GHALY NEUROSURGICAL ASSOCIATES
HEALTH ASSESSMENT FORM

Please take the time to complete this form, as it will assist the physician in your diagnosis and treatment.

Date: _____

Name: _____Age: _____Birthdate: _____

Height: _____Weight: _____ ___Right ___Left Handed

Do you use: _____Cane ____Walker ____Wheelchair ____None

Please describe the problem you are seeing the doctor for along with the symptom history:

_____

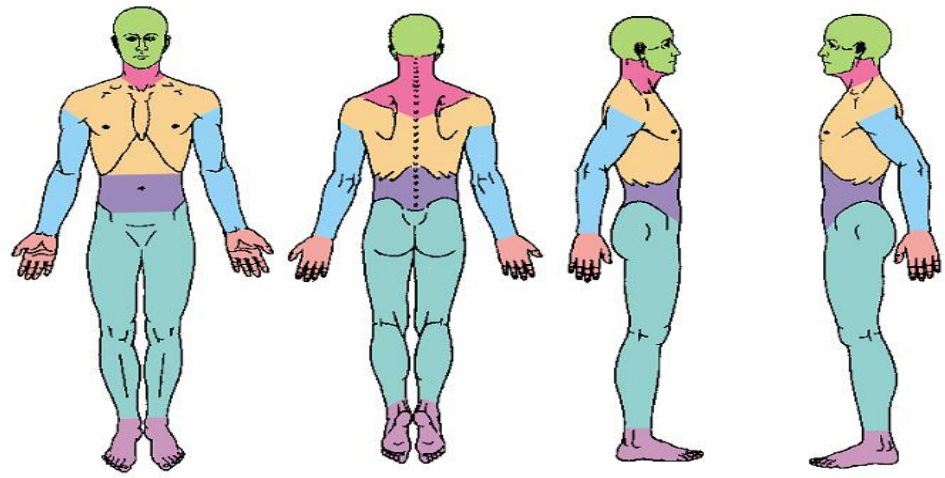
_____

_____

_____

Using the symbols below indicate on the picture which parts of your body are affected:

- - - pain ooo numbness/pins & needles sensation xxx burning /// stabbing



How long have you had this problem? _____Was onset Sudden / Gradual

Occupation (if retired, your previous occupation):_____

Are you currently working? Yes or No

If you answered YES, please describe the amount of sitting, lifting, carrying, &/or overhead work required by your job:

_____

_____

_____

If you answered NO, please answer the following questions:

When was your last day of work? _____ Are you currently on disability? Y or N

Is your problem associated with an injury or accident? Yes or NO

If YES, please describe the injury along with the date of occurrence:

_____

_____

_____

If YES, are you involved in any legal or lawsuit issues concerning the injury, disability, or medical treatment? YES or NO

Are you: ___Married ___Single ___Divorced ___Widowed # of Children_____

Use of alcohol: ___Never ___Rarely ___Moderate ___Daily

Use of Tobacco: ___Never ___Previously, but quit ___Yes/Packs per day_____

Use of street drugs: ___Never ___Previously, but quit ___Yes

Please check any of which YOU have a history of:

___Brain Tumor
___Aneurysm
___Stroke
___Arteriovenous Malformation
___Diabetes
___Seizures
___Hepatitis
___Tuberculosis
___Thyroid Disease
___Liver Disease
___Autoimmune Disease
___Lung Disease
___Kidney Disease
___Peripheral Vascular Disease/poor circulation
___Mental/Nervous Disorder
___Heart Disease
___Hypertension
___Heart Attack
___Blood Disorder
___Arthritis
___Gout
___Bone Disease
___Pneumonia

___Cancer (type) _____

Have you ever had: ___Chemotherapy ___Radiation Treatment

If you've had radiation, to what part of the body? _____

Have you had: X-Rays MRI's CAT scans EMG EEG

Please list any accidents you have been involved in:

_____

_____

_____

Please list any surgeries/hospitalizations/serious injuries you have had:

_____

_____

_____

_____

Please list any medications you are currently taking (including over-the counter drugs).

Include the name, dose and frequency.

