Chiari Neurosurgical Center

at NSPC

Established Patient Form

INSTRUCTIONS

Download this form on your computer.

Type in your answers in the form.

Check the appropriate boxes when indicated.

Some questions are asked more than once.

Save the form in a file on your computer hard drive.

The file has to remain in the original WORD for Windows format.

Transmit the saved file to our Center via email to ipendergast@nspc.com

If the file arrives in different format other than WORD for Windows, or it is incompletely filled, or it is hand-written, it will not be accepted, and you will be requested to restart the process, thus resulting in a delay in the evaluation and screening of your case.

**Last Name:**

**First Name:**

**DOB:**

**Height:**

**Weight:**

**Today’s date:**

**What are your top three Chief Complaints, in decreasing order of importance:**

1.

2.

3.

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **CERVICO MEDULLARY SYNDROME** | **Yes** | **No** |
|  |  |  |
| **Headaches** |  |  |
| Do you have a pressure headache? |  |  |
| Is your headache localized in the back of the head? |  |  |
| Is the headache aggravated by coughing and straining? |  |  |
| Does the pain radiate to neck and/or shoulders? |  |  |
| Do you have pain or pressure behind the eyes? |  |  |
|  |  |  |
| **Signs and symptoms of Brainstem and Lower Cranial Nerve compromise** |  |  |
| Do you have problems swallowing? |  |  |
| Do you have problems swallowing liquids? |  |  |
| Do you have problems swallowing solids? |  |  |
| Do you feel a lump in the back of your throat? |  |  |
| Do you feel pain in the back of your throat? |  |  |
| Do you have palpitations? |  |  |
| Do you pass out? |  |  |
| Do you “almost pass out”? |  |  |
| Do you have sleep apnea? |  |  |
| Do you use a CPAP or BiPAP machine at night? |  |  |
| Do you snore? |  |  |
| Do you gasp for air during your sleep? |  |  |
| Are you short of breath? |  |  |
| Do you have severe nausea? |  |  |
| Are you getting hoarse? |  |  |
|  |  |  |
| **Vision and eyes motion** |  |  |
| Are you sensitive to light? |  |  |
| Do you often change prescriptions for your glasses?  |  |  |
| Do you see double? |  |  |
| Do you see blurred? |  |  |
| Do you see floaters? |  |  |
| Do you have nystagmus? |  |  |
| Do staring at patterns on the floor make you dizzy? |  |  |
|  |  |  |
| **Hearing and equilibrium** |  |  |
| Do you feel pressure deep inside your ears? |  |  |
| Does changing position make you dizzy? |  |  |
| Do you feel unsteady while standing still? |  |  |
| Do you feel unsteady while walking? |  |  |
| Do you have disequilibrium? |  |  |
| Do you have a ringing in your ears? |  |  |
| Do you have decreased hearing? |  |  |
| Do you have decreased hearing for high pitch sounds? |  |  |
| Do loud sounds bother you? |  |  |
| Do you have vertigo (= feeling that room is spinning)? |  |  |
|  |  |  |
| **Cerebellar function** |  |  |
| Do you have tremors when you try to pick something up? |  |  |
| Do you have problems with motor coordination? |  |  |
| Are you klutzy? |  |  |
|  |  |  |
| **High cortical functions** |  |  |
| Do you have problems retaining short term memories? |  |  |
| Do you have problems with concentration? |  |  |
| Do you have problems multitasking? |  |  |
| Are you failing or losing ground in school? |  |  |
| Are you failing or losing ground at work? |  |  |
| Do you have problems in finding words? |  |  |
| Do you have long term memory loss? |  |  |
|  |  |  |
| **Behavior** |  |  |
| Do you have Attention Deficit Disorder? |  |  |
| Do you have Attention Deficit Hyperactivity Disorder? |  |  |
| Do you have Obsessive Compulsive Disorder? |  |  |
| Do you have Depression? |  |  |
| Do you have Anxiety? |  |  |
| Are you irritable? |  |  |
| Do you have Bipolar Disorder? |  |  |
| Do you have Asperger syndrome? |  |  |
| Do you have Autism? |  |  |
| Did you ever consider suicide? |  |  |
| Did you ever attempt suicide? |  |  |
|  |  |  |
| **Sensory and Pain** |  |  |
| Do you have areas of your body with no sensation? |  |  |
| Do you have areas of your body with decreased sensation? |  |  |
| Do you have areas of your body with increased sensation? |  |  |
| Do you have area of your body with abnormal and weird sensation? |  |  |
| Do you have tingling anywhere in your body? |  |  |
| Do you have burning pain anywhere in your body? |  |  |
| Do you have stabbing pain anywhere in your body? |  |  |
| Do you have problems figuring out the temperature of objects and water using your skin? |  |  |
| Do you have problems figuring out where your body parts are in space? |  |  |
| Do you have facial pain? |  |  |
| Do you have facial numbness? |  |  |
| Is your pain so intense that you considered suicide in the past? |  |  |
|  |  |  |
| **Motor** |  |  |
| Do you have focal weakness? |  |  |
| Do you have generalized weakness? |  |  |
| Do you have tremors? |  |  |
| Do you have muscle spasm? |  |  |
| Are your legs stiff? |  |  |
| Do you have a diagnosis of Parkinson disease? |  |  |
| Do you have seizures? |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **INTRACRANIAL PRESSURE** | **Yes** | **No** |
|  |  |  |
| **Intracranial HYPERtension** |  |  |
| Do you have a pressure headache? |  |  |
| Does the pressure headache involves most of your head? |  |  |
| Do you feel like the pressure is pushing your eyes out of their sockets?  |  |  |
| Does straining and exercise make the pressure headache worse? |  |  |
| Is your pressure headache worse in the morning? |  |  |
| Do you sleep with the head elevated, or with more than one pillow, or in a recliner? |  |  |
|  |  |  |
| Did you get a Lumbar Puncture, or multiple Lumbar Punctures? |  |  |
| Did you get an MRV? |  |  |
| Did you get a Cerebral Venogram? |  |  |
|  |  |  |
| Have you been diagnosed with Elevated CSF pressure, Idiopathic Intracranial Hypertension, or Pseudotumor? |  |  |
| Did you get a venous stent in the brain or in the neck? |  |  |
| Did you get a VP Shunt? |  |  |
| Did you get a Lumbar Shunt? |  |  |
|  |  |  |
| **Intracranial HYPOtension** |  |  |
| Do you have a headache localized on the top of your head? |  |  |
| Do you have a headache localized behind your eyes, which feels like they are getting sucked inside their sockets? |  |  |
| Does standing make the headache worse? |  |  |
| Does the headache feel like your brain is getting sucked downwards? |  |  |
| Is your headache worse in the evening? |  |  |
| Is your headache relieved by being completely flat while supine? |  |  |
| Do you sleep as flat in bed as possible? |  |  |
