

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:

668 N. Orlando Ave., Suite 1005
Orlando, FL 32751

PHONE: (407) 644-0101

Primary Care Physician (name and address):

Address: _____

Phone # _____ Fax # _____

Personal Information:

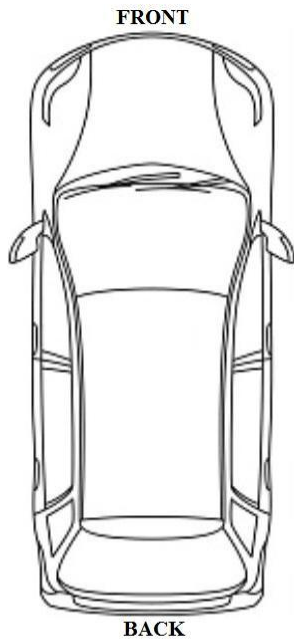
Name _____ Today's Date _____ Date of Birth _____
Age _____ Male _____ Female _____ Right handed _____ Left handed _____
Single _____ Married _____ Divorced _____ Separated _____ Widowed _____
Highest Education _____ Occupation / Profession: _____

Accident Information

Date of Injury: _____

Type of Case: Automobile Fall Motorcycle Pedestrian Other _____

Describe how the accident happened: _____



O - where patient sat
X - where impact occurred

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

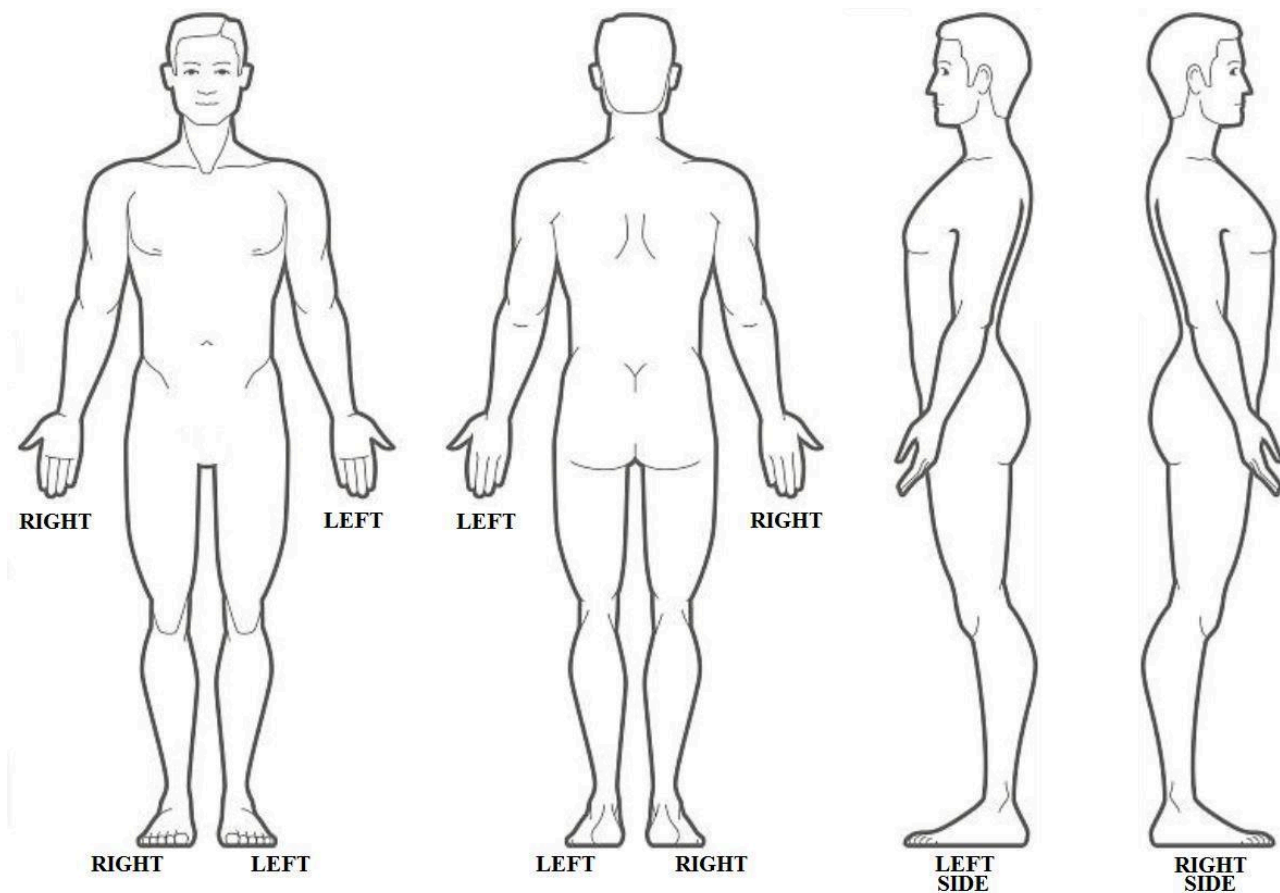
Pain Assessment: Mark the area(s) where you feel your symptoms/pain

