NEUROVERSION
Break the cycle of pain

New Patient Medical Summary
Long Covid (LHC), Chronic Fatigue Syndrome (ME/CFS)

Name: ______________________ DOB: ____________

Chief complaint(s), select all the apply: ☐ Long-Covid symptoms ☐ Chronic Fatigue Syndrome

Did your symptoms begin after: ☐ Covid diagnosis ☐ Covid vaccine ☐ Unsure

IF diagnosed with Covid, what was the date? Please provide multiple dates if applicable:

Date: __________ Date: __________ Date: __________ Date: __________

IF vaccinated for Covid, which vaccine(s) and approximate date(s): ☐ I have NOT been vaccinated for Covid

	☐ Pfizer	☐ Moderna	☐ Johnson & Johnson	☐ Other:
Date of 1st injection:				
Date of 2nd injection:				
Date of 1st booster:				
Date of 2nd booster:				
Date of 3rd booster:				
Date of 4th booster:				

When did your symptoms begin: ______________________

What medications have you *tried*? If you run out of room, please provide a separate list.

Medication Name	Side Effects (if any)	Effectiveness
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved

What non-pharmacologic approaches have you tried or currently trying? Complete following:

Therapy Type	Date(s) Tried (if known)	Effectiveness
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved
		☐ Worse ☐ No change ☐ Improved

What specialists have you seen for your *current* condition, please provide their names if known:

Specialty	Provider Name and/or Facility	Date of Last Visit/Consultation (if known)

Were you hospitalized? ☐ Yes ☐ No If Yes, location and approximate dates: ______________________

Did you have any labs/tests completed? ☐ Yes ☐ No If Yes, location: ______________________

GAD-7

Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it is hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid, as if something awful might happen	☐	☐	☐	☐

If you checked off any problems above, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficulty

The following questions are about your sleep:

Do you have trouble falling asleep or staying asleep?
☐ Yes, falling asleep ☐ Yes, staying asleep ☐ No

When in bed, do you experience uncomfortable sensations in your arms or legs? ☐ Yes ☐ No

If yes, do the sensations go away if you move your legs? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Have you been evaluated or treated for snoring? ☐ Yes ☐ No

If YES, how/when: ______________________

What time do you generally go to sleep at night? ______________________

How long does it take you to fall asleep? ______________________

Do you sleep during the day/take naps? ☐ Yes ☐ No

If YES, how often, how long and what time(s): ______________________

PCFS A.

Can you live alone without any assistance from another person?	☐ Yes	☐ No
Are there duties/activities at home or at work which you are no longer able to perform yourself?	☐ Yes	☐ No
Do you suffer from symptoms, pain, depression or anxiety?	☐ Yes	☐ No
Do you need to avoid or reduce duties/activities or spread these over time?	☐ Yes	☐ No

PCFS B.

How much are you currently affected in your everyday life by COVID-19?

Please indicate which one of the following statements applies to you.

- ☐ I have no limitations in my every life and no symptoms, pain, depression or anxiety related to the infection.
- ☐ I have negligible limitations in my everyday life as I can perform all usual duties/activities, although I still have persistent symptoms, pain, depression or anxiety.
- ☐ I suffer from limitations in my everyday life as I occasionally need to avoid or reduce usual duties/activities or need to spread these over time due to symptoms, pain, depression or anxiety. I am, however, able to perform all activities without any assistance.
- ☐ I suffer from limitations in my everyday life as I am not able to perform all usual duties/activities due to symptoms, pain, depressions or anxiety. I am, however able to take care of myself without any assistance.
- ☐ I suffer from severe limitations in my everyday life: I am not able to take care of myself and therefore I am dependent on nursing care and/or assistance from another person due to symptoms, pain, depression or anxiety.

PROMIS

Over the last 7 days…	Never	Rarely	Sometimes	Often	Always
How often did you feel tired?	☐	☐	☐	☐	☐
How often did you experience extreme exhaustion?	☐	☐	☐	☐	☐
How often did you run out of energy?	☐	☐	☐	☐	☐
How often did your fatigue limit you at work (include work at home)?	☐	☐	☐	☐	☐
How often were you too tired to think clearly?	☐	☐	☐	☐	☐
How often were you too tired to take a bath or shower?	☐	☐	☐	☐	☐
How often did you have enough energy to exercise strenuously?	☐	☐	☐	☐	☐

Review the following symptoms, rating them on a scale of 0 to 10. 0 – did not have any symptoms, 10 – most severe. The 1st column are symptoms you had before your Covid diagnosis and/or vaccine and the 2nd column are symptoms you had/currently have after Covid diagnosis and/or vaccine. This continues to next page.

Symptom description:	Pre-Covid/vaccine:	Post-Covid/vaccine:
Abdominal pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Acid reflex	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Altered menstrual cycle (leave blank if N/A)	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Anxiety	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Bloating	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Body vibrations	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Chest pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Constipation	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Depression	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Diarrhea	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Difficulty breathing	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Difficulty swallowing	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Dizziness when standing	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Extremity pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Extremity stiffness	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Extremity swelling	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Extremity temperature changes	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Facial pain	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Fast heartrate/pounding heartbeat	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Fatigue	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Fever	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Hair loss	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Headache	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Loss/change of smell	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Loss/change of taste	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Memory problems	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Muscle spasms	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Problems concentrating	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Rash	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Sleep problems	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Tinnitus	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Tremor	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Vision changes	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Worsened symptoms after mental activities	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10
Worsened symptoms after physical activity	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

To the fullest of my knowledge, I have accurately and truthfully completed my health history.

Signature: ______________________________ Date: ____________