

**NeuroSensory Center of Eastern Pennsylvania**

Suite 317 · 250 Pierce Street · Kingston, PA 18704

T: 570.763.0054 F: 570.763.0056

[*info@keystonensc.com*](mailto:info@keystonensc.com)[*www.neurosensorycenters.com*](http://www.neurosensorycenters.com)

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**ADULT PATIENT QUESTIONNAIRE**

Date of Initial Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_ BP: \_\_\_\_\_\_\_\_\_\_\_\_ (to be filled out by nurse at NSC)

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications/Supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please explain briefly why you are seeking treatment at the NSC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately when did your symptoms begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if you experienced any of the following problems:

\_\_\_ vertigo \_\_\_ double vision \_\_\_ ADD/ADHD

\_\_\_ dizziness \_\_\_ glaucoma \_\_\_ dyslexia

\_\_\_ imbalance \_\_\_ macular degeneration \_\_\_ tinnitus

\_\_\_ lightheadedness \_\_\_ short-term memory loss \_\_\_ facial paralysis

\_\_\_ headaches \_\_\_ concussion/head injury \_\_\_ anxiety/panic attacks

\_\_\_ migraines \_\_\_ stroke \_\_\_ depression

\_\_\_ recent visual changes \_\_\_ intracranial hemorrhage \_\_\_ cervical neck pain

\_\_\_ fluctuations in vision \_\_\_ Auditory Processing Disorder \_\_\_ low back pain

\_\_\_ changes in reading comprehension \_\_\_ changes in reading and writing abilities

\_\_\_ light sensitivity \_\_\_ loss of visual field

How would you best describe your symptoms?

\_\_\_ symptoms fluctuate

\_\_\_ symptoms are constant

\_\_\_ symptoms are intermittent

\_\_\_ symptoms are rare

Is there a time of year that they most commonly occur?

\_\_\_ spring

\_\_\_ summer

\_\_\_ fall

\_\_\_ winter

\_\_\_ no seasonal variation

Do your symptoms worsen with allergies?

\_\_\_ yes

\_\_\_ no

Please check if you have trouble with any of the following activities:

\_\_\_ Rapid head movements \_\_\_ Driving at night

\_\_\_ Reading \_\_\_ Walking up or down stairs

\_\_\_ Riding in a car \_\_\_ Motion sickness

\_\_\_ Being in a grocery store \_\_\_ Sleeping

\_\_\_ Being in a mall or open spaces \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any falls in the past year?

\_\_\_ No

\_\_\_ Yes

If you answered yes, how many? \_\_\_\_\_

Have you suffered any injuries as a result of a fall?

\_\_\_ No

\_\_\_ Yes

If you answered yes, please describe injuries. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do loud noises seem to bother you?

\_\_\_ No

\_\_\_ Yes

Do you have a hearing loss?

\_\_\_ No

\_\_\_ Yes

If you answered yes, please write if it is in both ears or just one ear and which one. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Severity of hearing loss: \_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_ Fluctuates

Do you have ringing in your ears or tinnitus?

\_\_\_ No

\_\_\_ Yes

If you answered yes, is it \_\_\_ Constant \_\_\_ Occasional \_\_\_ Rare

Do you have complaints of:

\_\_\_ Short-term memory loss \_\_\_ Difficulty sleeping

\_\_\_ Trouble with concentration \_\_\_ Fine motor deficits

\_\_\_ Difficulty focusing on a task \_\_\_ Gross motor deficits

\_\_\_ Distractibility \_\_\_ Emotional fluctuation

Is there anything that triggers or worsens your symptoms?

\_\_\_ No

\_\_\_ Yes (please explain). \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How do you rate your problem on a scale of 1 – 10? (Minor to Severe)

\_\_\_ Affect on everyday life?

\_\_\_ Limitations on ability to work?

\_\_\_ On a good day?

\_\_\_ On a bad day?

List tests/Xrays/Scans/MRI’s you have received as a result of your symptoms and results:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been diagnosed with:

\_\_\_ Meniere’s disease \_\_\_ Lupus

\_\_\_ Labyrinthitis \_\_\_ Sjogren’s Syndrome

\_\_\_ Stroke \_\_\_ Adult Onset (Type 2 Diabetes)

\_\_\_ TIA’s \_\_\_ Parkinson’s Disease

\_\_\_ Brain hemorrhage \_\_\_ Shingles

\_\_\_ Encephalitis \_\_\_ Chicken Pox

\_\_\_ Meningitis \_\_\_ Epstein Barr/Mononucleosis

\_\_\_ Sinus headaches \_\_\_ Lyme’s Disease

\_\_\_ Migraine headaches \_\_\_ Heavy Metal Toxicity

\_\_\_ Recurrent sinusitis \_\_\_ Autism Spectrum Disorder \_\_\_ Thyroiditis \_\_\_ Irritable Bowel syndrome

\_\_\_ Autoimmune Disease \_\_\_ Fibromyalgia

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your family have a history of:

\_\_\_ Adult onset (type 2 Diabetes) \_\_\_ Meningitis

\_\_\_ Meniere’s disease \_\_\_ Migraine headaches

\_\_\_ Stroke \_\_\_ ADD/ADHD/Autism

\_\_\_ TIA’s \_\_\_ Dyslexia

\_\_\_ Brain hemorrhage \_\_\_ Allergies

\_\_\_Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Anxiety disorder (panic attacks)

\_\_\_ Encephalitis \_\_\_ Depression

\_\_\_ Thyroiditis \_\_\_ Parkinson’s Disease

\_\_\_ Autoimmune Disease \_\_\_ Arthritis

\_\_\_ Lupus \_\_\_ Heavy Metal Toxicity

Last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Care Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Physical Exam \_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Physicians currently involved in your treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all hospitalizations and surgeries and dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate with a check mark (√) the extent to which you experience the following over the past two weeks:

**Not at all Just a little Quite a bit**

Feeling worried, guilty or anxious \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Feeling tense, uptight or nervous \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Feeling in a low mood, sad, or depressed \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Having difficulty concentrating or focusing \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Feeling “stressed out”; unable to cope \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Being forgetful, having memory problems \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Making mistakes when performing

common tasks or chores \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Not thinking as quickly or clearly as before \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Being angry; losing your temper \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Not having any enjoyment in life \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

Please tell us how you heard about us:

\_\_\_ TV \_\_\_ Radio \_\_\_ Newspaper \_\_\_ Yellow Pages \_\_\_ Friend or Relative \_\_\_ Website

\_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Patient, Parent, Guardian or Personal Representative Date