

**Please fill this out today and then
Fax this completed questionnaire to: (321)-441-1559**

If a question does not apply to your condition, please put N/A

You have been scheduled for a nerve testing appointment. Your appointment is scheduled here at the Open MRI of Orlando office for ___/___/2010 @ _____ '_____'am '_____'pm
Our address is

In order for the doctor to evaluate your condition thoroughly, a detailed history of your condition is needed. Complete **THOROUGHLY** this questionnaire to assist the physician in diagnosing and providing you appropriate care. We know that it is a lot of writing, but it will help the doctor to better help you. (If you lose this, please call our office and arrange to arrive 30 minutes earlier on your appointment date to complete the form.)

Put **N/A** after questions not applicable to you.

List all physicians and their addresses that you want this report are to be sent.

Primary Care Physician (name and address): _____

Phone # _____ Fax # _____

Accident Information

Name: _____ DOB _____ Age: _____ Male " " " " Female

Date Of Accident: _____ Where _____

Type of Case: " " " " Automobile " " " " Motorcycle " " " " Pedestrian " " " " Slip/Fall

Other: _____

Describe how the injury happened: _____

Was anyone else in the vehicle with you? _____

Were you the Driver or Passenger? _____ If passenger were you sitting in the front or the rear

TOTAL Damage to vehicle \$ _____

Seat Belted? Yes " " " " No " " " " Lap " " " " Shoulder

Vehicle was: Moving _____ MPH At a stop _____

Vehicle Struck: " " " " " " Head on " " " " Rearended " " " " Passenger's Side " " " " " " " " Driver side

During impact: Did you brace w/arms on steering wheel/dash/seat?

Did you brace w/legs on floor or brakes?

Was your head: " " " " Straight, " " " " Turned right/ left. " " " " " " " " Did it strike the headrest

Did you Strike any part of your body?(Against What?) _____

After collision: Did you experience loss of consciousness? _____ Minutes

Did you feel: " " " " Stunned " " " " Nervous " " " " Scared " " " " Dizzy " " " " Disoriented " " " " Lightheaded " " " " Confused

Immediate Symptoms: _____

Subsequent Symptoms: _____

Were you evaluated by paramedics? _____ Were you taken to hospital? _____ Via ambulance

Any emergency treatment? _____

Initial Treatment: When _____ Where _____

Dr. Name & Specialty: _____

Type of treatment: _____

Subsequent Treatment: (Including all Drs and testing) _____

PERSONAL INFORMATION

Name _____ Today's Date _____ Date of Birth _____
Age _____ Right handed Left handed Sex: Male Female
Single ____, Married ____, Divorced ____, Separated ____, Widowed ____,
Highest Education _____ Occupation /Profession: _____

