NEUROVERSION
Break the cycle of pain

New Patient Medical Summary
PTSD

Name: _____ DOB: _____

Chief complaint(s): _____

When did your symptoms begin? Date: _____ **OR** _____ DAYS _____ MONTHS _____ YEARS

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
		□ Worse □ No change □ Improved

Does your *current* medication regimen provide improvement of daily activities/function? □ Yes □ No
If YES, please list activities/functions you are able to perform with your *current* medication regimen:

Have you had issues with medication regimen compliance? □ Yes □ No

If YES, please explain why: _____

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
		□ 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)

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): _____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

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

Signature: _____ Date: _____