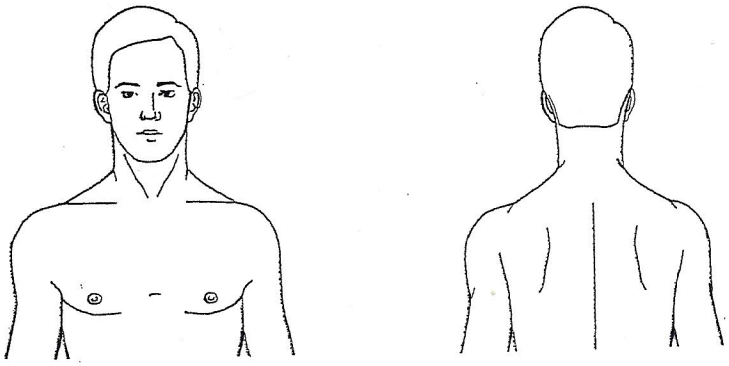
Patient # _____

Date _____

Brain



Please circle on the above drawing where you are having pain or symptoms.

Describe the sensations or symptoms you are experiencing (pain, aching, tingling, burning, numbness, etc.)

_____

Is this a result of an injury? **YES** ____ **NO** ____ If YES, give the date? _____(month-day-year)

If YES, explain how and where your injury occurred: _____

_____

Is this work related? **YES** ____ **NO** ___

If this was not an injury, how long have you been experiencing your symptoms? _____

Have you ever had a stroke or TIA? **YES** ____ **NO** _____ If YES, when?_____

If YES, how have your recovered? **PARTIALLY**____ **FULLY** ____

Have you ever had any brain surgery? **YES** ____ **NO** ____ If YES, when and where? _____

If YES, what was the surgery for? _____

Do you have any hearing loss? **YES** ____ **NO** ____ If YES, which ear? **Left** ____ **Right** ____ **Both** ____

Do you have any balance problems? **YES** ____ **NO** ____ If YES, explain _____

Do you have any vision problems? **YES** ____ **NO** ____ If YES, explain _____

Have you ever been diagnosed with cancer? **YES** ____ **NO** ____ If YES, when? _____

If YES, to what part of the body? _____

If YES, what kind of treatment was given? _____

If YES, what was the last date of your treatment? _____

Have you ever had x-rays, a CT scan, or MRI scan for *this* problem? **YES** ____ **NO** ____ If YES, when and where, and what did they show _____

Please give us your **HEIGHT** _____ **WEIGHT** _____