FAX THIS COMPLETED QUESTIONNAIRE TO:

(321) 441-1559

THOROUGHLY complete this questionnaire. We know that it is a lot of writing, but it will help the doctor to better diagnose and provide you the appropriate care.

Your appointment is ___/___/ 2019 @ ____am / pm

OUR ADDRESS IS:

Downtown Location:
801 N. Orange Ave Ste 535, Orlando, FL 32801

PHONE: (407) 644-0101

Primary Care Physician (name and address):
Address:_____
Phone #_____Fax #_____

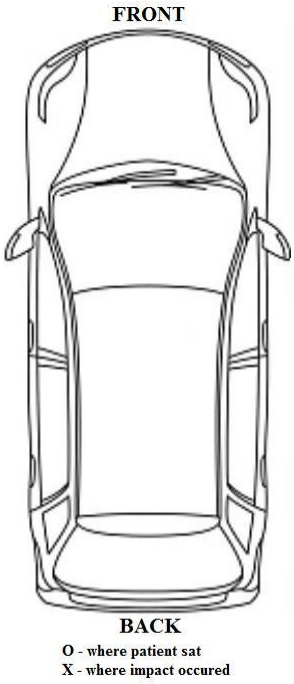
Personal Information:

Name_____ Today's Date_____ Date of Birth _____
Age_____ Male_____ Female_____ Right handed_____ Left handed_____
Single____ Married____ Divorced____ Separated____ Widowed____
Highest Education_____ Occupation /Profession: _____

Accident Information **Date of Injury:** _____

Type of Case: Automobile Fall Motorcycle Pedestrian Other_____

Describe how the accident happened: _____
_____



Were you the Driver? Yes or No Passenger? Yes or No

Were you sitting in the front seat or rear seat ?

Total Damage to you vehicle $ _____

Year/Make/Model of you vehicle: _____

Was your vehicle? Moving or Stopped

Seat Belt: Yes or No

Did your airbags deploy? Yes or No

Where was you vehicle struck?
Rear-end or Passenger side or Driver side

During Impact: Did you brace with arms on?
Steering Wheel - Dashboard - Seat
Did you brace with legs on?
Floor - Brakes
Was your head? Straight or Turned Right or Turned Left

Did you strike any part of your body? Yes or No **If yes against what**? _____
_____