| Does your headache feel a bit better while straining? |  |  |
| Do you have constant and intense nausea? |  |  |
|  |  |  |
| Did you get a Lumbar Puncture, or multiple Lumbar Punctures? |  |  |
| Did you get an MR Myelogram? |  |  |
| Did you get a CT Myelogram? |  |  |
| Did you undergo an ICP monitoring? |  |  |
|  |  |  |
| Have you been diagnosed with a Tarlov’s Cyst or a Perineural Cyst? |  |  |
| Have you been diagnosed with a CSF leak? |  |  |
| Have you been diagnosed with Intracranial HYPOtension? |  |  |
| Have you been diagnosed with both Intracranial HYPERtension and Intracranial HYPOtension at different times of your life? |  |  |
|  |  |  |
| Did you get one or more blood or glue patches? |  |  |
| Have you been operated for a CSF leak? |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **CONNECTIVE TISSUE DISORDERS** | **Yes** | **No** |
|  |  |  |
| **Connective Tissue Disorders** |  |  |
| Do you have joint hypermobility? (= Are you double-jointed?) |  |  |
| Do you have a family history of double jointedness?  |  |  |
| Do you have wound healing problems? |  |  |
| Are your scars thin and wide? |  |  |
| Do you bruise easily? |  |  |
| Did you suffer a number of traumatic joint dislocations? |  |  |
| Do you dislocate some of your joints at will? |  |  |
| Did you have congenital hip dislocation?  |  |  |
| Do you have problems with your dental enamel (= the coating of your teeth)? |  |  |
| Do you have herniated disk? |  |  |
| Do you have intestinal hernias, or bladder prolapses, or rectal prolapses? |  |  |
| Do you have any of the following features of EDS/Vascular type? Translucent skin; arterial/intestinal/uterine fragility or rupture; tendon and muscle rupture; clubfoot; premature aging of the skin of the hands and feet; early onset varicose veins; arteriovenous fistulae; carotid-cavernous fistula; pneumothorax (collapse of a lung); pneumohemothorax (collapse of a lung with a collection of air or gas and blood); gingival recession. |  |  |
| Do you have Mitral Valve Prolapse? |  |  |
| Do you have Mitral Valve Insufficiency? |  |  |
| Have you been diagnosed with EDS (Ehlers-Danlos Syndrome)? |  |  |
| Have you been diagnosed with Marfan syndrome? |  |  |
| Have you been diagnosed with Stickler syndrome? |  |  |
| Have you been diagnosed with Loys-Dietz syndrome? |  |  |
| Have you been diagnosed with a mix of 2 or more of the above syndromes? |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **TETHERED CORD SCREEN** | **Yes** | **No** |
| **Bladder function** |  |  |
| Do you have urinary urgency?  |  |  |
| Do you urinate less than 3 times per day? |  |  |
| Do you urinate more than 6 times per day?  |  |  |
| Do you urinate more than 12 times per day? |  |  |
| Do you have urinary incontinence?  |  |  |
| If incontinent, do you lose a small amount of urine at a time? |  |  |
| If incontinent, do you lose a large amount of urine at a time? |  |  |
| Do you have problems starting your urinary stream?  |  |  |
| Do you have difficulty emptying your bladder completely?  |  |  |
| Do you awaken from sleep to urinate during the night?  |  |  |
| Do you have a history of urinary tract infections?  |  |  |
| Have you been diagnosed with neurogenic bladder?  |  |  |
| Have you had urodynamic testing? |  |  |
| Have you had urological surgery? |  |  |
|  |  |  |
| **Sexual functions** |  |  |
| Do you have decreased interest in sex? |  |  |
| Do you have difficulty in maintaining arousal? |  |  |
| Do you have difficulty obtaining orgasm? |  |  |
| Do you have decreased sensation in your pelvic area? |  |  |
| (Male) Do you have erectile dysfunction? |  |  |
|  |  |  |
| **TC miscellaneous** |  |  |
| Do you have low back pain?  |  |  |
| Do you have pain in your legs?  |  |  |
| Do you have numbness in your legs? |  |  |
| Do you have restless leg syndrome?  |  |  |
| Do you have numbness under the soles of your feet?  |  |  |
| Do you keep your knees bent at night to relieve back or leg discomfort?  |  |  |
| Do you have low back pain, leg pain, or urinary symptoms while walking upstairs?  |  |  |
| Do you have a history of severe growing pains during childhood and adolescence?  |  |  |
| Were you a toe-walker as a child? |  |  |
| Do you have a pulling sensation up and down the spine? |  |  |
| Do you have a birthmark, or a hole in the skin, or a tuft of hair in the lumbar area (above, but not within, the “butt crack”)? |  |  |
| Do you have fecal incontinence? |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **STING SCREEN** | **Yes** | **No** |
|  |  |  |
| **Symptoms linked to the Glossopharyngeal Nerve** |  |  |
| Salivation problems (too much, too little, abnormal consistency) |  |  |
| Hearing problems (tinnitus, decreased hearing, painful hearing) |  |  |
| Ear numbness |  |  |
| Pain inside the ear |  |  |
| Heart rate problems (palpitations, tachycardia, tachyarrhythmias)  |  |  |
| Abnormal Blood Pressure (too high, too low, irregular, unstable) |  |  |
| Dysphagia for solids |  |  |
| Dysphagia for liquids |  |  |
| Pain during swallowing |  |  |
| Pain inside the mouth (constant, dull) |  |  |
| Pain inside the mouth (like an electric shock) |  |  |
| Foreign body sensation inside the mouth |  |  |
| Pain radiated behind the ear and the mastoid |  |  |
| Numb throat |  |  |
| Decreased or absent gag reflex |  |  |
| Nausea |  |  |
| Shortness of breath |  |  |
| Frequent coughing |  |  |
| Abnormal taste |  |  |
| Loss of bitter and/or sour taste |  |  |
| Deep abdominal pain |  |  |
|  |  |  |
| **Other Cranial Nerve related symptoms** |  |  |
| Speech problems |  |  |
| Tongue weakness |  |  |
| Abnormal sweating |  |  |
| Facial pain |  |  |
| Moodiness, emotional disturbances |  |  |
| Syncope |  |  |
| POTS (Postural Orthostatic Tachycardia Syndrome) |  |  |
| Dysautonomia |  |  |
| IBS (Irritable Bowel Syndrome) |  |  |
|  |  |  |
| **Comorbidities** |  |  |
| Former diagnosis of Ehlers-Danlos Syndrome or other connective tissue disorder |  |  |
| Diagnosis of Gastroparesis, or decreased gastric motility |  |  |
| Diagnosis of decreased instestinal motility |  |  |
| Diagnosis of severe constipation |  |  |
| Diagnosis of Pseudo-Seizures |  |  |
| Diagnosis of Seizures (with positive EEG) |  |  |
|  |  |  |
| **Past Surgical History** |  |  |
| Past oral tonsillectomy |  |  |
| Past dental extractions of molars |  |  |
| Former resection of one or more styloid processes, partial or total |  |  |
| Past Decompressive surgery for Chiari I Malformation  |  |  |
| Past Craniocervical Fusion surgery for Craniocervical Instability |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

