Please circle *YES* or *NO* to the following questions. This will aid us in completing your medical history.

Patient Signature	**Date**

1. Do you suffer from neck pain, with pain in your arms or hands? .... YES NO

2. Do you have weakness, numbness, or burning in either your arms or your hands? .... YES NO

3. Do your hands or arms fall asleep? .... YES NO

4. Do you have reduced feeling (sensation) in your hands or arms? .... YES NO

5. Do you suffer from a loss of"hand grip strength? .... YES NO

6. Do you suffer from back pain with pain in your buttocks, legs, or feet? .... YES NO

7. Do you have weakness, numbness, or burning in your buttocks, legs, or feet? .... YES NO

8. Do your legs or feet fall asleep? .... YES NO

9. Do you have reduced feeling (sensation) in your buttocks, legs, or feet? .... YES NO

10. Do you suffer from headaches or dizziness? .... YES NO

11. Do you have difficulty maintaining your balance? .... YES NO

12. Do you suffer from vertigo or blurred vision? .... YES NO

13. Do you suffer from a reduced hearing capacity .... YES NO

14. Do you suffer from ringing in your ears? .... YES NO

15. Do you have bladder or bowel control problems? .... YES NO

Print from and bring with you to your appointment