



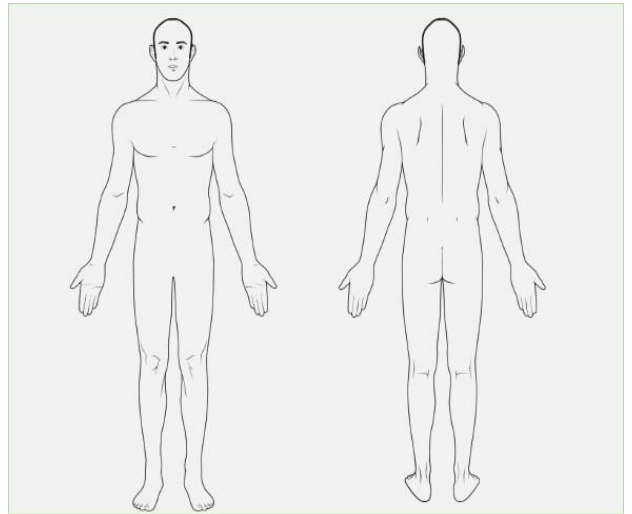
EMG and Nerve Study Questionnaire

Patient Name: _____

DOB: _____ Primary Care Provider: _____

Who referred you for nerve testing: _____

Draw the location of pain (or other problems) and/or describe what problems you are having?



Have you had an EMG or Nerve Study before? (year, doctor who did the study, results): _____

Have you had an MRI of your neck, mid-spine, or low back? (when/where MRI performed?) _____

List surgeries on spine and bones (year, location, what was performed): _____

Have you had any prior injections for your problem we're seeing you for today? Y N

Please list your medications that you currently take: _____
