# Confidential Patient Information

Patient#:_____

Name: _____ Hm/Cell Phone: _____ Work Phone:_____

Address: _____ City:_____ St: ____ Zip:_____

Date of Birth: _____ Age_____ Marital Status (circle one) M S D

Social Security Number _____-____-_____ E-mail Address _____

Occupation: _____ Employer:_____

Work Address: _____ City, St, Zip: _____

Spouse's Name: _____ # of Children: _____

Who may we thank for referring to our office? _____

Have you ever had Chiropractic care before? Yes ☐ No ☐ Date: _____

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Is this injury/illness related to: Automobile Accident: ☐

Date/Time: _____ Location:_____

Your Auto Insurance Co: _____ Phone:_____

Third Party Auto Insurance Co:_____ Phone: _____

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Due to changes in health insurance fees, patient self billing has become a much more cost-effective way for you, the patient, to get reimbursement for your care. Self billing allows us to keep our fees low so you can get the care you need without any added cost. Therefore, our policy is that all payment is due at the time of service and bills will no longer be sent to your insurance provider. Statements will be provided for individuals to submit their own bills ensuring that as your insurance provider pays for your care, they will send the reimbursement check directly to you.

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All charges are due when services are rendered…

Method of payment ( ) Check ( ) Cash ( ) Credit Card ( ) Care Credit

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Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Dr. Ptak will weigh your needs and desires when recommending your treatment program.

### Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

### Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

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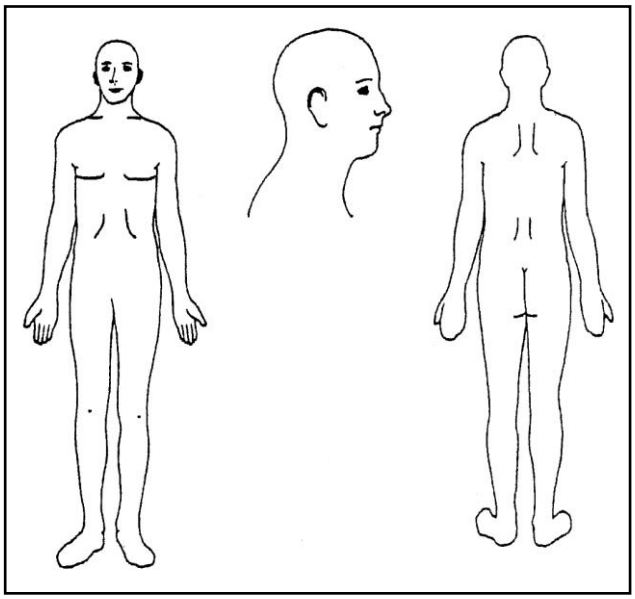
I authorize Ptak Chiropractic, Inc. to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date: _____

Parent or Legal Guardian Authorizing Care: _____

## Thank You For Allowing Us To Serve You!

PLEASE MARK AN X ON THE DIAGRAM BELOW WHERE YOUR PROBLEMS ARE



What hurts and how long has it hurt? (Scale 0 – 10)

1. _____
2. _____
3. _____
4. _____

When do you think these problems originally started?

1. _____
2. _____
3. _____
4. _____

List other Chiropractic or Medical Doctors you have consulted for these conditions.

1. _____
2. _____
3. _____

List all Medications: RX and/ or OTC

_____
_____
_____
_____
_____
_____
_____
_____

Check any of the following you have had in the six months:

( ) Headaches
( ) Sinus Congestion/ Allergies
( ) Vision Problems
( ) Ear Aches
( ) Dizziness
( ) Heart Problems
( ) Lung Problems / Congestion
( ) Blood Pressure Problems
( ) Ankle Swelling
( ) Prostate/ Sexual Dysfunction
( ) Menstrual Cycle Dysfunction
( ) Numbness
( ) Frequent Nausea/ Vomiting
( ) Abdominal Cramps
( ) Constipation
( ) Diarrhea
( ) Poor / Excessive Appetite
( ) Excessive Thirst
( ) Painful / Excessive Urine
( ) Discolored Urine
( ) Diabetes
( ) Cancer

Are you pregnant? ( ) Yes ( ) No ( ) Not Sure

# Vestibular Localization Form

## PART 1 INSTRUCTIONS: PATTERNS OF DIZZINESS

The purpose of this questionnaire is to identify difficulties you may be experiencing. Please answer every question, do not skip any questions. Circle yes or no where asked.

