NCS/EMG Questionnaire

Name:_____ DOB:_____ Date:_____

Best Contact Number:_____

Primary Care Physician:_____

Insurance Carrier:_____

Preferred Pharmacy:_____

Please list any allergies:

_____

Please List your current medications:

_____

_____

_____

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

1. _____
2. _____
3. _____

Do you smoke? Y/N For how long?_____ When did you quit? _____

What are your current symptoms?_____
When did your symptoms start?_____
Where is the locations of your discomfort?_____
_____
Other symptoms?_____
_____

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:_____