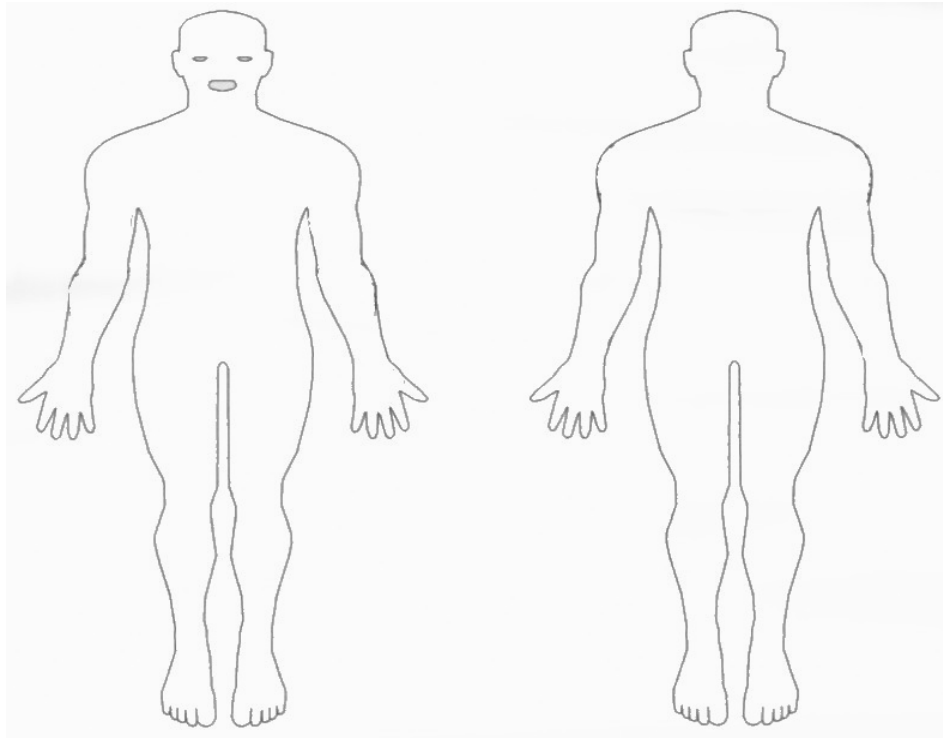
CURRENT MEDICAL COMPLAINTS

Main Complaint: Date symptom began and is it stable, on/off, getting worse/better.

Secondary Complaints: _____

Pain Assessment: Mark the area(s) where you feel your symptoms.

///// = Stabbing pain; 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 ____.

Mark (+) by what **increases** your symptoms (exacerbates or worsens the pain)

(-) by what **decreases** your symptoms (makes better, less painful)

leaning backward	lying down on the stomach	Corsets/ braces
turning around	lying sideways on the hips	ice/cold
lifting kids/bags/suitcases	walking	heat
computer workstation	walking upstairs/uphill	massage
prolonged sitting	walking downstairs/downhill	medication
prolonged standing	urinating	liquor
sneezing/ coughing	defecating/ straining	sleeping
driving	stretching	relaxation/yoga
intercourse	jumping	socializing / TV
household chores	Stress/Tension/	loud noises
no movement	touching/ pressure	push shopping cart

Discomfort Rating:

On a scale of 0 to 10 (0 being **no discomfort**, # 5 if discomfort starts **interfering with activities** and **10** being the **worst discomfort** you can imagine **and you would be crying**):

What is your Highest / Worst Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

What is your Lowest Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

What is your Usual / Average Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

What is your Current Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

Prior treatment for this specific accident:

Daily Biological Functions:

Sleeping 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__.

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_____

Review of Systems:

Please circle each symptom that applies to you.

- Unexplained changes in weight, fever or chills, or night sweats,
- Unusual change in voice, seizures, loss of consciousness, memory difficulties, disorientation, difficulty with speaking-writing- reading, dysphagia, double or loss of vision, tremors, difficulty walking, weakness, numbness or changes in sensation, or tingling, bleeding gums.
- Headache, history of head contusions, hearing or auditory problems, dizziness, ear buzzing, sinus (stuffy nose), ear pain, dental problems, or metal implants.
- Chest pain, palpitations, murmur, swollen feet and legs worse at the end of the day, cough, wheezing, shortness of breath walking up one flight stairs.
- Digestion problems, bloating, nausea, heartburns, vomiting, constipation, unexplained diarrheas or abdominal pain, sour mouth sensation after sleeping.
- Difficulty, urge or pain urinating, painful intercourse, vaginal secretions, bladder incontinence, kidney stones or infections.
- Diffuse muscle aching, fibromyalgia, legs or joint swelling, stiffness, painful foot sole or arch "*first steps in the morning*".
- Changes in skin moles, non-healing ulcers, dry skin, itching, nail fungus.
- HIV positive, Hepatitis, fainting, swollen armpit or groin glands, pale color, bleeding disorders, or recurrent infections.

Is there significant stress at work? Yes__ No____, at home? Y__ No____

Do you feel this stress makes your pain worse Yes__ No____

Any Food intolerance or allergy_____

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 similar complaints before? No / Yes, What was the rating percentage for complaint? _____

MEDICAL HISTORY

Past Medical History:

(UNRELATED TO THIS INJURY!!! Only those prior to this injury)

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

Specify when first started, in years (ie. 6 months = 0.5y)

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 _____

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

Name of Medication	Strength (mg)	Number per day (Dose)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Accidents you have had:

Type of Accident	Date	Area of body injured	Date of last treatment?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies:

Imaging Studies:

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

Operation	Month/Year	Hospital/City	Doctor
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family Medical History:

Father: alive? Yes___/No___ ; cause and age died _____
If alive, age___ and medical problems_____

