

**NeuroSensory Center of Eastern Pennsylvania**

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**Health History Form for HEAD INJURY/CONCUSSION/TBI/STROKE**

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

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

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

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

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

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

Date of Accident/Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_

Describe Accident/Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization (If applicable): Date and Duration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Were you unconscious after Accident/Incident? Yes / No. If Yes, Length of time:\_\_\_\_\_\_\_\_\_\_\_

If a Stroke/Head Injury, side which was/is affected: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Speech Deficits: Yes / No.

Difficulties with Eating/Swallowing: Yes / No

Any Symptoms prior to Accident/Incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any falls in the past year? Yes / No. If Yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you suffered any injuries as a result of a fall? Yes / No. If yes, please explain: \_\_\_\_\_\_\_\_\_

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

Current Symptoms:

\_\_\_ Imbalance \_\_\_ Tinnitus

\_\_\_ Vertigo \_\_\_ Cervical Neck Pain

\_\_\_Dizziness \_\_\_ ADD/ADHD

\_\_\_ Lightheadedness \_\_\_ Dyslexia \_\_\_ Headaches/Migraines \_\_\_ Anxiety/Panic Attacks

\_\_\_ Short-term Memory Loss \_\_\_ Depression

\_\_\_ Trouble with Concentration \_\_\_ Difficulty with Sleep

\_\_\_ Difficulty focusing on a Task \_\_\_ Problems with Coordination

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

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Visual Complaints:

\_\_\_ Double Vision \_\_\_ Visual Field Changes or Loss

\_\_\_ Loss of Vision \_\_\_ Ambulation Changes

\_\_\_ Light Sensitivity \_\_\_ Changes in Reading or Writing Abilities

\_\_\_ Change in Acuities \_\_\_ Changes in Reading Comprehension

\_\_\_ Objects Appear to Move

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

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How would you best describe your symptoms?

\_\_\_ Symptoms fluctuate

\_\_\_Symptoms are constant

\_\_\_ Symptoms are intermittent

\_\_\_ Symptoms occur very rarely

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 \_\_\_ Car sickness

\_\_\_ In grocery stores \_\_\_ Sleeping

\_\_\_ In malls or open places

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is there anything that triggers or worsens your symptoms? Yes / No. If Yes, please describe.

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

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 \_\_\_ ADD/ADHD/Autism

\_\_\_ ADD/ADHD/Autism \_\_\_ Central processing disorder

\_\_\_ Thyroiditis \_\_\_ Dyslexia

\_\_\_ Autoimmune Disease

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

Does your family have a history of:

\_\_\_ Meniere’s disease \_\_\_ Meningitis

\_\_\_ Labyrinthitis \_\_\_ Migraine headaches

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

\_\_\_ TIA’s \_\_\_ Central Processing disorder

\_\_\_ Brain hemorrhage \_\_\_ Dyslexia

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

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

\_\_\_ Thyroiditis \_\_\_ Parkinson’s disease

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

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

\_\_\_ Sjogren’s Syndrome \_\_\_ Adult Onset (Type 2 Diabetes)

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

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

\_\_\_ Rehab Facility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Signature of Patient, Parent, Guardian or Personal Representative Date