☐ N☐ ☐

ATTENTION DEFICIT

55. Since the accident, have you started to require medication to be able to focus steadily on any one problem? Y☐ N☐ ☐

You may provide further details about your thought process and cognition problems here:

_____
_____
_____

ABNORMALITIES OF EMOTION/PERSONALITY

EXCESS ANGER **Yes/No** **Getting worse**

56. Do you feel unexplained anger, irritation, frustration or lack of patience with others? Y☐ N☐ ☐
57. Do you feel unexplained intensity of anger? For example, you become furious over a very minor issue. Y☐ N☐ ☐

B. DECREASED EMOTIONS

58. Do you feel a sense a of lack of your usual emotional response? For example, you have no joy, excitement, or dislike in reacting to things. Y☐ N☐ ☐ ☐
59. Do you feel a loss of emotional drive? No interest in starting or doing anything? Y☐ N☐ ☐
60. Do goals and potential rewards not activate you into action. Y☐ N☐ ☐

C. DEPRESSION

61. Do you feel an unexplained sadness or a hopelessness? Y☐ N☐ ☐
62. Do you have crying spells without obvious cause? Y☐ N☐ ☐
63. Have you had thoughts of harming yourself? Y☐ N☐ ☐
64. Do you have a severe sense of fatigue (tiredness)? Y☐ N☐ ☐

D. ANXIETY **Yes/No** **Getting worse**

65. Do you feel excessively anxious about things, worried about what will happen next? Y☐ N☐ ☐
66. Do you feel nervousness (generally "on edge" – thrown off by minor noise or inputs)? Y☐ N☐ ☐
67. Do you have restlessness, unable to settle down and relax? Y☐ N☐ ☐

E. DECREASED SOCIALIZING

68. Do you feel that you don't want to be around other people? Y☐ N☐ ☐
69. Do you feel that you don't want to communicate with those around you? Y☐ N☐ ☐

F. OTHER CHANGES IN EMOTION & PERSONALITY

70. Do you have poor judgment (make many decisions you later feel you got wrong)? Y☐ N☐ ☐
71. Do you have decreased libido (decreased interest in sex)? Y☐ N☐ ☐
72. Do you have rapid changes in mood? Y☐ N☐ ☐
73. Do you have personality changes (seem like a different person)? Y☐ N☐ ☐
    In what way? _____
    _____
74. Are you more emotional now? Y☐ N☐ ☐
75. Are you unable to tolerate stress? Y☐ N☐ ☐
76. Do you experience sudden flashbacks – recalling a dangerous situation and being put abruptly into fear and panic? Y☐ N☐ ☐
77. Have you been told you have PTSD – Post-Traumatic Stress Disorder? Y☐ N☐ ☐

You may provide further details about your emotions and personality problems here:

_____
_____
_____
_____
_____
_____

SENSORY PROCESSING PROBLEMS

SENSITIVITY TO LIGHT	**Yes/No**	**Getting worse**
78. Do you feel uncomfortable until the lights are dimmed?	Y☐ N☐	☐
79. Do you find that bright lights are intolerable?	Y☐ N☐	☐

B. PROBLEMS WITH VISION

80. Are you are experiencing blurry vision? Y☐ N☐ ☐
81. Do you find that you cannot recognize routine objects you may look at? Y☐ N☐ ☐
82. Do you have double vision? Y☐ N☐ ☐

C. PROBLEMS WITH SOUND/HEARING

83. Do you have increased sensitivity to sound? Y☐ N☐ ☐
84. Do you have tinnitus/ringing in your ears? Y☐ N☐ ☐
85. Are you uncomfortable unless things are very quiet? Y☐ N☐ ☐
86. Do you have hearing loss? Y☐ N☐ ☐
87. Are you able to hear that someone is talking but can't recognize the sound? Y☐ N☐ ☐

D. PROBLEMS WITH TASTE OR SMELL

88. Do you have loss of the sense of smell/unable to detect odors? Y☐ N☐ ☐
89. Do you notice odd unexplainable odors that others cannot detect? Y☐ N☐ ☐
90. Do you have loss of the sense of taste? Y☐ N☐ ☐
91. Do you notice odd unexplainable tastes? Y☐ N☐ ☐

DIZZINESS/BALANCE PROBLEMS

A. LIGHT HEADEDNESS	**Yes/No**	**Getting worse**
92. Do you feel like you are about to faint when you get up?	Y☐ N☐	☐
93. Do you suddenly feel like you are going to faint for no reason?	Y☐ N☐	☐

B. SPINNING ROOM

94. Does the room appear to be spinning when you move a certain way? Y☐ N☐ ☐
95. Does the room appear to be spinning for no obvious reason? Y☐ N☐ ☐

C. FLOOR MOVEMENT

96. Does the floor or an object seem to be coming up at you or moving abnormally? Y☐ N☐ ☐
97. Do you suddenly start to feel the floor is moving for no obvious reason or when you move a certain way? Y☐ N☐ ☐

D. BALANCE PROBLEMS		**Yes/No**	**Getting worse**
98.	Do you have difficulty walking?	Y☐ N☐	☐
99.	Do you have a tendency to fall?	Y☐ N☐	☐
100.	Have you had numerous falls?	Y☐ N☐	☐
101.	Do you have problems going up and down steps?	Y☐ N☐	☐