**ME/CFS is relapsing-remitting for many patients, and patients observe that their symptom-picture changes over time. If a patient is unsure as to whether they should reply in the affirmative, ask them if they consider their experience of the symptom significant to their disease, not whether they are experiencing the symptom right now or in the recent past.**

|  |  |  |
| --- | --- | --- |
| **ME/CFS SYMPTOMS QUESTIONNAIRE** | **Yes** | **No** |
|  |  |  |
| **Section 1** |  |  |
| Fatigue |  |  |
| Sleep dysfunction (e.g. unrefreshing sleep, wakefulness at night and sleepiness during the day)  |  |  |
| Pain (muscles, joints, head or neck pain, headaches of new type or increased severity, e.g.)  |  |  |
| PEM (post-exertional malaise; a distinct worsening of symptoms after mental or physical exertion) |  |  |
| I have experienced these (four) symptoms for six months or more  |  |  |
|  |  |  |
| **Section 2** |  |  |
| Confusion  |  |  |
| Difficulty concentrating and / or issues with short-term memory |  |  |
| Disorientation  |  |  |
| Difficulty with information-processing / word retrieval |  |  |
| Spatial instability and disorientation |  |  |
| Inability to focus vision |  |  |
| Ataxia, muscle weakness, or fasciculations |  |  |
| Hypersensitivity to noise, photophobia, or ‘emotional overload’ / anxiety |  |  |
|  |  |  |
| **Section 3** |  |  |
| Hard to maintain your temperature (easy to get too hot or too cold) – (1) |  |  |
| Body temperature generally runs low – (1) |  |  |
| Temperature is noticeably different in morning versus evening - (1) |  |  |
| Sweating episodes - (1) |  |  |
| Recurrent feelings of feverishness with cold extremities - (1) |  |  |
| Gained or lost a significant amount of body weight - (1) |  |  |
| Abnormal appetite - (1) |  |  |
| Worsening of symptoms with stress - (1) |  |  |
| Orthostatic intolerance (POTS, NMH, DPH) - (2) |  |  |
| Light-headedness - (2) |  |  |
| Extreme pallor - (2) |  |  |
| Nausea & IBS - (2) |  |  |
| Urinary frequency & bladder dysfunction - (2) |  |  |
| Heart palpitations with or without cardiac arrhythmia - (2) |  |  |
| Shortness of breath on exertion - (2) |  |  |
| Tender lymph nodes - (3) |  |  |
| Recurrent sore throat - (3) |  |  |
| Recurrent flu-like symptoms - (3) |  |  |
| General malaise - (3) |  |  |
| New sensitivities to food, medication, and/or chemicals – (3) |  |  |
|  |  |  |
| **Section 4** |  |  |
| Impaired memory/concentration  |  |  |
| Sore throat |  |  |
| Tender cervical or axillary lymph nodes |  |  |
| Muscle pain |  |  |
| Multi-joint pain  |  |  |
| New headaches |  |  |
|  Post-exertional malaise |  |  |
| Unrefreshing sleep |  |  |
|  |  |  |
| **How was the onset of your ME/CFS** |  |  |
| Sudden |  |  |
| Gradual |  |  |
| Both |  |  |
|  |  |  |
| **When did your ME/CFS condition start?** |  |  |
| After a Viral Infection |  |  |
| After a Bacterial Infection |  |  |
| After an Unknown/Undiagnosed Infection |  |  |
| After an Allergic Reaction (mold, chemicals, drugs, etc.) |  |  |
| After a Trauma |  |  |
| After a Pregnancy |  |  |
| After a Surgery |  |  |
| A different trigger (specify) |  |  |
| No identifiable trigger |  |  |
|  |  |  |
|  |  |  |
| **SCORING (this section is to be filled by our Physicians)** | **Here** | **Min** |
| Section 1  |  | **5** |
| Section 2 |  | **2** |
| Section 3 – WHITE (1) |  | **1** |
| Section 3 – LIGHT BLUE (2) |  | **1** |
| Section 3 – ORANGE (3) |  | **1** |
| Section 4 |  | **4+1Y** |
|  |  |  |
| **CRITERIA MET (this section is to be filled by our Physicians)** | **Yes** | **No** |
|  |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **HORMONES AND AUTONOMIC NERVOUS SYSTEM** | **Yes** | **No** |
|  |  |  |
| **Hormones** |  |  |
| Do you have problems with finding a comfortable temperature? |  |  |
| Do you always feel cold? |  |  |
| Do you always feel hot? |  |  |
| Do you have hypothyroidism? |  |  |
| (Female) Do you have problems with your periods? |  |  |
| (Female) Did you have problems getting pregnant? |  |  |
| (Male) Do you have low testosterone levels?  |  |  |
| Do you have low cortisol level? |  |  |
| Do you have Hashimoto disease? |  |  |
| Do you have nipple discharges? |  |  |
|  |  |  |
| **Cardiovascular** |  |  |
| Do you have POTS (Postural Orthostatic Tachycardia Syndrome)? |  |  |
| Do you have arrhythmias? |  |  |
| Have you been diagnosed with Dysautonomia? |  |  |
| Do you have a diagnosis of SVT (Supra Ventricular Tachycardia)? |  |  |
