Maryland Neurological Center

11085 Little Patuxent Parkway Ste 212
Columbia, MD 21044
410-730-1212

NCS/EMG Questionnaire

Name:_____ **Date:**_____

Best Contact Number:_____

Primary Care Physician:_____

Insurance Carrier:_____

(For Office Use) BP_____ **Pulse**_____ **Height**_____ **Weight**_____

Please List your current medications:

_____
_____
_____
_____

Please list all physicians that you would like to receive your reports:

1. _____
2. _____
3. _____

Please list the location(s) of your discomfort:

_____
_____
_____

Please describe your pain/sensation(circle all that apply):

Aching Throbbing Sharp Dull Shooting Burning Numbness Tingling

Please rate the level of your pain on a scale of 0(no pain) to 10(worst pain)

(Circle One) 0 1 2 3 4 5 6 7 8 9 10

Patient Signature:_____ **Date:**_____