Carolina Concussion & Physical Medicine PLLC

• Concussion Rehab • Dizziness & Balance Rehab • Chiropractic

120 Capcom Ave, Ste 104 Wake Forest, NC 27587
Phone: (919) 435-7396 Fax: (919) 435-7396

Patient Health History Form

First Name _____ Middle Name / MI _____ Last Name _____ Date _____

Date of Birth _____

Patient Address Line 1 _____ Patient Address Line 2 _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____ Communication Preference _____

Emergency Contact Name _____ Emergency Contact Home Phone _____

Marital Status _____ Professional Title _____ Employer Name _____ Work Phone _____

Primary Physician _____

Referred by _____

How did you hear about us? _____

Insurance Information

Health Insurance Carrier

Primary Insurance Name _____ Primary Subscriber ID _____ Primary Group No. _____

Policy Holder Name _____ Policy Holder Date of Birth _____

If Motor Vehicle Accident or Work Comp Injury:

Insurance Company Name _____ Claim # _____ Insurance Company Phone _____

Address _____ City _____ State _____ Zip _____

Attorney / Case Manager Name _____ Phone _____

Please answer the following questions as best you can as they relate to you and your condition:

1. Briefly describe your complaint in your own words and approximate onset date:

_____

2. How would you describe your complaint? (select all that apply):

- Dizziness
- Vertigo
- Unsteadiness
- Lightheadedness
- Mental Fog
- Nausea
- Visual Disturbances (double vision, blurriness)
- Fatigue
- Poor Memory
- Neck Pain
- Lower Back Pain
- Arm Numbness or Tingling
- Leg Numbness or Tingling
- Stiffness
- Headaches
- Migraines
- Repeated Falls
- Insomnia or Poor Sleep
- Ringing in Ears

Additional Symptoms

_____

3. Is your condition a result of a motor vehicle accident or work injury?

No Yes

If yes, please described how the injury occurred as specifically as you can:

_____

4. What is your current pain level on a scale of 1-10? 0=No pain 10=Severe pain

0 1 2 3 4 5 6 7 8 9 10

If you are experiencing pain, please describe the location of your pain:

_____

5. What positions or activities make your condition worse?

_____

6. Does anything relieve your symptoms?

No Yes

If yes, please explain

_____

7. Have you seen other providers for this present complaint?

No Yes

If yes, who have you seen?

_____

What treatments/diagnostics have you received?

_____

8. Have you ever experienced this type of problem before?

No Yes

When & how many times did you have episodes?

_____

When was your most recent episode?

_____

9. Relevant medical history: (Please select current or previous conditions)

- Abdominal Issues
- Arthritis
- Asthma
- ADD/ADHD
- Neck or Back Pain
- Cancer
- Diabetes
- Depression/Mood Changes
- Hearing Loss
- Fibromyalgia
- Headaches
- High Blood Pressure
- High Cholesterol
- Head Injury
- Digestive Issues
- Dizziness
- Fainting Episodes
- Fatigue
- Multiple Sclerosis
- Migraines
- Neuropathy (numbness in arms/legs)
- Psychiatric Disorders
- Stroke
- Seizures
- Visual Deficits
- Vertigo
- Other

If you selected visual deficits, do you wear glasses?

Yes No

If other, please specify

_____

10. Relevant family medical history: (Please select all that apply)

- Arthritis
- Cancer
- Diabetes
- Heart Disease
- Migraines
- Kidney Disease
- Scoliosis
- Sciatica
- Back Problems
- Vertigo / Dizziness
- Digestive Issues
- Multiple Sclerosis
- Psychiatric Disorders
- Stroke
- Seizures
- Other

If other, please specify

_____

List any surgeries that you have had and approximate dates:

1. _____ **Date** _____

2. _____ **Date** _____

3. _____ **Date** _____

4. _____ **Date** _____

Are you allergic to any medication? Please list:

_____

Are you taking any medications?

No Yes

Please list

_____

Are you pregnant?

Yes No

Due Date

_____

Patient Smoking Status _____

Patient Smoking Frequency _____

Patient Smoking Start Date _____

Patient Smoking End Date _____

Do you consume alcohol?

◯ No ◯ Yes

If yes

◯ Light ◯ Medium ◯ Heavy

Do you exercise?

◯ Never ◯ Sometimes ◯ Frequently ◯ Regularly

Do you consume caffeine?

◯ No ◯ Yes

If yes, how much per day?

_____

Please complete the following questions below only if you are suffering from any of the following: TBI, Concussion injury, Dizziness, Vertigo, Incoordination, or Imbalance

If not, please check below and sign your name at the end of the intake form.

☐

11. Do you ever have any of the following sensations:

Spinning in circles?

◯ No ◯ Yes

If yes, what is the direction of the spin?