| Do you have coronary artery disease? |  |  |
| Do you have defective cardiac valves? |  |  |
| Do you have Mitral Valve Prolapse? |  |  |
|  |  |  |
| **Gastrointestinal and Bowel function** |  |  |
| Do you have occasional incontinence for stools?  |  |  |
| Do you have Irritable Bowel Syndrome? |  |  |
| Do you have diarrhea? |  |  |
| Do you have gastroparesis? |  |  |
| Do you have decreased gastrointestinal motility? |  |  |
| Do you have gastric reflux? |  |  |
| Do you vomit often? |  |  |
| Do you have Small intestinal bacterial overgrowth (SIBO)? |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **OTHER QUESTIONS** | **Yes** | **No** |
|  |  |  |
| **Metabolic and systemic disorders** |  |  |
| Do you have a Mast Cell disease (MCAD/MCAS)? |  |  |
| Do you have MITO (= a Mitochondrial Disorder)? |  |  |
| Do you have other enzymatic defects? |  |  |
| Do you have diabetes? |  |  |
| Have you been diagnosed with PANDAS? |  |  |
| Do you have drug allergies? |  |  |
| Do you have food allergies? |  |  |
| Do you have food intolerances? |  |  |
| Do you have gluten intolerance? |  |  |
| Are you allergic to latex? |  |  |
| Do you have environmental allergies? |  |  |
| Do you have osteopenia? |  |  |
| Do you have osteoporosis? |  |  |
| Do you have frequent infections? |  |  |
| Have you been diagnosed with Lyme disease? |  |  |
| Have you been suspected with MS (Multiple Sclerosis) in the past? |  |  |
| Have been formally diagnosed with MS? |  |  |
| Do you have lupus? |  |  |
| Do you have generalized pain? |  |  |
| Do you have a low pain threshold? |  |  |
| Do you have a formal diagnosis of Fibromyalgia? |  |  |
| Are you chronically on pain medications? |  |  |
| Are you constantly tired? |  |  |
| Do you have a restorative sleep at night? |  |  |
| Do you have a formal diagnosis of Chronic Fatigue? |  |  |
| Did you suffer from being exposed to Mold? |  |  |
| Have you contracted a tropical disease while abroad? |  |  |
| Have you contracted an unusual disease (like Rocky Mountain Spotted Fever or else)? |  |  |
|  |  |  |
| **Traumas** |  |  |
| Have you been involved in any severe motor vehicular accident? |  |  |
| Have you been the victim of a severe head and/or neck injury? |  |  |
| Did you suffer any severe whiplash injury? |  |  |
| Were you made worse by harsh manipulations by chiropractors or in PT? |  |  |
| Did you get worse after a Lumbar Puncture or an Epidural? |  |  |
| Did you get worse after delivery? |  |  |
| Do you have a past history of meningitis? |  |  |
|  |  |  |
| **Skin** |  |  |
| Do you have skin ulcers (= open sores)? |  |  |
| Do you have rashes? |  |  |
| Do you have areas of your skin which are discolored? |  |  |
| Do you have areas of your skin with reduced or no sweating? |  |  |
| Do you have areas of your skin with increased or excessive sweating? |  |  |
|  |  |  |
| **Miscellaneous** |  |  |
| Do you have a history of cancer? |  |  |
| Do you have a history of stroke? |  |  |
| Do you have nose bleeds? |  |  |
| Do you have a history of rheumatic fever? |  |  |
| Do you have angina? |  |  |
| Do you have high blood pressure? |  |  |
| Do you have low blood pressure? |  |  |
| Does your skin have a bluish hue? |  |  |
| Do you have an enlarged heart? |  |  |
| Do you have difficulty breathing at night? |  |  |
| Do you have a history of tuberculosis? |  |  |
| Do you have asthma? |  |  |
| Do you have hiccups? |  |  |
| Do you have chronic cough? |  |  |
| Do you cough a lot of phlegm? |  |  |
| Do you spit/cough blood? |  |  |
| Do you have gastric ulcers? |  |  |
| Do you vomit blood? |  |  |
| Do you have hemorrhoids? |  |  |
| Do you have a history of gallbladder stones? |  |  |
| Do you have a history of hepatitis or cirrhosis? |  |  |
| Do you have a history of kidney stones? |  |  |
| Do you urinate blood? |  |  |
| Do you have gout? |  |  |
| Do you have arthritis? |  |  |
| Do you have a history of leukemia or lymphoma? |  |  |
| Are you anemic? |  |  |
| Do you have psoriasis? |  |  |
| Do you have sexual transmitted diseases? |  |  |
| Do you have a bleeding disorder? |  |  |
| Do you have a blood clotting disorder? |  |  |
| Did you contract an infectious disease in a foreign country? |  |  |
| Did you receive transfusions in the past? |  |  |
| Were you breastfed as a baby? |  |  |
|  |  |  |
| **Implants** |  |  |
| Do you have a pacemaker? |  |  |
| Do you have a defibrillator |  |  |
| Do you have a neurostimulator? |  |  |
|  |  |  |

