

BARTECK WELLNESS CENTER

NEUROLOGICAL AND VASCULAR PATIENT QUESTIONNAIRE

NAME: _____

DATE: _____

For any **YES** answer, please notify the Doctor.

- | | | |
|---|----|-----|
| 1. Do you suffer from neck pain with pain in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 2. Do you have weakness, numbness or burning in your shoulder, arms or hands?
Comment: _____ | NO | YES |
| 3. Do your hands or arms fall asleep regularly?
Comment: _____ | NO | YES |
| 4. Do you have reduced feeling (sensation) or swelling in your hands or arms?
Comment: _____ | NO | YES |
| 5. Do you suffer from a loss of handgrip strength?
Comment: _____ | NO | YES |
| 6. Do you suffer from back pain with pain in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 7. Do you have weakness, numbness or burning in your buttocks, legs or feet?
Comment: _____ | NO | YES |
| 8. Do your legs or feet fall asleep regularly?
Comment: _____ | NO | YES |
| 9. Do you have reduced feeling (sensation) or swellings in your legs, feet?
Comment: _____ | NO | YES |
| 10. Do you suffer from cold hands or feet?
Comment: _____ | NO | YES |
| 11. Do you suffer from headaches, dizziness or memory loss?
Comment: _____ | NO | YES |
| 12. Do you have difficulty maintaining your balance?
Comment: _____ | NO | YES |
| 13. Do you suffer from vertigo or blurred vision?
Comment: _____ | NO | YES |
| 14. Do you suffer from a reduced hearing capacity?
Comment: _____ | NO | YES |
| 15. Do you suffer from ringing in your ears?
Comment: _____ | NO | YES |
| 16. Do you have bladder or bowel control problems on a regular basis?
Comment: _____ | NO | YES |

NOTE: Your health information will be kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential with Medicare.