# ALDANA CHIROPRACTIC
# NEUROLOGICAL/MRI/VASCULAR PATIENT QUESTIONNAIRE

**NAME:** _____ **DATE:**_____

***If you checked YES for any answer, please explain under comment:***

1. Do you suffer from neck pain with pain in your shoulder, arms or hands: YES ___ NO ___
   Comments: _____
2. Do you have weakness, numbness of burning in your shoulder, arms or hands? YES ___ NO ___
   Comments: _____
3. Do your hands or arms fall asleep regularly? YES ___ NO ___
   Comments: _____
4. Do you have reduced feeling (sensation) or swelling in your hands or arms? YES ___ NO ___
   Comments: _____
5. Do you suffer from a loss of handgrip strength? YES ___ NO ___
   Comments:_____
6. Do you suffer from back pain with pain in your buttocks, legs or feet? YES ___ NO ___
   Comments: _____
7. Do you have weakness, numbness or burning in your buttocks, lets or feet? YES ___ NO ___
   Comments: _____
8. Do our legs or feet fall asleep regularly? YES ___ NO ___
   Comments:_____
9. Do you have reduced feeling (sensation) or swelling in your legs, feet? YES ___ NO ___
   Comments:_____
10. Do you suffer from cold hand or feet? YES ___ NO ___
    Comments:_____
11. Have you ever tried any anti-inflammatory medication? YES ___ NO ___
    Comments:_____
12. Have you ever tried any Physical Therapy or Chiropractic treatments before? YES ___ NO ___
    Comments: _____
13. Have you ever had an MRI or CT Scan? YES ___ NO ___
    Comments: _____
14. Have you ever used a brace, splint, or similar prescribed treatment? YES ___ NO ___
    Comments:_____
15. If you have tried any treatment or medication, did anything help your problem? YES ___ NO ___
    Comments:_____

**NOTE:** Your health information is kept strictly confidential. Any information that we collect about you on this form will be kept confidential in our office. 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 by Medicare.