Please answer the questions by typing “X” in the appropriate column

|  |  |  |
| --- | --- | --- |
| **PAIN and QUALITY OF LIFE** | **Yes** | **No** |
|  |  |  |
| **Mankoski Pain Scale** |  |  |
| No pain. No medication needed. (MS 0) |  |  |
| Very minor annoyance. Occasional minor twinges. No medication needed. (MS 1) |  |  |
| Minor Annoyance. Occasional strong twinges. No medication needed. (MS 2) |  |  |
| Annoying enough to be distracting. Mild painkillers are effective (Aspirin, Ibuprofen, Tylenol). (MS 3) |  |  |
| Can be ignored if you are really involved in your work, but still distracting. Mild painkillers remove pain for 3-4 hours. (MS 4) |  |  |
| Can't be ignored for more than 30 minutes. Mild painkillers reduce pain for 3-4 hours. (MS 5) |  |  |
| Can't be ignored for any length of time, but you can still go to work and participate in social activities. Stronger painkillers (Codeine, Vicodin) reduce pain for 3-4 hours. (MS 6) |  |  |
| Makes it difficult to concentrate, interferes with sleep. You can still function with effort. Stronger painkillers are only partially effective. Stronger painkillers relieve pain (Oxycontin, Morphine). (MS 7) |  |  |
| Physical activity severely limited. You can read and converse with effort. Nausea and dizziness set in as factors of pain. Stronger painkillers are minimally effective. Stronger painkillers reduce pain for 3-4 hours (Oxycontin, Morphine). (MS 8) |  |  |
| Unable to speak. Crying out or moaning uncontrollably near delirium. Stronger painkillers are only partially effective. (MS 9) |  |  |
| Unconscious. Pain makes you pass out. Stronger painkillers are only partially effective. (MS 10) |  |  |
|  |  |  |
| **Modified Karnofsky Score** |  |  |
| I feel normal: No complaints, no evidence of disease. (KS 100) |  |  |
| I am able to carry on normal activity with minor symptoms. (KS 90) |  |  |
| I carry on normal activity with effort and some symptoms. (KS 80) |  |  |
| I am able to care for myself, but unable to carry on normal activities. (KS 70) |  |  |
| I require occasional assistance but can care for most of my needs. (KS 60) |  |  |
| I require considerable assistance and frequent care by others. (KS 50) |  |  |
| I am disabled and require assistance and frequent care by others. (KS 40) |  |  |
| I am severely disabled. I am hospitalized, but death is not imminent. (KS 30) |  |  |
| I am very sick. I require active supportive care by others. (KS 20) |  |  |
| I have fatal processes that are rapidly progressing. I am near death. (KS 10) |  |  |

