Dr. Olinka Hrebicek
Neurology

Please answer the following questions:

E-mail: _____ **GP/Walk-in clinic**: _____

Name: _____ Age: _____ Height: _____ Weight: _____
Handedness: [ ] Right [ ] Left
What is/was your occupation: _____
Are you married/live with a partner? [ ] Yes [ ] No. How many children do you have? _____
Neurological concerns (**why** you are here today and **when** did the problem start):

Please put an "X" beside the conditions/illnesses you have had:

[ ] Anxiety	[ ] Head injuries	[ ] Lupus
[ ] Arthritis	[ ] Heart disease	[ ] Migraine headaches
[ ] Asthma	[ ] Hepatitis	[ ] Peptic ulcer disease
[ ] Bleeding tendency	[ ] High blood pressure	[ ] Pneumonia
[ ] Blood clots	[ ] High cholesterol	[ ] Sleep apnea
[ ] Cancer	[ ] HIV	[ ] STI _____
[ ] Depression	[ ] Hypothyroidism	[ ] Stroke
[ ] Diabetes	[ ] IBD/Crohn's disease	[ ] Tuberculosis
[ ] Drug addiction _____	[ ] Jaundice	[ ] Other _____
[ ] Glaucoma	[ ] Kidney disease	_____

How much alcohol do you consume in a week? _____. Have you quit previously? _____
Do you smoke? _____. If you have quit, when? _____
Recreational drug use: [ ] never [ ] now [ ] in the past: which drugs _____

Previous injuries: _____

List all prescription medications (including all dosage details) you currently take:

Pharmacy Name/Location/Telephone:

List any over-the-counter drugs, supplements, herbs, or vitamins that you take: _____
_____

List medication **allergies** and reactions (i.e. rash) you have had: _____
_____

List any significant diseases that run in your family (i.e. diabetes, strokes, migraines, neurological diseases): _____

"Review of Systems"

Have you had any of the following recently (**please indicate with an "X"**)?

Cardiovascular
[ ] palpitations
[ ] blue painful hands
[ ] feeling faint
[ ] chest pains

Constitutional
[ ] weight loss
[ ] loss of appetite
[ ] fever
[ ] night sweats
[ ] headache
[ ] fatigue
[ ] heat or cold intolerance
[ ] sleep changes such as insomnia, vivid dreaming and/or acting out

ENT
[ ] deafness
[ ] spinning dizziness
[ ] ringing in the ears
[ ] discharge from the ears
[ ] nasal bleeding
[ ] trouble swallowing
[ ] change in your voice
[ ] pain chewing food
[ ] sinus problems
[ ] loss of smell/taste
[ ] dry mouth

Eyes
[ ] eye pain
[ ] tearing

Gastrointestinal
[ ] diarrhea
[ ] vomiting
[ ] swallowing problems
[ ] black stool
[ ] blood in your stool
[ ] loss of bowel control/constipation

Genitourinary
[ ] loss of bladder control
[ ] urinating too frequently
[ ] getting up at night to urinate
[ ] pain when urinating
[ ] blood in the urine
[ ] impotence/sexual dysfunction
[ ] menstrual change

Hematologic
[ ] bruising
[ ] easy bleeding
[ ] frequent infections

Musculoskeletal
[ ] arthritis
[ ] joint pain/ache
[ ] muscle pain/ache
[ ] change in size of feet/hands

Neurologic
[ ] mood change
[ ] depression/anxiety
[ ] tingling in the arms/legs
[ ] memory loss or slowed thinking
[ ] reduced arm swing while walking
[ ] change in handwriting
[ ] shaking of the hand(s), arm(s), leg(s), lips, or jaw while at rest or with action

Respiratory
[ ] shortness of breath
[ ] wheezing

Skin
[ ] rash
[ ] breast lump
[ ] breast discharge/milk
[ ] hair loss
[ ] pain combing your hair
[ ] coloured spots on your skin

Headache Questionnaire

Name: _____

Length of time you have suffered from headaches: _____Days _____Months _____Years

Headache duration

[ ] < 2 hrs [ ] 2 – 72 hrs [ ] over 72 hrs

Frequency (headaches per month)

[ ] < 2 [ ] < 4 [ ] < 8 [ ] < 16 [ ] > 16

Site of pain

[ ] One side [ ] Both sides [ ] Beginning on one side and spreading to the other

Type of pain

[ ] Throbbing/Pulsating [ ] Burning [ ] Tightening or pressing [ ] Goes away with sleep

Severity of pain

[ ] Mild [ ] Moderate [ ] Severe

Is the pain aggravated by routine physical activity? [ ] Yes [ ] No

Other symptoms:

[ ] Nausea
[ ] Vomiting
[ ] Aura i.e. Flashes of light or blurred vision or "zig-zag" patterns
[ ] Sensitivity to light
[ ] Sensitivity to smell
[ ] Sensitivity to sound

How many days in the last month did you have a headache? _____ Days

Have you identified any migraine triggers? _____.