NAME: DATE:

### Patterns of Dizziness

How would you explain your dizziness:

| | | |
|---|---|---|
| Lightheaded | Yes / No | |
| Disorientation | Yes / No | |
| False sense of motion that you are moving | Yes / No | If yes, in which direction _____ |
| False sense of motion the world is moving | Yes / No | If yes, in which direction _____ |

Please describe your dizziness without using the word "dizzy":

Are your dizziness symptoms (circle one): Recent (first episode) Reoccurring Chronic

What is the typical duration of your symptoms (circle one)?
A few seconds Several seconds to a few minutes Several minutes to one hour Days Weeks

| | |
|---|---|
| Do you have hearing loss with your vertigo? | Yes / No |
| Do you have any ringing in your ear with your vertigo? | Yes / No |
| Is there any correlation with timing of your symptoms and taking a new medication (aspirin, antibiotics, diuretics, etc.)? | Yes / No Maybe |
| Is there any correlation with timing of your symptoms and exposure to any environmental chemicals or toxins? | Yes / No Maybe |
| Can your symptoms of dizziness be reduced by visually fixating on a target? | Yes / No |
| Are your symptoms of dizziness worse in the dark? | Yes / No |
| Are there any other symptoms you experience besides false sense of motion? What? (ex. Nausea, anxiety, racing heart rate, etc.) _____ | Yes / No |
| Is there anything that can aggravate your vertigo? What?_____ | Yes / No |
| Does anything help your symptoms? What?_____ | Yes / No |

Do any of the following movements cause you to feel disorientated or dizzy?

| | |
|---|---|
| Turning to the right | Yes / No |
| Turning to the left | Yes / No |
| Suddenly stopping in a car or a plane landing | Yes / No |
| Suddenly starting to move forward in a car or plane | Yes / No |
| Looking out the window of a train or moving vehicle with your back facing the direction of movement | Yes / No |
| Looking out the window of a train or moving vehicle with your front facing the direction of movement | Yes / No |
| Moving side-to-side | Yes / No |
| Suddenly moving up or down on an elevator | Yes / No |

# Vestibular Localization Form

## PART 2 INSTRUCTIONS: DIZZINESS SYNDROMES

The purpose of this questionnaire is to identify difficulties you may be experiencing. Please select yes or no.

| Perilympathic Fistula and Superior Canal Dehiscence | Yes / No |
|---|---|
| Did your dizziness start after trauma to your ear by sudden changes of pressure to your ear? | Yes / No |
| Did your dizziness start after heavy weight bearing or excessive straining with bowel movements? | Yes / No |
| Can sneezing, straining, or changes of pressure trigger your dizziness? | Yes / No |
| Can putting your head down to one side trigger your dizziness? | Yes / No |
| Can loud noises or sounds at times trigger your dizziness? | Yes / No |
| Have you started to notice your own voice much louder than before? | Yes / No |
| Have you notice any distortions of sensations of sound? | Yes / No |
| **Benign Paroxysmal Positional Vertigo** | |
| Can positional changes such as turning over in bed, bending over and then straightening up, or tilting your head trigger your symptoms? | Yes / No |
| Are your symptoms of dizziness prompted by eye or head movements and then decrease in less than one minute? | Yes / No |
| Does your dizziness become less noticeable each time you repeat the same movement? | Yes / No |
| Do your episodes of dizziness come in sudden and brief spells? | Yes / No |
| **Vestibular Neuronitis** | |
| Did your dizziness come on suddenly? | Yes / No |
| Did your dizziness start after a recent viral or bacterial infection? | Yes / No |
| Do you have a history of Herpes Zoster outbreaks? | Yes / No |
| Did your dizziness start during a period of exhaustion or weakened immune system? | Yes / No |
| **Meniere's** | |
| Do you notice a feeling of fullness in the ear or on the side of your head accompanying your episodes of dizziness? | Yes / No |
| Do you have episode of ringing in your ear accompanying your episodes of dizziness? | Yes / No |
| Have you experienced two or more episodes of vertigo lasing at least 20 minutes each? | Yes / No |
| **Vestibular Migraine** | |
| Do you experience flickering light spots (visual aura) before your episodes of dizziness or headaches? | Yes / No |
| Do you experience a throbbing headache before or after your episodes of dizziness? | Yes / No |
| Do you become extremely sensitive to light and sound before or after you episodes of dizziness? | Yes / No |
| Have you noticed your episodes of dizziness can be provoked by stress, low blood sugar levels, diet, chocolate, red wine, caffeine, cheeses or MSG? | Yes / No |