|  |  |  |
| --- | --- | --- |
| **PROVOCATIVE TESTS** | **Yes** | **No** |
|  |  |  |
|  |  |  |
| **Craniocervical Junction Tests** |  |  |
|  |  |  |
| Sit straight up. Put your hands, palms down, on the top of your head. Push your head down into your chest, straight down, without flexing or extending your neck. Do it very gently at the beginning, then as intensely as you can do it and you can take it. During this routine, do your main symptoms get **A LOT worse**? |  |  |
| Sit straight up. Grab your head, palms up, underneath your chin and mastoids. Push your head upwards towards the ceiling. Do it very gently at the beginning, then as intensely as you can take. During this routine, do your main symptoms get **A LOT better**? |  |  |
| After you stopped pulling up your head towards the ceiling, did you experience **a STRONG rebound** in your symptoms, for a while? |  |  |
| IMPORTANT: If/when the symptoms changed for the worse, was the change so intense that **“you felt in Hell”?** |  |  |
| IMPORTANT: If/when the symptoms changed for the better, was the change so intense that **“you felt in Heaven”**? |  |  |
| When riding in a car on a bumpy road, do your symptoms get **A LOT worse**? |  |  |
|  |  |  |
|  |  |  |
| OPTIONAL CRANIOCERVICAL JUNCTION TESTS |  |  |
| While flexing the neck forward, with the chin touching the chest, do your main symptoms get **A LOT worse**? |  |  |
| While extending the neck backwards, all the way back, do your main symptoms get **A LOT worse**? |  |  |
| While rotating the neck, all the way to the right, and all the way to the left, do your main symptoms get **A LOT worse**? |  |  |
|  |  |  |
|  |  |  |
| **Intracranial Pressure Tests** |  |  |
|  |  |  |
| Strain like you are trying to go at the bathroom for a very constipated #2. Hold it for a few seconds. Does this maneuver make your head feel like exploding, causing **INTENSE pain**? |  |  |
| Stay in bed flat for two minutes, then stand up on your feet. Does this manever cause an **INTENSE Headache**, localized at the top of your skull and behind the eyes ? |  |  |
|  |  |  |
|  |  |  |
| **Styloid Tests** |  |  |
|  |  |  |
| Put two fingers together. Place the tip of those fingers in the soft spot which is below the earlobe and behind the mandible. Push, gently at the beginning, then as intensely as you can take, aiming inward and forward. Does it cause **INTENSE pain**? |  |  |
|  |  |  |
|  |  |  |
| OPTIONAL STYLOID TEST |  |  |
| Open your mouth and reach inside with your finger. Push sideways against the lateral wall of your mouth, ½ inch BEHIND your last molars. Does it cause **INTENSE pain**? |  |  |
|  |  |  |
|  |  |  |
| **Celiac Plexus Test** |  |  |
|  |  |  |
| Close your right hand in a fist. Place it below your ribs, in the front, in the middle (= where your stomach is). Place your other hand, open and flat, on top of the fist, then push backwards and deep. Does it cause **INTENSE pain**? |  |  |
|  |  |  |
|  |  |  |
| **Filum Terminale Tests** |  |  |
|  |  |  |
| FIRST TEST. Walk on your heels for 20 ft. Stabilize yourself against a wall, if needed. (If you are unable to perform the test, enter N/A). Focus on any change of symptoms occurring in your low back, legs, and bladder (and bowel, if applicable). Did those symptoms get **A LOT worse**? |  |  |
| SECOND TEST. A few seconds after the end of the First test, walk on your toes for 20 ft. Stabilize yourself against a wall, if needed. (If you are unable to perform the test, enter N/A). Focus on any change of symptoms occurring in your low back, legs, and bladder (and bowel, if applicable). Did those symptoms get **A LOT better**? |  |  |
|  |  |  |
|  |  |  |
| OPTIONAL FILUM TERMINALE TESTS |  |  |
| Cross your leg (like a Buddhist monk or like in Yoga). If you are unable to perform the test, enter N/A. Focus on any change of symptoms occurring in your low back, legs, and bladder (and bowel, if applicable). Did they get **A LOT better**? |  |  |
| Supine in bed. Straighten your legs. Grab the headboard (or something else solid). Have somebody else grabbing your ankles and then pulling your legs away from your pelvis. The maneuver should be done very gently at the beginning, then as intensely as you can take. Focus on any change of symptoms occurring in your low back, legs, and bladder (and bowel, if applicable). Did they get **A LOT worse**? |  |  |
|  |  |  |
|  |  |  |
| **BEIGHTON SCORE Test (refer to the pics below)** |  |  |
|  |  |  |
| RIGHT HAND. Can you bend your pinky backwards beyond 90 degrees?  |  |  |
| LEFT HAND. Can you bend your pinky backwards beyond 90 degrees? |  |  |
| RIGHT HAND. Bend your wrist forward. Grab your thumb. Can you push it to the forearm? |  |  |
| LEFT HAND. Bend your wrist forward. Grab your thumb. Can you push it to the forearm? |  |  |
| RIGHT ARM. Does your elbow bend the other way, a little bit? |  |  |
| LEFT ARM. Does your elbow bend the other way, a little bit? |  |  |
| RIGHT LEG. Does your knee bend the other way, a little bit? |  |  |
| LEFT LEG. Does your knee bend the other way, a little bit? |  |  |
| Can you touch the floor with the palms of your hands without bending your knees? |  |  |
|  |  |  |
|  |  |  |



