Please complete the following 2-page questionnaire and bring it with you to your EMG appointment with Dr Selk. Thank you.

Name: _____

When did your symptoms begin?

Are you □ Right-handed or □ Left-handed?

Do you have any of the following:

- Fever: □ No □ Yes
- Chills □ No □ Yes
- Night Sweats: □ No □ Yes
- Numbness: □ No □ Yes If yes, where?
  _____
- Tingling: □ No □ Yes If yes, where?
  _____
- Weakness: □ No □ Yes If yes, where?
  _____
- Pain: □ No □ Yes If yes, where?
  _____
  If yes, is it: □ sharp □ dull □ aching □ burning □ electrical/shock-like □ other_____
  If yes, is it □ constant or □ comes and goes?

If your symptoms are in your arm / hand -do you have neck pain? □ No □ Yes
If yes, which bothers you more, my arm/hand □ or my neck □
If yes, does the sensation travel up___ or down___ your arm?

If your symptoms are in your leg / foot – do you have low back pain □ No □ Yes
If yes, which bothers you more? My leg/foot □ or my low back □
If yes, does the sensation travel up___ or down___ your leg?

Are symptoms worse when you:

- Cough, sneeze, or have a bowel movement? □ No □ Yes
- Move your Neck (if you have arm/hand symptoms) □ No □ Yes
- Move your back (If you have leg/foot symptoms)? □ No □ Yes

Do you get shock/ electrical sensations when you flex your neck? □ No □ Yes

Are symptoms worse at night? □ No □ Yes

Do symptoms wake you in night? □ No □ Yes

Do you shake your hands at night to restore sensation? □ No □ Yes

Have you worn a night brace or splint? □ No □ Yes If yes, did it help? □ No □ Yes

List any medical conditions that have been diagnosed by a doctor: (ie thyroid, diabetes)

List any medications that you currently take:

List any surgeries you have had and when:

Do you have any allergies? □ No □ Yes If yes, what?
_____

Do you smoke? □ No □ Yes If yes, how much? _____/ day x ____years

Do you ever drink alcohol? □ No □ Yes If yes how much per week?
_____

Do you use illicit substances? (ie: marijuana, IV drugs) □ No □ Yes If yes, what?
_____

Is there any family history of nerve disease, early cane use,
_____

Person completing this form: _____ Relationship to patient: _____

Date: _____