NeuroDx
Neurodiagnostic Technologies™
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Today's Date: _____

Patient: _____
Last First Middle Initial

Social Security #: _____

Date of Birth: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home#: _____ Mobile#: _____

Work #: _____ E-mail Address: _____

Primary Insurance: _____

ID#: _____ Group #: _____

Policy Holder's Name (if different than patient): _____

Social Security #: _____

Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance: _____

ID#: _____ Group #: _____

Policy Holder's Name (if different than patient): _____

Social Security #: _____

Date of Birth: _____ Relationship to Patient: _____

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LAST NAME	FIRST NAME	MI	DATE OF STUDY/ APPT TIME	AGE	DATE OF BIRTH	SEX	HT	WEIGHT	INSURANCE

BEST CONTACT PHONE NUMBER	DOMINANT HAND (circle one) Left Right	RACE / ETHNICITY

OCCUPATION	HOBBIES

1. Please describe the primary symptom(s) that resulted in a referral for this test:

_____

2. How long have these symptoms been going on for?

_____

3. Are you aware of any specific cause(s) for these symptoms, such as an injury? **yes / no (circle one)**

If YES, please explain:_____

4. How have these symptoms changed since onset?

They've **worsened / improved/ fluctuated / no change (circle one)**

5. What describes the nature of your symptoms? Circle all that apply.

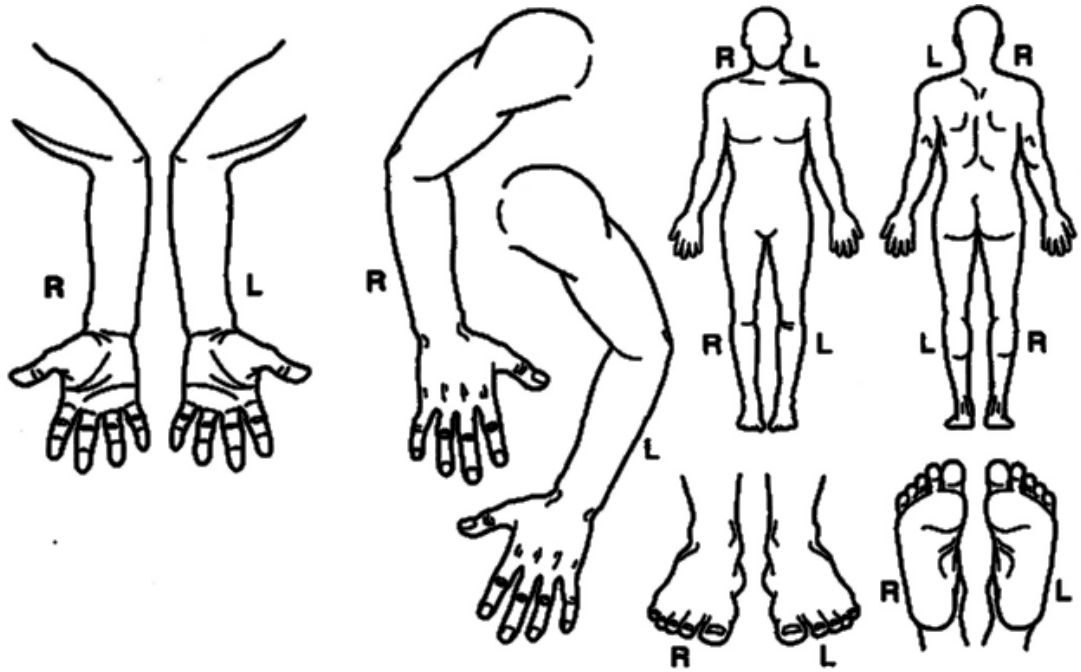
Numbness	Sharp pain	Weakness
Tingling	Dull pain (ache)	Muscle atrophy
Burning	Shooting pain	Color changes in skin
Cold feeling	Pain with exercise or walking	Skin symptoms

Other: _____

6. What part(s) of your body is/are affected by these symptoms?

_____

7. Carefully use diagram to identify the **EXACT** location of your symptoms



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8. Are your symptoms present **continuously** or **intermittently (circle one)**?

If intermittent, about how long do they typically last at a time?

_____

9. Are they worse in the **morning, afternoon,** or **evening**? **(circle one)**

Do they wake you up at night? **yes / no**

10. Are there any activities that make your symptom(s) worse? **yes / no** If so, which ones?_____

11. Is there anything that makes them better? **yes / no**

If YES, what?_____

12. Do you have NECK pain? **yes / no**

Do you have any pain shooting down either arm from the neck? **yes/ no**

If so, which side? **right / left / both**

What parts of the arm/forearm/hand/fingers are affected by this pain?

[ ] Same as #7

[ ] If different, describe:_____

13. Is this NECK pain worsened by any of the following (**circle any that apply**): NONE OF THESE

Coughing	Straining during a bowel movement
Sneezing	Moving the head or neck in any particular direction
Laughing	→If Yes, which direction: _____

14. Do you have BACK pain? **yes / no**

Do you have any pain shooting down either thigh/calf/foot from the back? **yes/ no**

If so, which side? **right / left / both**

What parts of the thigh/calf/foot are affected?

[ ] Same as #7

[ ] If different, describe:_____

15. Is this BACK pain worsened by any of the following (**circle any that apply**): NONE OF THESE

Coughing	Lying down
Sneezing	Straining during a bowel movement
Laughing	Bending forwards
Walking	Bending backwards
Sitting	Other: _____

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16. Do you have any muscle weakness? **yes / no**

If so, which body parts are affected (circle all that apply):

Face	Right arm	Left arm
Neck	Right hand	Left hand
Torso	Right thigh	Left thigh
	Right calf	Left calf
	Right ankle	Left ankle
	Right foot	Left foot

During what types of activities is your weakness most notable? _____

_____

17. Do you have difficulty with any of the following activities because of muscle weakness (circle those that apply)?

Walking upstairs	Shampooing your hair	Writing
Walking downstairs	Driving	Getting into or out of a car/chair
Exercise	Buttoning your clothes	Gripping/opening things
	Moving things on/off shelves	(a) with your right hand
		(b) with your left hand

18. Do you have any trouble keeping balance? **yes / no**

19. Have you undergone any testing (MRI, X-ray, prior nerve conduction / EMG study) for your symptoms to date? **yes / no** If so, what tests and where?

_____

20. Have you undergone any treatments or surgeries for your symptoms to date? (for example: carpal tunnel release surgery, ulnar nerve surgery, cervical / lumbar spine surgery)

Surgery/Treatment	Date	Location	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

21. Have you ever been diagnosed with diabetes? **yes / no**

If YES: Approximately when were you diagnosed? _____ (date)
Do you take insulin for this issue? **yes / no**
What was your most recent Hemoglobin A1C (example: 6.5): _____

22. Have you ever been diagnosed with cancer? **yes / no**

If YES: What type? _____
Have you ever had chemotherapy? **yes / no** _____ (date)
Have you ever had radiation therapy? **yes / no** _____ (date)

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23. Have you ever been diagnosed with any of the following conditions?

Y	N	
		Bleeding disorder
		Lupus
		Urinary problems
		Bowel problems
		Sexual dysfunction
		Shortness of breath / lung disease / COPD
		Vitamin B12 deficiency

Y	N	
		Arthritis
		Stomach problems or ulcers
		Kidney problems
		Liver problems
		Alcohol / drug abuse
		Depression / anxiety / bipolar
		Other:

Y	N	
		High blood pressure
		High cholesterol
		Heart disease
		Stroke / TIA
		Obesity
		Peripheral arterial disease
		Other:

24. Does anyone in your family have nerve or muscle disease, or have symptoms similar to yours? **yes/no**

25. Do you use blood thinners? **yes / no** Do you have a latex allergy? **yes / no**

Thank you for taking the time to complete this health questionnaire. We will review additional details during today's visit.

NeuroDx Team