NEW PATIENT QUESTIONAIRE – DISORDERS OF THE HEAD

Patient Name: _____ Age: ___ Referred by:_____

B/P: _____ HR: _____ Resp: _____ Weight: _____ Height: _____ R_____ L_____ Handed

What is your primary complaint that brought you here today?

When did you first begin to notice symptoms? Please describe:

Do you have headaches normally? Worst headache of your life?

Do you have stiffness of the neck with the headaches?

Does light hurt your eyes? Where are the headaches located?

Have you had prior head trauma, injury or surgery?

Have you noticed new problems with your vision or hearing? Please describe.

Have you had any difficulty with words or speech? Please describe.

Have you had recent episodes of nausea/vomiting, loss of appetite, dizziness or loss of balance?

Have you noticed any weakness of arms or legs?

Changed in your memory (long or short term)? Confusion or disorientation?

Have you had episodes or passing out or seizures? Please describe

Prior testing?