E. GAZE PROBLEMS

102. When you look up or to the side, does it make you feel dizzy? Y☐ N☐ ☐

You may provide further details about your dizziness, balance and sensory problems here:

_____
_____
_____
_____

8. PROBLEMS WITH SLEEP

A. INSOMNIA (Decreased Sleep)

103. Do you have difficulty falling asleep (insomnia)? Y☐ N☐ ☐
104. Do you have difficulty staying asleep? Y☐ N☐ ☐

B. INCREASED SLEEPINESS

105. Do you have an increased sleep requirement (hours per night)? Y☐ N☐ ☐

C. SNORING

106. Are you being told that you are Snoring? Y☐ N☐ ☐

You may provide further details about your sleep problems here:

_____
_____

ABNORMAL MOVEMENT

A. TREMORS OR SHAKING		**Yes/No**	**Getting worse**
107.	Are you experiencing tremors/shaking or other uncontrolled movements?	Y☐ N☐	☐
108.	Do you have tremors/abnormal movements that start suddenly for no reason?	Y☐ N☐	☐
109.	Do you have tremors/abnormal movements that start when you reach for something?	Y☐ N☐	☐

B. SEIZURES

110. Have you been told you are having seizures? Y☐ N☐ ☐
111. Have you been told you suddenly shake severely, fall, and lose consciousness? Y☐ N☐ ☐
112. Have you noticed part of your body having prolonged repetitive motions? Y☐ N☐ ☐

C. STARING FITS

113. Have you been told you are having staring episodes? Y☐ N☐ ☐
114. Have you been told that you pause, stare, did not move, or did not respond to people around you for a few moments: Y☐ N☐ ☐

You may provide further details about your movement problems here:

_____
_____

HORMONAL DYSFUNCTION (HYPOTHALAMIC/INTAKE)

	Yes/No	Getting worse
115. Do you have frequent nausea /vomiting?	Y☐ N☐	☐
116. Do you have rapid/excessive weight increase?	Y☐ N☐	☐
117. Do you have rapid/excessive weight loss?	Y☐ N☐	☐
118. Are you unable to tolerate any alcohol?	Y☐ N☐	☐
119. Are you experiencing excess hunger?	Y☐ N☐	☐
120. Are you experiencing loss of appetite/Anorexia?	Y☐ N☐	☐

You may provide further details about your hormonal problems here:

_____
_____

Other information related to medical and head injury/ symptoms history:

_____
_____
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_____
_____

DISCLAIMERS

☐ **THIS BOX MUST BE CHECKED.**

I confirm that the information given above is correct to the best of my knowledge. I have read and understood the contents of this form and I take full responsibility for the information given above. I have had the opportunity to ask questions regarding the Patient History Form. By signing my name electronically on this form, I am agreeing that my electronic is the legal equivalent of my manual signature.

X _____ _____ _____

Signature of Patient or Personal Representative | Date | Verified by Physician/Nurse/ Medical assistant

If you have been assisted in filling out the questions above, please provide name and signature below:

Name : _____ Date : _____Signature : _____

DISCLOSURES & ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective September 1, 2017), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

X _____ _____ _____

Signature of Patient or Personal Representative | Date | Name (& Description of Personal Representative)

MEDICAL RELEASE OF INFORMATION:

I hereby authorize **Texas Center for Neurosciences PLLC , International Center for Neurosciences PLLC and Dr. Remi Nader, MD**, to release any Medical Information (from my medical and other records) required to process my claim, to any insurance or third party payor, any other person or entity financially responsible for my care/ treatment, any representative of local, state or federal agencies in accordance with the law, for the purpose of conducting a medical audit, utilization reviews, quality assurance reviews, or to any referring physician or skilled/health care facility.

X _____ _____ _____

Signature of Patient or Personal Representative | Date | Name (& Description of Personal Representative)

AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION/ CONSENT TO PUBLICATION/PHOTOGRAPHY

I authorize **Texas Center for Neurosciences PLLC & International Center for Neurosciences PLLC.** to take photographs or videos of myself/ my surgery or the below named patient or to use information contained in my medical record such as history and physical, progress notes, consultations, operative reports, laboratory and pathology reports, radiological images and reports, other hospital and clinic documents for the purpose of medical publication and studies. I understand that *ALL IDENTIFYING INFORMATION WILL BE REMOVED* if used for that purpose. I understand that I have the right to revoke this authorization at any time and that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply for information that has already been released. I understand that this authorization is voluntary and I can refuse to sign this authorization. I need not sign this authorization in order to assure treatment. I fully and completely release **Texas Center for Neurosciences PLLC, International Center for Neurosciences PLLC and Dr. Remi Nader, MD** from any claims or liabilities arising from the use of this information. I also understand that the information gathered will be the property of Texas Center for Neurosciences PLLC & International Center for Neurosciences PLLC. I understand that disclosure of this information carries with it the potential of unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

X _____ _____ _____

Signature of Patient or Personal Representative | Date | Name (& Description of Personal Representative)