**In a few words, tell us the history of your present illness:**

(max 3-4 paragraphs)

**Past trauma/injury history:**

(make a list, add dates)

**Past surgical history:**

(make a list of your past surgeries; focus specially on neurosurgical procedures) (for the neurosurgical procedures: add dates, name of the hospital, last name of the surgeon)

**Past medical history:**

(make a list of your other medical problems)

**Medications:**

(list the names and the dosages)

**Allergies/Intolerances (Agent – Reaction): e.g. meds, foods, contrast, dyes, or latex:**

(list names and the effects)

**Family history:**

**Social history:**

Marital status:

Work/Disability history:

Tobacco Current user:

Tobacco Previous user:

Counseled to quit:

Alcohol: occasionally Caffeine:

Recreational Drugs:

**If you have seen other specialists in the field of Chiari, Syringomyelia, EDS, Connective Tissue Disorders, Dysautonomia, and ME/CFS in the past, list their names below:**

DO NOT FILL BELOW THIS LINE

THIS SECTION IS RESERVED TO OUR MEDICAL STAFF

**Vital signs:**

Blood Pressure:

Heart Rate:

Respiratory Rate:

Temperature:

**Physical Exam:**

General - Well developed, well-nourished female resting comfortably

Head – Normocephalic, atraumatic

Neck – Supple, nontender, no lymphadenopathy

ENT - Moist mucous membranes, TM pearly grey, good dentition, uvula midline

Heart - S1, S2 regular rate and rhythm

Lungs - Clear to auscultation bilaterally, no wheezes, rales or rhonchi

Abdomen - Soft, nontender, nondistended.  Positive bowel sounds

Extremities - No clubbing, cyanosis or edema

**Neurological Exam:**

Patrient is alert and oriented to person, place and time.

Attention and short-term memory are intact; mood and affect are normal.

Speech is fluent and comprehension is intact; no dysphasia is noted.

Fundoscopic exam is benign; discs flat, venous pulsations are seen on the right.

Visual fields are full to confrontation.

EOMs are intact, PERRL, no nystagmus, no ptosis.

No facial asymmetry or weakness; normal facial sensation to touch and pin.

Hearing is intact to finger rub, the Weber is midline;

Tongue, palate and pharynx intact; gag reflex is present bilaterally.

No dysarthria or dysphonia is noted.

Gait and station are normal

Muscle strength and bulk are intact; no pronator drift is noted.

DTRs 1-2+ and symmetrical; plantar responses are flexor.

Tone is normal; no abnormal movements or tremors are noted.

Coordination and rapid alternating movements are intact.

Romberg (Standard & Tandem) is normal

Sensation is intact to touch, vibration, position sense, pin and temperature.

|  |  |  |
| --- | --- | --- |
| **BEIGHTON SCORE** |  |  |
|  |  |  |
| Rest palm of the hand and forearm a flat surface with palm side down and fingers out straight. Can the fifth finger be bent/lifted upwards at the knuckle to go back beyond 90 degrees? – RIGHT SIDE |  |  |
| Rest palm of the hand and forearm a flat surface with palm side down and fingers out straight. Can the fifth finger be bent/lifted upwards at the knuckle to go back beyond 90 degrees? -LEFT SIDE |  |  |
| With the arm out straight, the palm facing down, and the wrist then fully bent downward, can the thumb be pushed back to touch the forearm? – RIGHT SIDE |  |  |
| With the arm out straight, the palm facing down, and the wrist then fully bent downward, can the thumb be pushed back to touch the forearm? – LEFT SIDE |  |  |
| With arms outstretched and palms facing upwards, does the elbow extend (bend too far) upwards more than an extra 10 degrees beyond a normal outstretched position? – RIGHT SIDE |  |  |
| With arms outstretched and palms facing upwards, does the elbow extend (bend too far) upwards more than an extra 10 degrees beyond a normal outstretched position? – LEFT SIDE |  |  |
|  While standing, with knees locked (bent backwards as far as possible), does the lower part of either leg extend more than 10 degrees forward? – RIGHT SIDE  |  |  |
|  While standing, with knees locked (bent backwards as far as possible), does the lower part of either leg extend more than 10 degrees forward? – LEFT SIDE |  |  |
| Can you bend forward and place the palms of your hands flat on the floor in front of your feet without bending your knees? |  |  |