# Vestibular Localization Form

## PART 3 INSTRUCTIONS: PREVIOUS DIAGNOSIS

The purpose of this questionnaire is to identify difficulties you may be experiencing.

### Previous Diagnosis

Have you ever been diagnosed or suffered from with the following conditions (circle all that apply):

- Benign Proxysmal Positional Vertigo (BPPV)
- Meniere's Disease
- Ototoxicty
- Otosclerosis
- Tinnitus
- Hearing Loss
- Acoustic Neuroma
- Stroke
- Migraine
- Transient Ischemic Attack (TIA)
- Perilympathic Fistula
- Superior Canal Dehiscence
- Endolymphatic hydrop
- Autoimmune Inner Ear Disease
- Cervigogenic Syndrome
- Vestibulopathy
- Cerebellum Disease
- Cholesteatoma
- Enlarged Vestibular aqueduct
- Vestibular Neuritis or Labyrinthitis
- Mal de Debarqument
- Neurototoxcity
- Trauma to your ear
- Trauma to your head/brain
- Concussion

NAME: DATE:

# Brain Region Localization Form

## INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

**KEY:**

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

NAME: DATE:

| Frontal lobe Prefrontal, Dorsolateral and Orbitofrontal (Areas 9, 10, 11, and 12) | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 1. | Difficulty with restraint and controlling impulses or desires | ○ | ○ | ○ | ○ | ○ |
| 2. | Emotional instability (lability) | ○ | ○ | ○ | ○ | ○ |
| 3. | Difficulty planning and organizing | ○ | ○ | ○ | ○ | ○ |
| 4. | Difficulty making decisions | ○ | ○ | ○ | ○ | ○ |
| 5. | Lack of motivation, enthusiasm, interest and drive (apathetic) | ○ | ○ | ○ | ○ | ○ |
| 6. | Difficulty getting a sound or melody out of your thoughts (Perseveration) | ○ | ○ | ○ | ○ | ○ |
| 7. | Constantly repeat events or thoughts with difficulty letting go | ○ | ○ | ○ | ○ | ○ |
| 8. | Difficulty initiating and finishing tasks | ○ | ○ | ○ | ○ | ○ |
| 9. | Episodes of depression | ○ | ○ | ○ | ○ | ○ |
| 10. | Mental fatigue | ○ | ○ | ○ | ○ | ○ |
| 11. | Decrease in attention span | ○ | ○ | ○ | ○ | ○ |
| 12. | Difficulty staying focused and concentrating for extended periods of time | ○ | ○ | ○ | ○ | ○ |
| 13. | Difficulty with creativity, imagination, and intuition [R] | ○ | ○ | ○ | ○ | ○ |
| 14. | Difficulty in appreciating art and music [R] | ○ | ○ | ○ | ○ | ○ |
| 15. | Difficulty with analytical thought [L] | ○ | ○ | ○ | ○ | ○ |
| 16. | Difficulty with math, number skills and time consciousness [L] | ○ | ○ | ○ | ○ | ○ |
| 17. | Difficulty taking ideas, actions, and words and putting them in a linear sequence [L] | ○ | ○ | ○ | ○ | ○ |

