Neurosurgery Brain and Spine Questionnaire

What is the primary reason for your visit today? (circle one)

Back Pain / Neck Pain / Leg Pain / Arm Pain / Brain (fill out only what applies to your symptoms)

Is your pain: RIGHT sided LEFT sided BOTH sides

What, if any, is your secondary reason for your visit? (circle all that apply)

Back Pain / Leg Pain / Neck Pain / Arm Pain / Brain / Groin Pain / Shoulder Pain / Foot Pain / Buttocks / Other: _____

Is your pain: RIGHT sided LEFT sided BOTH sides

How long has your primary reason been a problem?

_____

_____

_____

Is the current problem a result of: (circle all that apply)

Approximate date of injury:_____/_____/_____

Work Injury / Auto Accident / Sports Injury / Lifting / Bending / Falling / No apparent cause / Other: _____

Is there any litigation pending? (circle all that apply)

Lawsuit / Auto Claim / Worker's Comp / Disability Claim / Social Security Claim / None
CLAIM #_____

What have you had done for this problem? (circle all that apply)

Treatments: Nothing / Chiropractic Care / Acupuncture / Injections / Physical Therapy / Surgery

Dates of treatments: _____

_____

Names of medications tried: _____

_____

Have you had any of the following?

Imaging: EMG / X-Ray / CT Scan / Myelogram / MRI /Angiogram / Other: _____

_____

Procedures: Shunt Placement / Coiling / Clipping /

Other (s):_____

Have you seen the following specialties?

Endocrinologist (Name):_____

Ophthalmologist (Name):_____

Do you have any numbness? **YES or NO**

Where: _____

How frequent? Constant / Intermittent

Do you have any weakness? **YES or NO**

Where: _____

How frequent? Constant / Intermittent

Do you have any trouble controlling your bladder? **YES or NO**

Do you have any trouble controlling your bowels? **YES or NO**

What makes the pain worse? (circle all that apply)

During Exercise / After Exercise / Sitting / Standing / Walking / Bending / Pushing / Pulling / Squatting / Lying down / Coughing / Other: _____

What reduces your pain? (circle all that apply)

Lying down / Sitting / Standing / Walking / Medication / Shifting or Changing positions / Manipulation / Nothing / Other: _____

Do you use a cane, walker or wheel chair to help you get around? _____

Have your symptoms caused you to: (circle all that apply)

Limit / Stop / No Change Working (if previously working)

Limit / Stop / No Change Housework & Yardwork

Limit / Stop / No Change Daily Activities

Please check all that apply and indicate how long these symptoms have been occurring:

☐Seizures _____

☐Headaches _____

☐Blackouts _____

☐Dizziness_____

☐Paralysis or weakness of limb(s) _____

☐Nervousness _____

☐Difficulty in going to sleep _____

☐Difficulty with memory for past events _____

☐Difficulty with memory for recent events _____

☐Difficulty with thinking or problem solving _____

☐Excessive Nasal Drainage _____

☐Loss of sensation _____

☐Loss of balance _____

☐Loss of coordination _____

☐Double vision _____

☐Difficulty in speaking _____

☐Depression _____

☐Early morning awakening _____

Please list any/all other symptoms that you are having:

_____

_____

_____