



# Weill Cornell Medicine

## Brain & Spine Center

### Chiari Patient Questionnaire

Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Right-handed

Left-handed

What is currently your most bothersome symptom? \_\_\_\_\_

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Please check off any of the following symptoms you are currently experiencing:

**Headaches**    **No Headaches**

Location of headaches:

Back of the head

Front of the head

Side of the head

Left

Right

Do your headaches worsen with:

Coughing

Laughing

Sneezing

Bending Forward

Straining

Looking Up

How would you describe the pain of your headaches?

Pressure

Sharp

Pounding

Stabbing

Throbbing

Aching

Do your headaches change based on your position (i.e standing, sitting, lying down)?

Yes

No

If yes, do your headaches improve when lying down?

Yes

No

Are your headaches worse during a certain time of day?

Yes, AM

Yes, PM

No

On a scale of 1 to 10, with 1 being very mild and 10 being the most severe, how would you rate your headaches? \_\_\_\_\_

What helps alleviate or decrease your headaches? \_\_\_\_\_



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### Eyes

- Light sensitivity     Double vision     Loss of vision     Blurry vision

### Ears, Nose, Mouth, Throat

- Dizziness     Vertigo (spinning)     Ringing in your ears  
 Hoarseness     Facial pain/numbness     Difficulty swallowing, choking  
 Decrease of hearing

### Neurological

- Problems with speaking     Problems with thinking     Problems with memory  
 Neck pain     Back pain  
 Arm pain     Arm numbness     Arm tingling     Arm weakness  
 Leg pain     Leg numbness     Leg tingling     Leg weakness  
 Balance instability     Seizures     Black out spells

### Cardiovascular

- Chest pain     Palpitations

### Respiratory

- Chronic cough     Shortness of breath     Recurrent pneumonia

### Gastroenterological

- Nausea     Vomiting     Abdominal pain  
 Poor appetite     Diarrhea     Constipation  
 Bowel incontinence

### Genitourinary

- Problems starting urination     Urgency to urinate     Frequency to urinate  
 Wake up to urinate     Urinary incontinence

### Sleep

- Snoring     Long pauses of breathing during sleep  
 Wake up gasping for air     Daytime sleepiness  
 Diagnosed sleep apnea (if yes, what type? \_\_\_\_\_ )

### Mood

- Diagnosed Anxiety     Diagnosed Depression     Diagnosed Panic Attacks



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**Do you have a diagnosis of any of the following:**

- Syringomyelia
- Scoliosis
- Tethered cord
- Spina bifida
- Hydrocephalus
- Idiopathic Intracranial Hypertension (Pseudotumor Cerebri)
- Ehlers-Danlos Syndrome
- Postural Orthostatic Tachycardia Syndrome

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How did you hear about the Chiari CARE program? \_\_\_\_\_

Who first diagnosed your Chiari Malformation? \_\_\_\_\_

What symptoms led you to have your first imaging? \_\_\_\_\_

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**Have you had a previous surgery for your Chiari Malformation?**  Yes  No

If yes, who performed the surgery and when? \_\_\_\_\_

What were your main symptoms prior to surgery? \_\_\_\_\_

\_\_\_\_\_

Which symptoms were resolved \_\_\_\_\_

\_\_\_\_\_

Which symptoms decreased \_\_\_\_\_

\_\_\_\_\_

Which symptoms remained the same? \_\_\_\_\_

\_\_\_\_\_

Do you have any new symptoms post-operatively? \_\_\_\_\_