| Frontal Lobe Precentral and Supplementary Motor Areas (Area 4 and 6) | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 18. | Initiating movements with your arm or leg has become more difficult | ○ | ○ | ○ | ○ | ○ |
| 19. | Feeling of arm or leg heaviness, especially when tired | ○ | ○ | ○ | ○ | ○ |
| 20. | Increased muscle tightness in your arm or leg | ○ | ○ | ○ | ○ | ○ |
| 21. | Reduced muscle endurance in your arm or leg | ○ | ○ | ○ | ○ | ○ |
| 22. | Noticeable difference in your muscle function or strength from one side to the other | ○ | ○ | ○ | ○ | ○ |
| 23. | Noticeable difference in your muscle tightness from one side to the other | ○ | ○ | ○ | ○ | ○ |
| **Frontal Lobe Broca's Motor Speech Area (Area 44 and 45)** | | 0 | 1 | 2 | 3 | 4 |
| 24. | Difficulty producing words verbally, especially when fatigued | ○ | ○ | ○ | ○ | ○ |
| 25. | Find the actual act of speaking difficult at times | ○ | ○ | ○ | ○ | ○ |
| 26. | Notice word pronunciation and speaking fluency change at times | ○ | ○ | ○ | ○ | ○ |
| **Parietal Somatosensory Area and Parietal Superior Lobule (Areas 3,1,2 and 7)** | | 0 | 1 | 2 | 3 | 4 |
| 27. | Difficulty in perception of position of limbs | ○ | ○ | ○ | ○ | ○ |
| 28. | Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall | ○ | ○ | ○ | ○ | ○ |
| 29. | Frequently bumping body or limbs into the wall or objects accidently | ○ | ○ | ○ | ○ | ○ |
| 30. | Reoccurring injury in the same body part or side of the body | ○ | ○ | ○ | ○ | ○ |
| 31. | Hypersensitivities to touch or pain perception | ○ | ○ | ○ | ○ | ○ |

# Brain Region Localization Form

## INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions. Follow the 0 to 4 key, and select which best fits for all of your answers.

## KEY:

0 = I never have symptoms (0% of the time)
1 = I rarely have symptoms (Less than 25% of the time)
2 = I often have symptoms (Half of the time)
3 = I frequently have symptoms (75% of the time)
4 = I always have symptoms (100% of the time)

| Parietal Inferior Lobule (Area 39 and 40) | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 32. | Right/left confusion [L] | ○ | ○ | ○ | ○ | ○ |
| 33. | Difficulty with math calculations [L] | ○ | ○ | ○ | ○ | ○ |
| 34. | Difficulty finding words [L] | ○ | ○ | ○ | ○ | ○ |
| 35. | Difficulty with writing [L] | ○ | ○ | ○ | ○ | ○ |
| 36. | Difficulty recognizing symbols or shapes [R] | ○ | ○ | ○ | ○ | ○ |
| 37. | Difficulty with simple drawings [R] | ○ | ○ | ○ | ○ | ○ |
| 38. | Difficulty interpreting maps [R] | ○ | ○ | ○ | ○ | ○ |
| **Temporal Lobe Auditory Cortex (Areas 41, 42)** | | **0** | **1** | **2** | **3** | **4** |
| 39. | Reduced function in overall hearing | ○ | ○ | ○ | ○ | ○ |
| 40. | Difficulty interpreting speech with background or scatter noise | ○ | ○ | ○ | ○ | ○ |
| 41. | Difficulty comprehending language without perfect pronunciation | ○ | ○ | ○ | ○ | ○ |
| 42. | Need to look at someone's mouth when they are speaking to understand what they are saying | ○ | ○ | ○ | ○ | ○ |
| 43. | Difficulty in localizing sound | ○ | ○ | ○ | ○ | ○ |
| 44. | Dislike of left predictable rhythmic, repeated tempo and beat music [L] | ○ | ○ | ○ | ○ | ○ |
| 45. | Dislike of non-predictable rhythmic with multiple instruments [R] | ○ | ○ | ○ | ○ | ○ |
| 46. | Noticeable ear preference when using your phone | ○ right, ○ left, ○ no preference | | | | |
| **Temporal Lobe Auditory Association Cortex (Area 22)** | | **0** | **1** | **2** | **3** | **4** |
| 47. | Difficulty comprehending meaning of spoken word [L] | ○ | ○ | ○ | ○ | ○ |
| 48. | Tend toward monotone speech without fluctuations or emotions [R] | ○ | ○ | ○ | ○ | ○ |