◯ Left ◯ Right

The world is spinning around you?

◯ No ◯ Yes

You are still and the world is spinning around you?

◯ No ◯ Yes

Falling to one side?

◯ No ◯ Yes

If yes, then describe which side?

◯ Left ◯ Right

12. Because of this present problem, have you had any falls?

◯ No ◯ Yes

If yes, approximately how many falls?

_____

Have you injured yourself from falling?

◯ No ◯ Yes

13. Is your condition the result of a recent or past head injury(s)?

◯ No ◯ Yes

If yes, please give the date(s) of injury(s) and briefly describe the incident(s):

_____

14. Approximately when did you notice symptoms?

_____

15. Please describe in your own words where you were & how your episode came on:

_____

16. Does anything trigger the onset of your episodes?

◯ No ◯ Yes

If yes, please explain

_____

17. Did you have a recent cold or flu prior to your initial episode?

No Yes

18. When you have an episode, how long do they last on average?

Seconds Minutes Hours Days

19. Do you have headaches or migraines?

No Yes

If yes, is it on one side of your head?

No Yes

Do you see an aura prior to your headache?

No Yes

Does your headache affect your vision?

No Yes

How many times per week do you have a headache?

_____

Authorizations

I authorize Dr. Michael DeCriscio to evaluate and provide me (or minor child) treatment.

Initials

_____

I authorize all payments of insurance benefits for services rendered to be made directly to Carolina Concussion & Physical Medicine, PLLC and/or Dr. Michael DeCriscio. I understand that many insurance companies do not cover all charges for specialized services and that I am responsible for and will pay for all charges prior to receiving such services.

Initials

_____

I authorize Carolina Concussion & Physical Medicine, PLLC to release any of my (or my minor child) medical information necessary to communicate with my physicians, other healthcare providers, insurance payers and if applicable, my attorney.

Initials

_____

I have the right to review the handout called Privacy Practices Notice at the clinic.

PLEASE LIST THE PERSON/PERSONS THAT MAY HAVE ACCESS TO YOUR MEDICAL RECORDS:

Name **Phone**

_____ _____

Name **Phone**

_____ _____

Name **Phone**

_____ _____

First Name **Middle Name / MI** **Last Name**

_____ _____ _____

Patient (or Parent/Guardian) Signature

Date

Dizziness Handicap Inventory (DHI)

P1. Does looking up increase your problem?

Yes Sometimes No

E2. Because of your problem, do you feel frustrated?

Yes Sometimes No

F3. Because of your problem, do you restrict your travel for business or recreation?

Yes Sometimes No

P4. Does walking down the aisle of a supermarket increase your problem?

Yes Sometimes No

F5. Because of your problem, do you have difficulty getting into or out of bed?

Yes Sometimes No

F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing, or to parties?

Yes Sometimes No

F7. Because of your problem, do you have difficulty reading?

Yes Sometimes No

P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?

Yes Sometimes No

E9. Because of your problem, are you afraid to leave your home without having someone accompany you?

Yes Sometimes No

E10. Because of your problem, have you been embarrassed in front of others?

Yes Sometimes No

P11. Do quick movements of your head increase your problem?

Yes Sometimes No

F12. Because of your problem, do you avoid heights?

Yes Sometimes No

P13. Does turning over in bed increase your problem?

Yes Sometimes No

F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?

Yes Sometimes No

E15. Because of your problem, are you afraid people may think that you are intoxicated?

Yes Sometimes No

F16. Because of your problem, is it difficult for you to go for a walk by yourself?

Yes Sometimes No

P17. Does walking down a sidewalk increase your problem?

Yes Sometimes No

E18. Because of your problem, is it difficult for you to concentrate?

Yes Sometimes No

F19. Because of your problem, is it difficult for you to walk around your house in the dark?

Yes Sometimes No

E20. Because of your problem, are you afraid to stay home alone?

Yes Sometimes No

E21. Because of your problem, do you feel handicapped?

Yes Sometimes No

E22. Has your problem placed stress on your relationship with members of your family or friends?

Yes Sometimes No

E23. Because of your problem, are you depressed?

Yes Sometimes No

F24. Does your problem interfere with your job or household responsibilities?

Yes Sometimes No

P25. Does bending over increase your problem?

Yes Sometimes No

Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. Arch Otolaryngol Head Neck Surg 1990;116: 424-427

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PRIVACY PRACTICES

I understand that a copy of Carolina Concussion & Physical Medicine, PLLC (CCPM) Privacy Policy is available at my request. If I would like a copy in the future, I may ask for one. I also understand that a copy of the Privacy Policy is available in the reception area.

I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

Parent or Legal Guardian Signature

Date

First Name **Middle Name / MI** **Last Name**