

INSTRUCTIONS: PLEASE FILL OUT ENTIRE QUESTIONNAIRE AND RETURN TO THE CHIARI INSTITUTE WITH A COPY OF YOUR INSURANCE CARDS VIA MAIL, FAX TO 516-570-4444, OR EMAIL TO TCI@NSHS.EDU.

PATIENT NAME: _____ HOME# _____

DATE OF BIRTH: _____ AGE: _____ WORK # _____

SSN: _____ CELL # _____

OCCUPATION: _____ E-MAIL: _____

ADDRESS: _____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE#: _____

PCP: _____ NEUROLOGIST: _____

PHONE: _____ PHONE: _____

ADDRESS: _____ ADDRESS: _____

DIAGNOSIS: _____

Primary Insurance: _____
Member Name: _____ Member ID: _____ DOB _____
Members SS#: _____ Members Employer: _____
Plan name: _____ Effective Date: _____
Phone number on the back of the card: _____
Type of Policy (PLEASE CIRCLE ONE): HMO / PPO / AID/POS / INDEM /Out of state AID/Commercial
What is the patient's co-pay to see a specialist? \$ _____
Does the patient have out of network benefits? YES NO
If yes, what are pts out-of-network costs?
\$ _____ deductible \$ _____ maximum out-of-pocket/ Patient is responsible for _____ % of charges
Is a referral needed for office consultation? <input type="checkbox"/> yes <input type="checkbox"/> no (if patient is using out-of-network benefits, no referral is necessary) NOTES:
YOU MUST ASK YOUR INSURANCE CARRIER WHETHER OR NOT YOU WILL BE UTILIZING THEIR OUT-OF-NETWORK BENEFITS FOR THE HOSPITAL CHARGES (RADIOLOGIC WORKUP or INPATIENT STAY). IF THIS IS SO, YOUR INSURANCE COMPANY MAY HOLD YOU RESPONSIBLE FOR CO-INSURANCE AND DEDUCTIBLES. PATIENTS SHOULD BE ADVISED TO INSIST THAT THESE SERVICES BE COVERED AT AN IN-NETWORK RATE.
** PLEASE INCLUDE A COPY OF ALL INSURANCE CARDS WITH QUESTIONNAIRE.
Secondary Insurance: _____
Member Name: _____ Member ID: _____ DOB _____
Members SS#: _____ Members Employer: _____
Plan name: _____ Effective Date: _____
Phone number on the back of the card: _____
Type of Policy (PLEASE CIRCLE ONE): HMO / PPO / AID/POS / INDEM /Out of State AID/Commercial
Is a referral needed for office consultation? <input type="checkbox"/> yes <input type="checkbox"/> no

Has the patient had prior neurosurgery? YES NO When: _____

Neurosurgeon: _____ Patient Ht _____ Wt _____

Will the patient need sedation with testing? YES NO

Is the patient pregnant? YES NO



THE CHIARI INSTITUTE
SYMPTOM QUESTIONNAIRE

Name: _____

Date of birth: ___/___/___

Date: _____ Page 2

Your Phone #: _____

Self report of symptoms: please check any symptoms you have had as a result of your disease

HEADACHES	YES	NO
Do you have pain/pressure at the base of your head?		
Does your pain radiate behind your eyes?		
Does your pain radiate to your neck or shoulders?		
Is it worsened by coughing/sneezing/bowel movements?		
Do you have general neck pain/stiffness?		
Women: Is your headache worsened by menses?		
OCULAR DISTURBANCES		
Do you have pain or pressure behind your eyes?		
Are you sensitive to light?		
Do you have blurred vision?		
Do you have double vision?		
Are you missing a portion of your visual field when looking straight ahead (Field Cuts)?		
OTONEUROLOGIC DISTURBANCES		
Do you have pressure in your ears?		
Do you have dizziness with position changes?		
Do you have feelings of unsteadiness when standing?		
Do you have feelings of unsteadiness when walking?		
Do you have high-pitched ringing in your ears?		
Do you have tremors?		
Do you have decreased hearing?		
Do you have very sensitive hearing?		
Do you have vertigo (feelings that you or the room are spinning)?		
CRANIAL NERVE/BRAIN STEM SYMPTOMS		
Do you have difficulty swallowing?		
Do you have throat tightness?		
Do you have difficulty speaking?		
Is your voice changing, becoming hoarse?		
Do you have sleep apnea?		
Do you snore?		
Have you ever "passed out"?		
Do you have palpitations?		
Do you ever have shortness of breath?		

