PAIN DIAGNOSIS CONSULTANTS, LLC
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http://paindiagnosis.net info@paindiagnosis.net

Carpal Tunnel – Neuropathy Screening Questionnaire

Name: _____

Address: _____

Date of Birth: _____-_____-_____ **Last Four Numbers of SSN:** _____

Email: _____ **Sex (circle):** Fem Male **Height:** _____

Handedness: Right Left Both **Cell phone:** _____

Home phone: _____ **Work phone:** _____

List doctors you would like us to mail a copy of your report to:

_____

Circle any of the following that you may have:

1. Abnormal Pulse Unusual sensitivity to electrical stimulation
2. Uncontrolled: High Blood Pressure Pulse Heart Rhythm Seizures Epilepsy
3. Swollen: Wrists Hands Legs Ankles Feet
4. Infection of: Wrists Hands Legs Ankles Feet
5. Uncontrolled pain to the: Wrists Hands Legs Ankles Feet
6. Large scars over the: Wrists Hands Legs Ankles Feet
7. Metal plates or rods in the: Wrists Hands Legs Ankles Feet
8. Electrical devices in your body (list): Heart Pacemaker Spinal Cord Stimulator

Please circle any of the following that apply to you: On: Blood thinners Aspirin

Anemia Diabetes Low Thyroid High Thyroid Low B12 Low Folate

Prior Carpal Tunnel Prior Neuropathy Rheumatoid Arthritis Allergy to Alcohol or Tape

Numbness-Tingling-Weakness-Pain-Hands-Wrists Numbness-Tingling-Weakness-Pain-Legs-Feet

_____ _____

Patient signature & Authorization **Date**

Your signature authorizes us to release your test results to the above physicians.