HEAD/BRAIN

REFERRED BY: Doctor: ⍑ Former Patient:⍑ Phone Book:⍑ Internet: ⍑ Ins. Co: ⍑

Referring Doctors Name/address & Phone #_____

Family Doctors name/address & Phone #:_____

Other Doctors name/address & Phone #:_____

Present Illness**:** **PLEASE CIRCLE ALL THAT APPLY**

Chief Complaint: Pain/ Headache/ Front/ Back/ Sides/ Eyes/Face/ Neck **Right/ Left**

Symptoms are: mild/moderate/severe/excruciating/dull/sharp/constant

Any Weakness of: face/arms/hands/fingers/grip/legs/toes **Right/Left**

Any Numbness of: face/arms/hands/fingers/legs/ toes/genitals **Right/ Left**

Date of onset:_____ Injury related: Yes No How_____

Any other associated symptoms?: decreased vision/double vision/difficulty swallowing/change in voice/difficulty walking/ falling/ headache/ nausea/ vomiting/change in hearing/ change in smell/change in taste/

Other Symptoms or Concerns: _____

Treatments tried: _____

Are activities restricted? No Yes: limited working/ not working/ limited housework/ no housework
limited sports activity/ no sports activity/yard work/ shopping/ no exercising / driving

Any prior history of above complaints? No Yes: -if yes- How long_____
Explain prior complaints:_____

Tests performed: None/X- Ray/ CT Scan/ MRI