Mother: alive? Yes___/No___, cause and age died _____
if alive, age: _____, diseases _____

Brothers and sisters_____

Functional History:

Previous Functional 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_____/_____

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)_____

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
1. I feel sad sometimes
2. I am sad all of the time
3. I am so sad/unhappy that I can't stand it | 2. | 0. I have not lost interest in other people
1. I am less interested in other people than I used to be
2. I have lost most of my interest in other people
3. I have lost all interest in other people |
| 3. | 0. I am not particularly discouraged about the future
1. I feel discouraged about the future
2. I feel I have nothing to look forward to
3. I feel the future is hopeless and things cannot improve | 4. | 0. I make decisions about as well as I ever could
1. I put off making decisions more than I used to
2. I have greater difficulty in making decisions than before
3. I can't make decisions at all anymore |
| 5. | 0. I do not feel like a failure
1. I feel I have failed more than the average person
2. As I look back on my life, all I see is a lot of failure
3. I feel I am a complete failure as a person | 6. | 0. I don't feel I look any worse than I used to
1. I am worried that I am looking old or unattractive
2. I feel that there are permanent changes in my appearance
3. I believe that I look ugly |
| 7. | 0. I get as much satisfaction out of things as I used to
1. I don't enjoy things like I used to
2. I don't get real satisfaction out of anything anymore
3. I am dissatisfied or bored with Everything | 8. | 0. I can work about as well as before
1. It takes an extra effort to get started at doing something
2. I have to push myself very hard to do anything
3. I can't do any work at all |
| 9. | 0. I don't feel particularly guilty
1. I feel guilty a good part of the time
2. I feel quite guilty most of the time
3. I feel guilty all of the time | 10. | 0. I can sleep as well as usual
1. I don't sleep as well as I used to
2. I wake up 1-2 hours earlier than usual 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
1. I feel I may be being punished
2. I expect to be punished
3. I feel I am being punished | 12. | 0. I don't get more tired than usual
1. I get tired more easily than I used to
2. I get tired from doing anything
3. I am too tired to do anything |
| 13. | 0. I don't feel disappointed in myself
1. I am disappointed in myself
2. I am disgusted with myself
3. I hate myself | 14. | 0. I don't feel that I am worse than Anyone else
1. I am critical of myself for my weaknesses and mistakes
2. I blame myself all of the time for my faults
3. I blame myself for everything bad that happens |

- | | |
|--|--|
| <p>15. 0. I am not more irritated now than I ever
 1. I get annoyed to irritated more easily than I used to
 2. I feel irritated all of the time now
 3. I don't get irritated at all by things that used to irritate me</p> | <p>16. 0. I haven't lost much weight, if any, lately
 1. I have lost more than 5 pounds
 2. I have lost more than 10 pounds
 3. I have lost more than 15 pounds</p> |
| <p>17. 0. I don't have thoughts of killing myself
 1. I have thoughts of killing myself, but I would not carry them out
 2. I would like to kill myself
 3. I would kill myself if I had the chance</p> | <p>18. 0. I am more worried about my health than usual
 1. I am worried about my physical problems such as aches and pains, upset stomach, 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</p> |
| <p>19. 0. I don't cry anymore than usual
 1. I cry more than I used to
 2. I cry all of the time now
 3. I used to be able to cry, but now I can't cry even though I want to</p> | <p>20. 0. I have not noticed any recent change in my interest in sex
 1. I am less interested in sex
 2. I am much less interested in sex
 3. I have lost interest in sex completely</p> |
| <p>21. 0. My appetite is not worse than usual
 1. My appetite is not as good as it used to be
 2. My appetite is much worse now
 3. I have no appetite at all</p> | |

OFFICE USE ONLY

11-16 ml _____
17-26 MO _____
>26s _____

DIRECTIONS

We are located in the Open MRI office space @ 668 N. Orlando Ave,
Maitland, FL 32751

I-4 to Maitland Blvd. East.

Maitland Blvd. East 2.2 miles until it ends at SR17-92 SW. (stay in right lane)

Turn Right onto SW (southwest) SR17-92 and go ¼ mile.

Located on left side of SR17-92 immediately after Mercedes-Benz dealership.

Golden / Yellow 2 story bldg. (Maitland Exchange building)