_____

_____

_____

_____

_____

Do you have allergies to any medications, iodine, shellfish, infusions or IVP dye? Yes or No

Describe your allergic reaction: _____

Please indicate which, if any of the following that you have seen / tried for your problem:

General Practitioner or D.O.	Chiropractor	Accupuncture
Anesthesiologist (injections)	Napropath	Physical / Occupation Therapy

Other: _____

Have your parents, grandparents, sisters, or brothers had any of the following:

(M = mother F = father G = grandparent B = brother S = sister)

___Brain Tumor	___Thyroid Disease	___Heart Disease
___Aneurysm	___Liver Disease	___Hypertension
___Stroke	___Autoimmune Disease	___Heart Attack
___Arteriovenous Malformation	___Lung Disease	___Blood Disorder
	___Kidney Disease	___Arthritis
___Diabetes	___Peripheral Vascular Disease/poor circulation	___Gout
___Seizures		___Bone Disease
___Hepatitis	___Mental/Nervous Disorder	___Pneumonia
___Tuberculosis		

___Cancer (type) _____

FOR THE BRAIN OR HEADACHE PATIENT

Do you have headaches: Yes No Since when? _____

Which part of your head? _____What time of day? _____

What makes it worse? _____What makes it better? _____

How long do they last? _____

Do any other symptoms come with it? _____

Do you have any of the following:

___Headaches	___Dizziness	___Numbness on one side
___Confusion	___Seizures	___Double Vision
___Balance problems	___Difficulty talking	___Difficulty hearing
___Difficulty walking		

FOR THE PERIPHERAL NERVE OR CARPAL TUNNEL PATIENT

Do you have numbness, tingling or pain in your hands:	YES	NO
If YES, does it wake you up at night?	YES	NO
Do you have weakness in your hand grip?	YES	NO
Does rubbing your hand or massage help?	YES	NO
Are you currently using hand splint(s)?	YES	NO
If YES, does it help?	YES	NO

FOR THE SPINE PATIENT

Were you engaged in any activity when your symptoms first started (please describe).

_____

_____

Are your symptoms worse at a certain time of the day (when)? _____

How often do you have the symptoms?

___Constant ___Intermittently daily ___Once / day ___Once / Week

What is the character of the pain?

___Burning ___Electric shock ___Sharp ___Shooting ___Stabbing ___Deep ache

___Other (describe)_____

Do any of these factors aggravate the symptoms?

___Lifting ___Standing ___Climbing stairs ___Neck movement ___Coughing

___Sneezing ___Walking ___Sitting ___Driving car ___Straining bowels

___Arm(s) overhead ___Other (describe): _____

Does bed rest relieve your pain? YES NO

Do other activities relieve the pain (describe): _____

Does the pain prevent you from certain activities (describe): _____

How long can you sit? _____ How far can you walk? _____

How long can you walk before the pain begins? _____

Please indicate if you have any of the following symptoms using L = LEFT, R = RIGHT or B = BOTH:

	Weakness	Stiffness	Numbness	Tingling	Pain
Hand					
Arm					
Shoulder					
Hip					
Leg					
Foot					

Have changes occurred in any of the following functions?

___Bowel ___Bladder ___Sexual function

If YES, please describe: _____

_____

FOR THE SPINE PATIENT (continued)

Please answer the next 6 questions if your problem is related to your BACK:

1. Rate your back pain on a scale of 0 – 10 (10 being the worst pain) _____
2. Do you have any leg or hip symptoms (describe):

   _____

   _____
3. Does the pain stop you from walking a certain distance (& how far?) _____
4. If you stop walking, how long does the pain last? _____
5. Does your back get "stuck" when you bend forward? YES NO
6. Are certain positions more comfortable (describe):

   _____

   _____

Please answer the next 4 questions if your problem is related to your NECK:

1. Rate your neck pain on a scale of 0 – 10 (10 being the worst pain) _____
2. Do you have any shoulder or arm symptoms (describe):

   _____

   _____
3. Does your neck make a noise when moved a certain way? YES NO
4. Are certain positions more comfortable (describe):

   _____

   _____

_____

Patient **Printed** Name

_____

Patient **Signature**

Date: _____