**Neuroradiological findings:**

**Assessment:**

**Plan:**

Paolo A. Bolognese, M.D.

Chiari Neurosurgical Center

NSPC

**APPENDIX - EDS REFERENCES**

<https://www.ehlers-danlos.com>

<https://www.ehlers-danlos.com/eds-diagnostics/>

<https://www.ehlers-danlos.com/assessing-joint-hypermobility/>

<https://www.ehlers-danlos.com/eds-types/>

<https://www.ehlers-danlos.com/2017-eds-international-classification/#article>

<https://www.ehlers-danlos.com/pdf/2017-FINAL-AJMG-PDFs/Castori_et_al-2017-American_Journal_of_Medical_Genetics_Part_C-_Seminars_in_Medical_Genetics.pdf>

<https://www.ehlers-danlos.com/wp-content/uploads/hEDS-Dx-Criteria-checklist-1-Fillable-form.pdf>

<https://www.ehlers-danlos.com/pdf/2017-FINAL-AJMG-PDFs/Henderson_et_al-2017-American_Journal_of_Medical_Genetics_Part_C-_Seminars_in_Medical_Genetics.pdf>

**Abbreviations:**

ACDF - anterior cervical discectomy and fusion

ADI – atlanto dens interval

BDI – basion dens interval

B - Brain

BI – basilar impression/basilar invagination

C - cervical

CCF - craniocervical fusion

CCF-R – craniocervical fusion revision

CCI - craniocervical instability

CCJ – craniocervical junction

CDU – color Doppler ultrasound

CMI - Chiari malformation type 1

CM-II - Chiari malformation type 2

CM-III - Chiari malformation type 3

CM-IV - Chiari malformation type 4

CMJ – cervicomedullary junction

CP – cranioplasty

CRANI - craniectomy

CRIP - chronically raised intracranial pressure

CTD – connective tissue disorder(s)

CTS - carpal tunnel syndrome

CXA – clivo axial angle

DP - duraplasty

DR - durarraphy

DTRs - deep tendon reflexes

EDS - Ehlers-Danlos syndrome

EMG - electromyography

EOMs - extraocular movements

FT – filum terminale

FFT – fat filum terminale

Grabb – Grabb-Oakes Measurement (aka pB-C2)

HC - head circumference

HDCT - hereditary disorder of connective tissue

HNP – herniated nucleus polposus (= disc herniation)

HYPER – intracranial hypertension

HYPO - intracranial hypotension

IBS - irritable bowel syndrome

ICT – invasive cervical traction

ICP – intracranial pressure

IIH – idiopathic intracranial hypertension

JP – Jackson Pratt drain

L - lumbar

LLCT – low lying cerebellar tonsils

LMP – lateral mass plates

L-TOMY - laminotomy

MALS – median arcuate ligament syndrome

MC – meningocele

MCAD – mast cell activation disorder

MCAS – mast cell activation syndrome

MIST – minimally invasive subpial tonsillectomy

MS – multiple sclerosis

MTH – minimal tonsillar herniation

N/A - not applicable

NICT - non invasive cervical traction

N/T - not tested

NMH - neurally mediated hypotension

oTC - occult variant of tethered cord

PERRLA - pupils equal round & reactive to light, and accomodating

PFD - posterior fossa decompression,

PFR - posterior fossa revision

PLIF – posterior lumbar interbody fusion

PMC - pseudomeningocele

POTS - postural orthostatic tachycardia syndrome

PT – physical therapy

PTC - pseudotumor cerebri

PTH - persistent tonsillar herniation

RECONS – reconstructions (in CT imaging)

RO - retroflexed odontoid

SFT - section of filum terminale

SEBO - small intestinal bacterial overgrowth (SIBO)

SM - syringomyelia

SyPe – syringo peritoneal

SyPl – syringo pleural

SySa – syringo subarachnoid

SSEP – somatosensory evoked potentials

STING – Styloid Induced Neuropathy (of the) Glossopharyngeal (nerve)

SSS - soft spot syndrome

T - thoracic

TC – tethered cord

TH – tonsillar herniation

TR – tonsillar resection (subpial)

TS – tonsillar shrinking

TCS - tethered cord syndrome

TMJ – temporomandibular joint

TOO – transoral odontoidectomy

XI – eleventh cranial nerve (= accessory nerve)

XII – twelfth cranial nerve (= hypoglossal nerve)