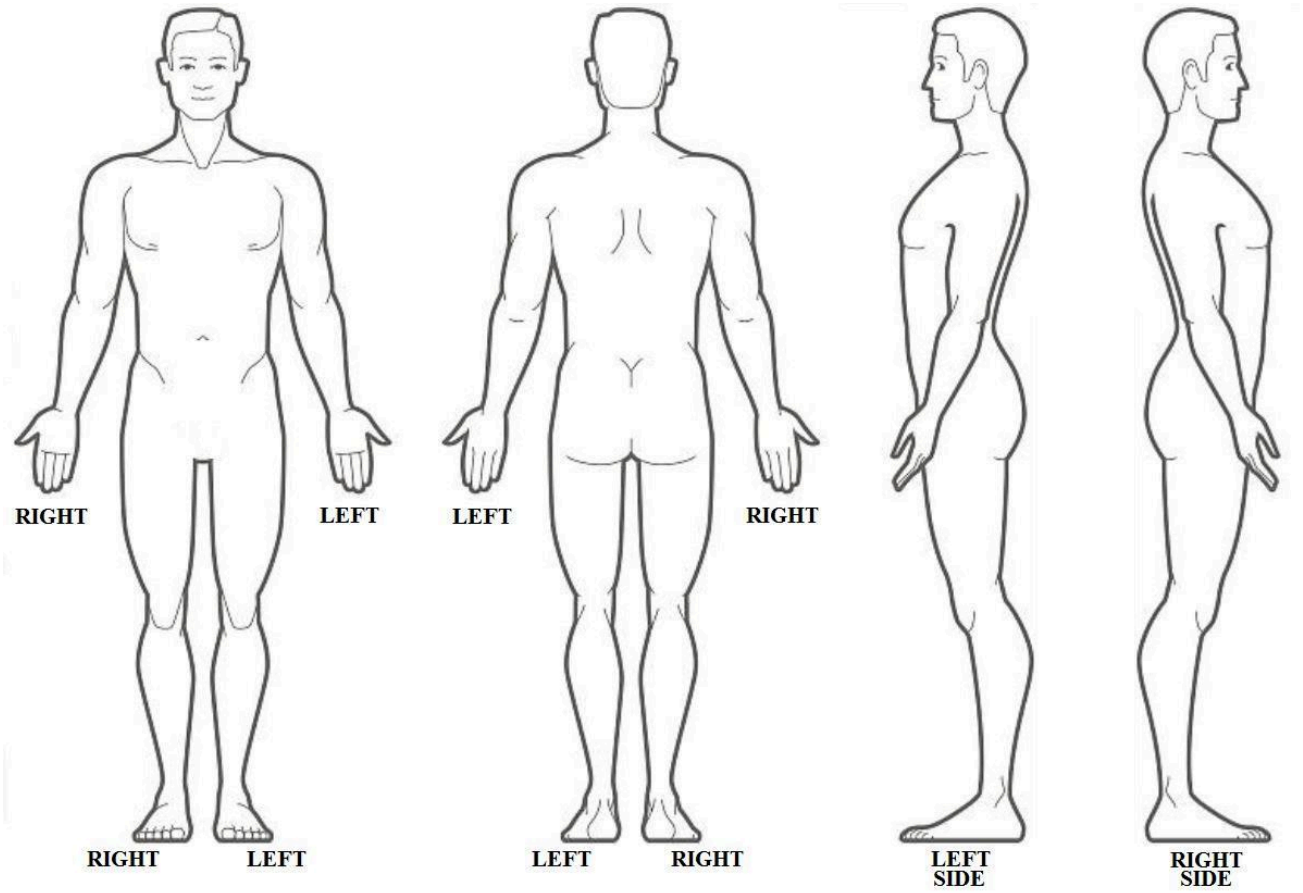
Was anyone in the vehicle with you? Yes or No **If yes who**? _____
_____

After collision: Did you experience Loss of consciousness? Yes or No If so, how many minutes? _____
Did you feel: Stunned Nervous Scared Dizzy Disoriented Lightheaded Confused
Immediate Symptoms:_____
Subsequent Symptoms:_____

Were you evaluated by paramedics? Yes or No
Were you taken to hospital? Yes or No **By ambulance**? Yes or No
Hospital Treatment? Yes or No **Did they do**? X-rays - CT Scans – MRIs

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

/////= Stabbing 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___

After Hospital Treatment:
Dr. Name & Specialty:_____
Type of treatment: _____
Other Treatment: _____

Previous treatment for this injury:_____
_____

MRI, CT, X-rays for this injury:_____

Current Main / Primary Complaint

Location of your pain: _____
Describe pain: ___sharp, ___stabbing, ____dull, ____aching, ____burning, ___throbbing
Intensity: (from 1-10, if 10 is like cutting your arm off with no anesthesia) _____
When do you experience the pain worst? _____
How frequently do you experience the pain? _____
What makes your pain worse? _____
What makes your pain less? _____
Anything else? _____
_____

Secondary Complaint

Location of your pain: _____
Describe pain: ___sharp, ___stabbing, ____dull, ____aching, ____burning, ___throbbing
Intensity: (from 1-10, if 10 is like cutting your arm off with no anesthesia) _____
When do you experience the pain worst? _____
How frequently do you experience the pain? _____
What makes your pain worse? _____
What makes your pain less? _____
Anything else? _____
_____

Third Complaint

Location of your pain: _____
Describe pain: ___sharp, ___stabbing, ____dull, ____aching, ____burning, ___throbbing
Intensity: (from 1-10 , if 10 is like cutting your arm off with no anesthesia _____
When do you experience the pain worst? _____
How frequently do you experience the pain? _____
What makes your pain worse? _____
What makes your pain less? _____
Anything else? _____

Daily Functions:

***Sleeping difficulties*?** No/Yes

- **o** difficulty getting to sleep
- **o** awakens from pain
- **o** easily awakens (cannot sleep through the night)
- o early awakening (before expected)
- o 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__