/////= Stabbing
TTTT= Throbbing

0000= Tingling
SSSS=Shooting

XXXX= Burning
DDDD=Dull

AAAA= Aching
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? _____

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__

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?
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>
_____	_____	_____	<u>Yes or No</u>

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? _____

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 ONLY 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 |

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

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

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

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

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

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

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

OFFICE USE ONLY

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

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 finish 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:

DIRECTIONS

We are located in the Open MRI office space @ 668 N. Orlando Ave., Suite 1005, Maitland, FL 32751

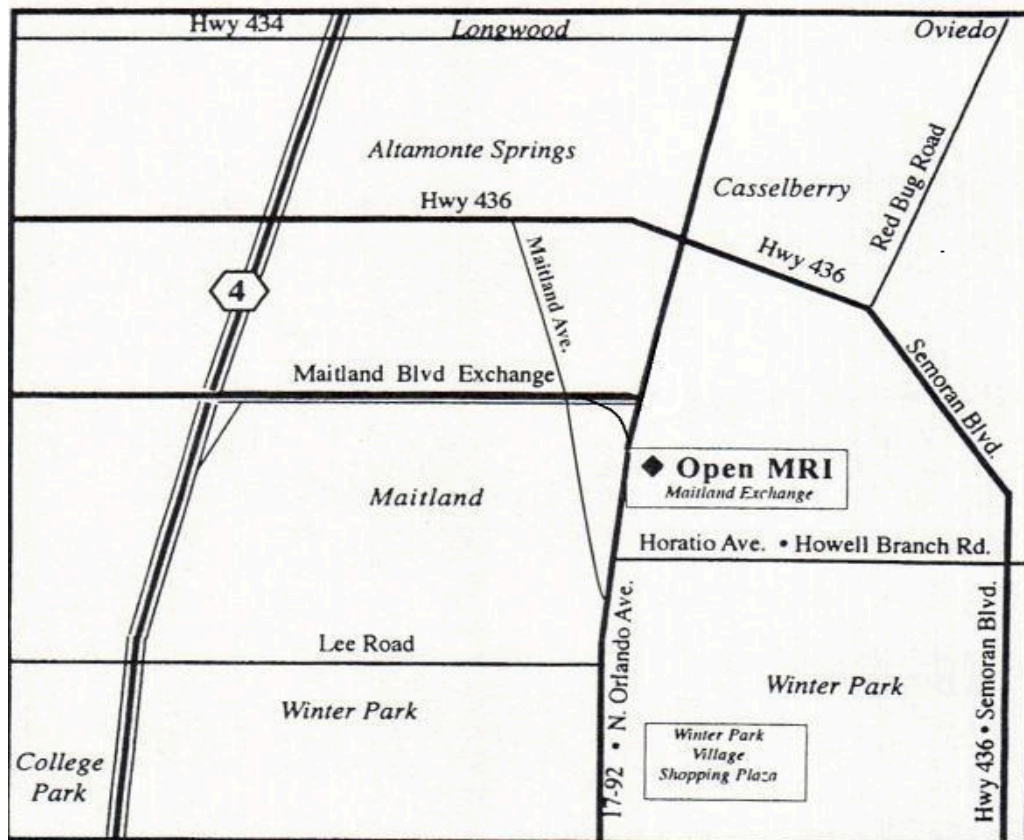
I-4 to Maitland Blvd. East

Maitland Blvd. East 2.2 miles until it ends at 17-92 S-W (stay in right lane)

Turn Right onto SW (southwest) SR 17-92 and go ¼ mile

Located on Left side of SR 17-92 immediately after Mercedes-Benz dealership

Golden/Yellow 2 story building (Maitland Exchange building)



PHONE: (407)
644-0101