| Medial Temporal lobe and Hippocampus | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 49. | Memory less efficient | ○ | ○ | ○ | ○ | ○ |
| 50. | Memory loss that impacts daily activities | ○ | ○ | ○ | ○ | ○ |
| 51. | Confusion about dates, the passage of time, or place | ○ | ○ | ○ | ○ | ○ |
| 52. | Difficulty remembering events | ○ | ○ | ○ | ○ | ○ |
| 53. | Misplacement of things and difficulty retracing steps | ○ | ○ | ○ | ○ | ○ |
| 54. | Difficulty with memory of locations (addresses) [R] | ○ | ○ | ○ | ○ | ○ |
| 55. | Difficulty with visual memory [R] | ○ | ○ | ○ | ○ | ○ |
| 56. | Always forgetting where you put items such as keys, wallet, phone, etc. [R] | ○ | ○ | ○ | ○ | ○ |
| 57. | Difficulty remembering faces [R] | ○ | ○ | ○ | ○ | ○ |
| 58. | Difficulty remembering names with faces [L] | ○ | ○ | ○ | ○ | ○ |
| 59. | Difficulty with remembering words [L] | ○ | ○ | ○ | ○ | ○ |
| 60. | Difficulty remembering numbers [L] | ○ | ○ | ○ | ○ | ○ |
| 61. | Difficulty remembering to stay or be on time [L] | ○ | ○ | ○ | ○ | ○ |
| **Occipital Lobe (Area, 17, 18, and 19)** | | **0** | **1** | **2** | **3** | **4** |
| 62. | Difficulty in discriminating similar shades of color | ○ | ○ | ○ | ○ | ○ |
| 63. | Dullness of colors in visual field | ○ | ○ | ○ | ○ | ○ |
| 64. | Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach out for objects | ○ | ○ | ○ | ○ | ○ |
| 66. | Floater or halos in visual field | ○ | ○ | ○ | ○ | ○ |

# Brain Region Localization Form

## INSTRUCTIONS:

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### KEY:

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4 = I always have symptoms (100% of the time)

| Cerebellum - Spinocerebellum | | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| 67. | Difficulty with balance, or balance that is worse on one side | ○ | ○ | ○ | ○ | ○ |
| 68. | A need to hold the handrail or watch each step carefully when going down stairs | ○ | ○ | ○ | ○ | ○ |
| 69. | Feeling unsteady and prone to falling in the dark | ○ | ○ | ○ | ○ | ○ |
| 70. | Proness to sway to one side when walking or standing | ○ | ○ | ○ | ○ | ○ |
| **Cerebellum - Cerebrocerebellum** | | **0** | **1** | **2** | **3** | **4** |
| 71. | Recent clumsiness in hands | ○ | ○ | ○ | ○ | ○ |
| 72. | Recent clumsiness in feet or frequent tripping | ○ | ○ | ○ | ○ | ○ |
| 73. | A slight hand shake when reaching for something at the end of movement | ○ | ○ | ○ | ○ | ○ |
| **Cerebellum - Vestibulocerebellum** | | **0** | **1** | **2** | **3** | **4** |
| 74. | Episodes of dizziness or disorientation | ○ | ○ | ○ | ○ | ○ |
| 75. | Back muscles that tire quickly when standing or walking | ○ | ○ | ○ | ○ | ○ |
| 76. | Chronic neck or back muscle tightness | ○ | ○ | ○ | ○ | ○ |
| 77. | Nausea, car sickness, or sea sickness | ○ | ○ | ○ | ○ | ○ |
| 78. | Feeling of disorientation or shifting of the environment | ○ | ○ | ○ | ○ | ○ |
| 79. | Crowded places cause anxiety | ○ | ○ | ○ | ○ | ○ |
| **Basal Ganglia Direct Pathway** | | **0** | **1** | **2** | **3** | **4** |
| 80. | Slowness in movements | ○ | ○ | ○ | ○ | ○ |
| 81. | Stiffness in your muscles (not joints) that goes away when you move | ○ | ○ | ○ | ○ | ○ |
| 82. | Cramping of hands when writing | ○ | ○ | ○ | ○ | ○ |
| 83. | A stooped posture when walking | ○ | ○ | ○ | ○ | ○ |
| 84. | Voice has become softer | ○ | ○ | ○ | ○ | ○ |
| 85. | Facial expression changed leading people to frequently ask if you are upset or angry | ○ | ○ | ○ | ○ | ○ |
| **Basal Ganglia Indirect Pathway** | | **0** | **1** | **2** | **3** | **4** |
| 86. | Uncontrollable muscle movements | ○ | ○ | ○ | ○ | ○ |
| 87. | Intense need to clear your throat regularly or contract a group of muscles | ○ | ○ | ○ | ○ | ○ |
| 88. | Obsessive compulsive tendencies | ○ | ○ | ○ | ○ | ○ |
| 89. | Constant nervousness and restless mind | ○ | ○ | ○ | ○ | ○ |
| **Autonomic Reduced Parasympathetic Activity** | | **0** | **1** | **2** | **3** | **4** |
| 90. | Dry mouth or eyes | ○ | ○ | ○ | ○ | ○ |
| 91. | Difficulty swallowing supplements or large bites of food | ○ | ○ | ○ | ○ | ○ |
| 92. | Slow bowel movements and tendency for constipation | ○ | ○ | ○ | ○ | ○ |
| 93. | Chronic digestive complaints | ○ | ○ | ○ | ○ | ○ |
| 94. | Bowel or bladder incontinence resulting in staining your underwear | ○ | ○ | ○ | ○ | ○ |
| **Autonomic Increased Sympathetic Activity** | | **0** | **1** | **2** | **3** | **4** |
| 95. | Tendency for anxiety | ○ | ○ | ○ | ○ | ○ |
| 96. | Easily startled | ○ | ○ | ○ | ○ | ○ |
| 97. | Difficulty relaxing | ○ | ○ | ○ | ○ | ○ |
| 98. | Sensitive to bright or flashing lights | ○ | ○ | ○ | ○ | ○ |
| 99. | Episodes of racing heart | ○ | ○ | ○ | ○ | ○ |
| 100. | Difficulty sleeping | ○ | ○ | ○ | ○ | ○ |