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

Name of Medication	Strength (mg)	How Many Per Day?	Were you taking Medication before your Accident?
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No
_____	_____	_____	Yes or No

Allergies: _____

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_____

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 before? No / Yes, What was the rating percentage? _____

REVIEW OF SYSTEMS:

Please check **ONLY** those you had **"BEFORE THIS INJURY"**

GENERAL:

□yes □no Unexplained changes in weight
□yes □no Fever
□yes □no Chills
□yes □no Night sweats

NEUROLOGICAL:

□yes □no Unusual change in voice
□yes □no Seizures
□yes □no Loss of consciousness
□yes □no Memory difficulties
□yes □no Disorientation
□yes □no Difficulty with speaking
□yes □no Difficulty with writing
□yes □no Difficulty with reading
□yes □no Dysphagia
□yes □no Double vision
□yes □no Loss of vision
□yes □no Tremors
□yes □no Difficulty walking
□yes □no Weakness
□yes □no Numbness
□yes □no Changes in sensation
□yes □no Tingling

HEAD:

□yes □no Headache
□yes □no History of head contusions
□yes □no Hearing
□yes □no Auditory problems
□yes □no Dizziness
□yes □no Ear buzzing
□yes □no Sinus (stuffy nose)
□yes □no Ear pain
□yes □no Dental problems
□yes □no Metal implants
□yes □no Bleeding gums

CARDIOLOGY/PULMONARY:

□yes □no Chest pain
□yes □no Palpitations
□yes □no Murmur
□yes □no Swollen feet legs worse at the end of the day.
□yes □no Cough
□yes □no Wheezing
□yes □no Shortness of breath walking up one flight Stairs.

GASTROINTESTINAL:

□yes □no Digestion problems
□yes □no Bloating
□yes □no Nausea
□yes □no Heartburn
□yes □no Vomiting
□yes □no Constipation
□yes □no Unexplained diarrhea
□yes □no Abdominal pain
□yes □no Sour mouth sensation after sleeping.

GENITAL/URINARY:

□yes □no Difficulty urinating
□yes □no Urge urinating
□yes □no Pain urinating
□yes □no Painful intercourse
□yes □no Vaginal secretions
□yes □no Bladder incontinence
□yes □no Kidney stones
□yes □no Kidney infections

MUSCULAR/SKELETAL:

□yes □no Diffuse muscle aching
□yes □no Fibromyalgia
□yes □no Legs or joint swelling
□yes □no Stiffness
□yes □no Painful foot sole or arch "*first steps in the morning*".

SKIN/HAIR:

□yes □no Changes in skin moles
□yes □no Non-healing ulcers
□yes □no Dry skin
□yes □no Itching
□yes □no Nail fungus

ENDOCRINE/HEMATOLOGICAL/IMMUNE:

□yes □no HIV positive
□yes □no Hepatitis
□yes □no Fainting
□yes □no Swollen armpit
□yes □no Swollen groin glands,
□yes □no Pale color
□yes □no Bleeding disorders
□yes □no Recurrent infection

PAST MEDICAL HISTORY - **UNRELATED TO THIS INJURY !!! - (Only what was prior to this injury)**

If diagnosed by physician check "X". if probably, write **a** "P"
Specify when first started, in years (ie. 6 months)

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_____

Is there significant stress at work? Yes__ No___
How does this make your pain worse?_____
Any Food intolerance or allergy_____

Imaging Studies (Before this Injury):

_____
_____
_____
_____

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 _____
Number of Brothers_____Number of Sisters_____

Functional History:

Previous 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_____/_____

Educational Background: (circle you answer)
What was your highest level of Schooling?
High school, Technical school, Associates, College
Did you have any learning disabilities prior to the accident? Yes / No
Were you ever held or left back a grade in school? Yes / No
Have you had any history of ADHD prior to the accident? Yes / No
Did you have any need for Special Education Classes prior to the accident?? Yes / No
Did you ever require tutoring prior to the accident? Yes / No
On average what were your grades? A's, B's, C's, D's, F's

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)_____

***Complete Boxes Below <u>ONLY</u> if you have had any Prior Motor Vehicle Collisions**

with Injuries?

