Diagnostic Testing Screening Tool

Patient Name:_____ **Date:** _____

Dear Patient:

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Doctor determine what diagnostic tests* might be appropriate for you.

Please check all that apply:

	Low Back Pain		Numbness, Tingling in Legs
	Neck Pain		Numbness, Tingling in Feet
	Burning Sensation		Numbness, Tingling in Hands
	Weakness in the arms		Weakness in the legs
	You are Diabetic		Loss of sensation in Hands
	Muscle Weakness		Loss of sensation in Feet
	Radiating pain to the arm		Radiating pain to the leg
	You have Neuropathy		Pins and Needles Sensation
	Blurred Vision		Hearing Problems
	Hypertension		Hypotension
	Dizziness or Vertigo		***Headaches***
	Unsteady gait		***History of falls due to dizziness***

Patient Signature: _____

*Electropmyography/Nerve Conduction Studies, Autonomic System Testing, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing.