Name: _____ Date of Birth : _____

Are you right or left handed? _____ Location of Symptoms: _____

Pain, Numbness, Tingling, Weakness, Burning Sensation, other: _____
If Numbness and tingling is present, it is present at nighttime? _____

When did the symptoms start? _____ Injury? _____

Past Medical History: Please Circle
Diabetes Thyroid Disease Cancer HIV/AIDS
Immune Disease Kidney Disease Other: _____

Family History: Please Circle
Diabetes Cancer Muscle Disorder Nerve Disorder

Do you work? Yes or No if yes, what do you do? _____

Do you smoke? Yes or No If yes, how many cigarettes a day? _____

Do you drink alcohol? Yes or No If yes how many times a week? _____
How many drinks (average) do you have when you do drink? _____

Current Medications:

_____
_____
_____
_____
_____

Allergies to Medications or Latex:

_____
_____

Review of Systems: Circle all current symptoms

Sleeplessness Anxiety Depression Stress Shortness of breath

Chest pain Palpitations Diarrhea Constipation Difficulty Swallowing

Frequency of Urination Day/Night Urgency of Urination Leakage of Urine

Neck pain Back pain Other pain: _____ Easy bruising/bleeding