Date of **PRIOR** MVA: _____Type of Collision: □ Head-on
□ Rear-ended
□ Side-impact
Driver's side impact
Passenger side impact

Area of Body Injured:
1) _____ 3) _____
2) _____ 4) _____

Property Damage Amount: $_____.00

Last Treatment Date:_____

Date of other **PRIOR** MVA: _____Type of Collision: □ Head-on
□ Rear-ended
□ Side-impact (T-Bone):
Driver's side impact
Passenger side impact

Area of Body Injured:
1) _____ 3) _____
2) _____ 4) _____

Property Damage Amount:$_____.00

Last Treatment Date:_____

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
4. I have lost all interest in other people

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.
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

BECK Inventory Questionnaire (Continued):

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

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

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

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

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

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

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

OFFICE USE ONLY

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

Neurobehavioral Symptom Inventory (NSI)

Name: _____ **Date:** _____

Please rate the following symptoms to how much they have disturbed you **IN THE LAST TWO WEEKS.** Rate each symptom from 0 to 4, as based on the following definitions.

0 = None – Rarely if ever present; not a problem at all.

1 = Mild – Occasionally present, but it does not disrupt my activities; I can usually continue what I'm doing and it does not concern me.

2= Moderate – Often present, occasionally disrupts my activities; I can usually continue what I'm doing with some effort; I feel somewhat concerned.

3= Severe – Frequently present and disrupts activities; I can only do things that are fairly simple or take little effort; I feel I need help.

4= Very Severe- Almost always present and I have been unable to perform at work, school or home due to this problem;
I probably cannot function without help.

Number	Symptom Description					
1	Feeling dizzy	0	1	2	3	4
2	Loss of balance	0	1	2	3	4
3	Poor coordination, clumsy	0	1	2	3	4

Vestibular Total:

Number	Symptom Description					
4	Headaches	0	1	2	3	4
5	Nausea	0	1	2	3	4
6	Vision problems, blurring, trouble seeing	0	1	2	3	4
7	Sensitivity to light	0	1	2	3	4
8	Hearing difficulty	0	1	2	3	4
9	Sensitivity to noise	0	1	2	3	4
10	Numbness or tingling on parts of my body	0	1	2	3	4
11	Change in taste and/or smell	0	1	2	3	4

Somatosensory Total:

Number	Symptom Description					
12	Loss of appetite or increased appetite	0	1	2	3	4
13	Poor concentration, can't pay attention, easily distracted	0	1	2	3	4
14	Forgetfulness, can't remember things	0	1	2	3	4
15	Difficulty making decisions	0	1	2	3	4
16	Slowed thinking, difficulty getting organized, can't find things	0	1	2	3	4

Cognitive Total:

Number	Symptom Description					
17	Fatigue, loss of energy, getting tired easily	0	1	2	3	4
18	Difficulty falling asleep or staying asleep	0	1	2	3	4
19	Feeling anxious or tense	0	1	2	3	4
20	Feeling depressed or sad	0	1	2	3	4
21	Irritability, easily annoyed	0	1	2	3	4
22	Poor frustration tolerance, feeling easily overwhelmed by things	0	1	2	3	4

Affective Total:

TOTAL: _____

Directions to Downtown location:

When traveling west on I-4:

Exit Ivanhoe Blvd, at the bottom of the offramp turn left (east) onto Lakeview. Stay in the far right lane on Lakeview as it turns to the right, it will become Orange Avenue. The Sixth Street on your left will be Park Lake, Turn Left. The second driveway on your left is the driveway to the parking garage for the 801 building. Drive up to the 4th floor and turn right at the elevator, our reserved spots are straight ahead marked MD Diagnostics.

When traveling east on I-4:

Exit the Amelia street exit. Stay in the middle lane and continue straight onto Garland Avenue. After you pass through Colonial, continue straight for approx. 2 blocks. Turn right onto Marks street and another right on Orange Ave. Merge to the far left lane, 2 streets on your left will be Park Lake, Turn Left (See red arrow on map below). The second driveway on your left is the driveway to the parking garage for the 801 building. Drive up to the 4th floor and turn right at the elevator, our reserved spots are straight ahead marked MD Diagnostics.