On a scale of 0 – 10, on average how painful were these headaches?
(0 = no pain at all, and 10 = pain as bad as it can be)

0 1 2 3 4 5 6 7 8 9 10

How many days in the last 3 months did you miss work or school, or your productivity was reduced by half because of your headaches? _____ Days

How many days in the last 3 months did you NOT do work around the house, or your productivity was reduced by half because of your headaches? _____ Days

How many days in the last 3 months did you miss family, social, or leisure activities because of your headache? _____ Days

In a month how many days are you **completely free** of headaches? _____ Days

Have you had new or different headaches in the past 6 months? [ ] Yes [ ] No

Please mark the preventative and abortive agents you have tried.

Preventative Agents	**Dose**
[ ] Betablocker such as Propranolol, Nadolol Metoprolol, or Atenolol	
[ ] Nortriptyline, Amitriptyline	
[ ] Topiramate (Topomax)	
[ ] Gabapentin (Neurontin)	
[ ] Epival (Divalproex sodium) Valproic Acid (Depakene)	
[ ] Verapamil, Flunarizine (Sibelium)	
[ ] Cymbalta (Duloxetine)	
[ ] Effexor (Venlafaxine)	
[ ] Sandomigran	
[ ] Other	

Abortive Agents	**Dose**
[ ] Sumatriptan (Imitrex)	
[ ] Zolmitriptan (Zomig)	
[ ] Frovatriptan (Frova)	
[ ] Eletriptan (Relpax)	
[ ] Naratriptan (Amerge)	
[ ] Rizatriptan (Maxalt)	
[ ] Almotriptan (Axert)	
[ ] Tylenol (Acetaminophen)	
[ ] Non-steroid anti-inflammatory medication – (i.e., Naproxen)	

Non-Pharmacological Treatments

[ ] Acupuncture
[ ] Chiropractic Therapy
[ ] Massage
[ ] Physiotherapy
[ ] Other

Thank you for taking the time to complete this questionnaire

Pain and Function Assessment Questionnaire

Primary Diagnosis _____

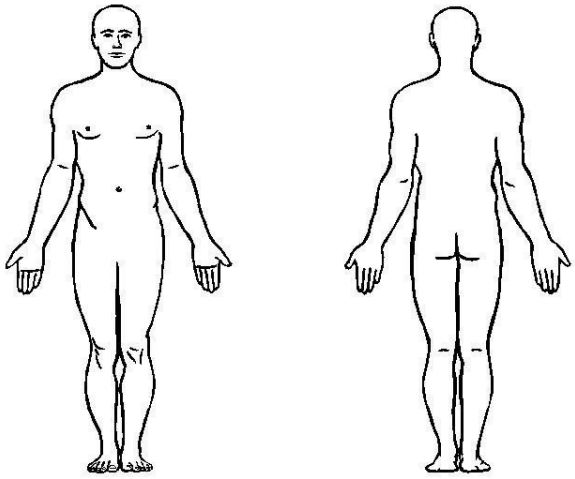
Medications for Pain _____

Duration of Pain _____

Do you think that the doctors and nurses understand your pain? [ ] Yes [ ] No

Location of Pain: Mark on drawing. R L L R

E = External
I = Internal
(Use arrow to show direction and extent of spread, if any)



1. Quality of Pain – Describe how the pain feels _____

_____

2. Intensity of Pain – Rate the pain on a 0 – 5 scale (No Pain = 0, Worst Pain = 5)

a) The worst the pain gets _____
b) The least the pain gets _____

3. Duration of Pain – After the pain comes on, for what length of time does it last?

_____

4. Trigger Factors– What makes the pain worse? (Consider posture, movement, eating, for example) _____

_____

5. Relieving Factors – What makes the pain better? (Consider posture, movement, eating, for example) _____

_____

6. Effects of Pain – Any associated symptoms with the pain?

[ ] Nausea [ ] Constipation [ ] Anxiety
[ ] Depression [ ] Other _____

Is the pain preventing you from doing what you would like to do? Explain.

_____

_____

_____

Thank you for taking the time to complete this questionnaire

PHQ-9 – Nine Symptom Checklist

Name: _____ Date: _____

Over the last **2 weeks**, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

2. Feeling down, depressed, or hopeless
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

3. Trouble falling or staying asleep, or sleeping too much
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

4. Feeling tired or having little energy
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

5. Poor appetite or overeating
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

7. Trouble concentrating on things, such as reading the newspaper or watching television
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

9. Thoughts that you would be better off dead or of hurting yourself in some way
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

GAD-7 Screening Questions

Name: _____ Date: _____

During the last **2 weeks**, how often have you been bothered by the following problems?

1. Feeling nervous, anxious, or on edge
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

2. Not being able to stop or control worrying
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

3. Worrying too much about different things
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

4. Trouble relaxing
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

5. Being so restless that it is hard to sit still
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

6. Becoming easily annoyed or irritable
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

7. Feeling afraid, as if something awful might happen
[ ] Not at all [ ] Several days [ ] More than half the days [ ] Nearly every day

If you off checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?
[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely difficult