EMG Consult Form

**** To best address your referring physicians' concerns, please complete the entire form prior to being seen as it relates to your current symptoms for which you were referred ONLY. A separate study will be required for other complaints****

Name ______________________________ Date: ______________

Handedness: ☐ Left ☐ Right ☐ Ambidextrous

What is your age today: ______________

Occupation: _______________________________

Email: ________________________________

Who is your Primary Care physician?: _____________________________

Medical History:

____

____

____

Surgical History: ____

____

Medications: ____

____

____

Alcohol intake: ____________________________ drinks a week

Symptoms that brought you here today:

☐ Numbness ☐ Tingling ☐ Pain ☐ Weakness ☐ Other: _______________________________

Are your symptoms: ☐ Coming and going ☐ Constant ☐ Improving ☐ Worsening ