NAME: _____ Birth Date: _____ Phone Number: _____

Please indicate whether or not you are experiencing any of these conditions by entering the appropriate number.

"0" = not experiencing; "1" = experiencing If experiencing, indicate severity on the 1 – 10 scale. "1" = least severe; "10" = most severe

OVERALL FATIGUE	0 or 1	1 2 3 4 5 6 7 8 9 10
FATIGUE ON EXERTION	0 or 1	1 2 3 4 5 6 7 8 9 10
DECREASED MEMORY	0 or 1	1 2 3 4 5 6 7 8 9 10
DIFFICULTY CONCENTRATING	0 or 1	1 2 3 4 5 6 7 8 9 10
CONFUSION	0 or 1	1 2 3 4 5 6 7 8 9 10
BODY PAIN	0 or 1	1 2 3 4 5 6 7 8 9 10
NECK PAIN	0 or 1	1 2 3 4 5 6 7 8 9 10
FACIAL PAIN	0 or 1	1 2 3 4 5 6 7 8 9 10
HEADACHES	0 or 1	1 2 3 4 5 6 7 8 9 10
DECREASED STRENGTH	0 or 1	1 2 3 4 5 6 7 8 9 10
WEAK GRIP STRENGTH	0 or 1	1 2 3 4 5 6 7 8 9 10
LEG WEAKNESS	0 or 1	1 2 3 4 5 6 7 8 9 10
POOR BALANCE	0 or 1	1 2 3 4 5 6 7 8 9 10
NUMBNESS IN HANDS/FEET	0 or 1	1 2 3 4 5 6 7 8 9 10
TINGLING IN HANDS/FEET	0 or 1	1 2 3 4 5 6 7 8 9 10
DIZZINESS	0 or 1	1 2 3 4 5 6 7 8 9 10
CLUMSINESS	0 or 1	1 2 3 4 5 6 7 8 9 10
CHRONIC NAUSEA	0 or 1	1 2 3 4 5 6 7 8 9 10
IRRITABLE BOWEL	0 or 1	1 2 3 4 5 6 7 8 9 10
FREQUENT or URGENT URINATION	0 or 1	1 2 3 4 5 6 7 8 9 10
DIFFICULTY SWALLOWING	0 or 1	1 2 3 4 5 6 7 8 9 10
BLURRED VISION	0 or 1	1 2 3 4 5 6 7 8 9 10
SENSITIVITY TO LIGHT or SOUND	0 or 1	1 2 3 4 5 6 7 8 9 10
DEPRESSION	0 or 1	1 2 3 4 5 6 7 8 9 10
INSOMNIA	0 or 1	1 2 3 4 5 6 7 8 9 10

WORSENING SYMPTOMS WITH NECK MOVEMENT? ◯ Y or ◯ N

SYMPTOMS STARTED WITHIN 6 MONTHS OF A TRAUMA, FALL or ACCIDENT? ◯ Y or ◯ N

HAVE YOU BEEN DIAGNOSED WITH: (Check all that apply)

☐ CHIARI MALFORMATION	☐ FIBROMYALGIA	☐ CFS	☐ MYOFASCIAL PAIN	☐ TMJ
☐ POTS	☐ NMH	☐ MIGRAINES	☐ DAILY HEADACHES	

Please download, print and complete. Mail or deliver in person the questionnaire with the MRI scan of your brain or cervical spine to:

Froedtert & the Medical College of Wisconsin SpineCare
1155 N. Mayfair Road, Suite 200
Milwaukee, WI 53226
Phone: 414-955-7188
Fax: 414-955-0110