



Chronic Neurological Patient History (NPQ)

Patient Name _____ Date: _____

Please describe any problem you are currently experiencing or have experienced in the past to help us get a better understanding of your health history. For example, if you now, or as a child, frequently were ill with ear infections please write that in the ears/nose/throat section below. Again please be as detailed as possible as this form is VERY IMPORTANT to us. We need to know as much about you as possible in order to properly evaluate and treat your condition.

1. WHOLE BODY

HEAD: (concussions, stroke, headaches, dizziness, etc.)

EARS/NOSE/THROAT: (ear infections, inner ear problems, nose bleeds, frequent strep infections, difficulty swallowing, loss of hearing, smelling or taste etc.)

EYES: (corrective lenses, dryness, double/blurry vision, etc.)

THYROID: (hyper/hypothyroidism? Medication for this?)

ARMS/LEGS: (pain, skin disorders, abnormal weakness, loss of limbs/fingers/toes-briefly explain how loss occurred, etc.)

ABDOMINAL/REPRODUCTIVE AREA: (nausea, ulcers, kidney stones, ovarian cancer, prostate problems, diabetes, bladder control, any cancers, etc.)

LUNG/HEART: (difficulties breathing, asthma, heart attacks, angina, stroke, rapid/slow heart rate, pacemaker, etc.)

BLOOD: (anemia, etc.)

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THE FOLLOWING QUESTIONS HAVE TO DO WITH BRAIN STEM FUNCTION:

HIGH IML

Are you sensitive to light or have blurring vision?

Have you experienced an increase in sweating?

Do you have trouble sleeping, continuously waking up during the night or trouble getting to sleep?

Have you experienced an increase in pulse or heart rate, or experienced heart palpitations?

Do you have a history of urinary tract infections?

Have you experienced visual changes before migraine headaches?

Do you have, or have you had bedsores or lesions?

LOW IML

Do you fatigue easily?

Do you have cold hands or feet?

Do you experience frequent urination or are you unable to control urinary or bowel movements?

Do you have episodes of fainting or hypoxia?

For the next several questions please answer briefly and give the dates each began to the best of your knowledge and if you can think of what contributed to it.

1. Any history of fainting/loss of consciousness?

2. Noticeable changes in your handwriting?

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3. Changes in sexual function?
4. Are you more irritable or angry?
5. Episodes of depression or anxiety?
6. Problems with equilibrium, loss of balance, tripping, dropping things, etc?
7. Difficulty scanning pages while reading a book?
8. Difficulty adding or subtracting?
9. Difficulty moving your eyes? Or double vision?
10. Difficulty expressing what you would like to say?
11. Any changes in speech?
12. Any changes in sensation?
13. Any changes in memory?
14. Any changes in hearing?

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15. Excess dryness or wetness of the eyes or nose?

2. FULL DESCRIPTION (DETAILED) OF WORK ACTIVITIES

What do you do? What are your duties?

How many hours per week do you work?

Do you do a lot of lifting or twisting at work?

3. LIFESTYLE

Describe Hobbies/Activities/Exercise. History of diets? Any changes?

Diet (List briefly the types of foods you generally eat.)

What type of vitamins/supplements?

Rate your salt/sugar/fat consumption. (Mark each: **Low/Moderate/High**)

Salt	L	M	H
Sugar	L	M	H
Fat	L	M	H