CRANIAL NERVE/BRAIN STEM SYMPTOMS	YES	NO
EXTRACRANIAL DISTURBANCES		
Do you suffer from prickling, tingling or numbness of your extremities?		
Do you have increased sensitivity to pain or touch?		
Do you have diminished sensitivity to pain?		
Do you have partial or complete loss of sensation in your extremities?		
Do you have an abnormal burning pain in your extremities?		
Do you have pain or decreased sensation over a specific portion of your extremities?		
Do you have any noticeable skin changes?		
If you close your eyes, do you have difficulty determining your foot positioning?		
Do you have weakness of your extremities?		
Do you have loss of muscle tone?		
Do you have difficulty picking up small objects with your fingers?		
Do you have stiffness of your arms or legs?		
Bladder Function		
Do you have the urge to urinate?		
Do you have difficulty initiating your urine stream?		
Do you have difficulty controlling your urine (incontinence)?		
Other:		
Bowel Function		
Do you have constipation?		
Do you suffer from diarrhea?		
Do you have difficulty controlling your bowels?		
Other:		
Sexual Function		
Do you have decreased interest in sexual relations?		
Do you have difficulty maintaining arousal?		
Do you have difficulty obtaining orgasm?		
Do you have decreased sensation in your pelvic area?		
Other:		
Systemic Symptoms		
Do you suffer from chronic fatigue?		
Do you suffer from short-term memory loss?		
Do you suffer from long-term memory loss?		
Do you suffer from depression?		
Do you suffer from irritability?		
Do you have nipple discharge?		
Do you have joint hypermobility?		
Do you have wound healing problems		
Women: Do you have irregular periods?		



THE CHIARI INSTITUTE
SYMPTOM QUESTIONNAIRE

Name: _____

Date of birth: ___/___/___

Date: _____ Page 3

Please complete the following information about recent tests and consultations.

NEUROLOGIC TESTS	YES	NO	DATE (MONTH/YEAR)
MRI Brain			
Cine MRI (CSF flow study)			
MRI Cervical Spine			
MRI Thoracic Spine			
MRI Lumbar Spine			
CT Head			
CT Cervical Spine			
CT Thoracic Spine			
CT Lumbar Spine			
CT Myelogram			
X-ray Skull			
X-ray shunt series			
X-ray Cervical Spine			
X-ray Thoracic Spine			
X-ray Lumbar Spine			
PET Scan: Brain			
Lumbar Puncture			
Stellate Ganglion Block			
Other:			

TESTS (CONTINUED)	YES	NO	DATE (MONTH/YEAR)
Miscellaneous Tests	xxx	xxx	XXXXXXXXXXXXXX
Vestibular Function Testing			
Tilt Table			
Holter Monitor			
Barium Swallow			
Sleep Apnea Monitoring			
Sleep EEG Monitoring			
Pulmonary Function Tests			
Other:			
Laboratory	xxx	xxx	XXXXXXXXXXXXXX
Pituitary Hormone Profile			
Lyme Titer			
Rheumatology Panel			
Other:			
Consultations	xxx	xxx	XXXXXXXXXXXXXX
Pain Management			
Neurology			
Neuropsychology			
Cardiology			
Rheumatology			
Allergist			
ENT/Otolaryngology			
Other:			

KARNOFSKY SCALE: Please check the statement that <u>best</u> describes your current level of functioning. Please choose only one.	Your Answer	Score (For office use)
I feel normal: No complaints, no evidence of disease.		100
I am able to carry on normal activity with minor symptoms.		90
I carry on normal activity with effort and some symptoms.		80
I am able to care for myself, but unable to carry on normal activities.		70
I require occasional assistance but can care for most of my needs.		60
I require considerable assistance and frequent care by others.		50
I am disabled. I require considerable assistance and frequent care by others.		40
I am severely disabled. I am hospitalized, but death is not imminent		30
I am very sick. I require active supportive care by others.		20
I have fatal processes that are rapidly progressing. I am near death		10

