STROKE, TIA

CLIENT NAME: _____

Submit the Client Information Questionnaire with this form

1. What is the date(s) of the episode?

2. Were any of the following studies completed?
   __ carotid ultrasound _____(date)
   __ head CT scan or MRI scan _____(date)
   __echocardiogram _____(date)

3. Is client on any medications? (accurate name, dosage, and reason)

4. Was client hospitalized (Y/N)? (if yes give details)

5. When did client last see their doctor for evaluation?

6. Please check any of the of the following that your client has had:

   __elevated cholesterol __stroke
   __diabetes __ __heart attack
   __high blood pressure __peripheral vascular disease
   __coronary artery disease

7. Has surgery ever been done on any carotid artery(ies)?
   __no
   __yes; please give details _____
   _____:

8. Give the date and result of the most recent blood pressure readings:

9. Are there any residuals (limitation of movement, speech, or vision)? Give full details.

10. Does client have any other major health issues? (please give details)