# Brain Region Localization Form

## INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please select yes or no.

| Epileptiform Activity | Yes / No |
|---|---|
| Have you ever been diagnosed with a seizure disorder? | Yes / No |
| Have you ever been diagnosed with epilepsy? | Yes / No |
| Have you ever been told that you seemed frozen, absent, or tuned out at times without any recollection of the event? | Yes / No |
| Have you ever experienced sudden muscle stiffness and rigidity throughout your body? | Yes / No |
| Have you ever experienced sudden muscle jerks throughout your body? | Yes / No |
| Have you ever experienced a total loss of your muscle tone that lead to loss of control of your muscles or a fall? | Yes / No |
| Have you ever been told that you stare into space while you're lip smacking, chewing, or fidgeting that you are not aware of? | Yes / No |
| Do you ever experience sudden emotional responses such as anxiety, sadness, cry, or laugh for no real reason? | Yes / No |
| Do you ever experience sudden racing heart rate, sudden loss of bladder function, intestinal spasm, respiration, sweating, or any other sudden changes of function? | Yes / No |
| Do you ever experience sudden involuntary muscle contractures or jerks in any individual parts of your limbs or face? | Yes / No |
| Do you ever experience sudden involuntary head rotation and your eyes move forcefully to one side? | Yes / No |
| Do you ever experience sudden involuntary shift in your eyes to the side or upwards? | Yes / No |
| Do you ever experience sudden vocalization of random words or notice a sudden inability to speak? | Yes / No |
| Do you ever experience any spontaneous sensations of tingling, pins and needles" numbness, coldness, burning or other random sensations in any region of your body? | Yes / No |
| Do you ever experience a ringing sensation in your ears (tinnitus), sounds, or voices spontaneously? | Yes / No |
| Do you ever experience spontaneous perception of smells such as burning rubber, foul smells, or other odors without finding the source of the odor? | Yes / No |
| Do you ever experience flashing lights, stars, or jagged lines in your visual field? | Yes / No |

SIGNATURE: DATE:

# Peripheral Nerve Localization Form

## INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions and select which best fits for all of your answers.

NAME: DATE:

| Peripheral Nerves Intake | | Yes | No | Pain Level 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. | Do you have pain in your spine? | Yes | No | | | | | | | | | | | |
| 2. | Do you have pain in your arms? | Yes | No | | | | | | | | | | | |
| 3. | Do you have pain in your legs? | Yes | No | | | | | | | | | | | |
| 4. | Do you have pain over your abdomen / torso? | Yes | No | | | | | | | | | | | |
| 5. | Do you have weakness in your back? | Yes | No | | | | | | | | | | | |
| 6. | Do you have weakness in your shoulders? | Yes | No | | | | | | | | | | | |
| 7. | Do you have weakness in your hips or glutes? | Yes | No | | | | | | | | | | | |
| 8. | Do you have weakness in your arms? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 9. | Do you have weakness in your legs? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 10. | Do you have weakness in your feet? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 11. | Do you have weakness on one side of the body? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 12. | Do you have cramping? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 13. | Do you get weak with exercises or movement? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 14. | Do your muscles cramp and freeze with movement? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 15. | Do you have a loss in muscle size? Where: _____ | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 16. | Have your noticed your muscles jumping? Where: _____ | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 17. | Do you have weakness with your face? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 18. | Do you have problems talking? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 19. | Do you have problems swallowing? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 20. | Do you have sensory loss or pain down your arm? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 21. | Do you have sensory loss or pain down your leg? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 22. | Do you have sensory loss on once side of the body? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 23. | Do your have sensory loss over your shoulders? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 24. | Do you have sensory loss with one arm or portion of the arm? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 25. | Do you have sensory loss with one or both hands or a single finger? If so, which areas: _____ | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 26. | Do you have bowel or bladder control issues? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 27. | Do you have sensory loss over your abdomen or torso? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 28. | Do you have pain or sensory loss over your hips? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 29. | Do you have pain or sensory loss in one or both legs? | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 30. | Do you have sensory loss in your feet or a portion of your foot. If so where: _____ | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 31. | Do you have sensory loss in your face? If so where: _____ | Yes | No | Mild | | | Moderate | | | | Severe | | | |
| 32. | Do you have high arches? | Yes | No | | | | | | | | | | | |
| 33. | Do you have hammertoes? | Yes | No | | | | | | | | | | | |

# Peripheral Nerve Localization Form

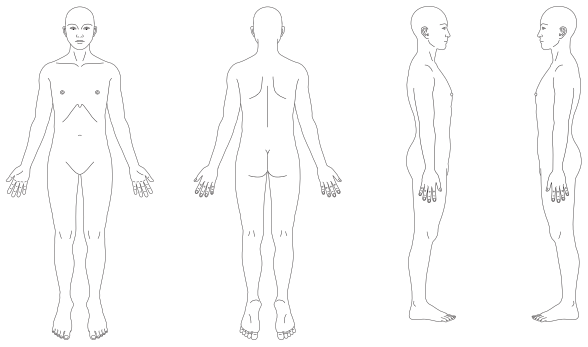
## INSTRUCTIONS:

The purpose of this questionnaire is to identify difficulties that you may be experiencing. Please answer every question, do not skip any questions and select which best fits for all of your answers.

NAME: DATE:

| Gait: | | Yes No | Pain Level |
|---|---|---|---|
| 1. | Do you fall frequently? How Often: _____ | Yes No | |
| 2. | Do you have a hard time standing on your toes or heels? | Yes No | Mild Moderate Severe |
| 3. | Do you fall to one side? | Yes No | Mild Moderate Severe |
| 4. | Do you walk with your legs wide or far apart? | Yes No | Mild Moderate Severe |
| 5. | Do you waddle when you walk? | Yes No | Mild Moderate Severe |
| 6. | Do you have a hard time going up or down stairs? | Yes No | Mild Moderate Severe |
| 7. | Is one or both arms tight or spastic? | Yes No | Mild Moderate Severe |
| 8. | Is one or both of your legs spastic? | Yes No | Mild Moderate Severe |
| 9. | Do your feet slap when you walk? | Yes No | Mild Moderate Severe |
| 10. | Do you have to high step when you walk? | Yes No | Mild Moderate Severe |
| 11. | Do you shuffle when you walk? | Yes No | Mild Moderate Severe |
| 12. | Is it hard to start walking? | Yes No | Mild Moderate Severe |
| 13. | Is it hard to turn if you stop walking? | Yes No | Mild Moderate Severe |

DOCTOR USE ONLY:



SIGNATURE: DATE: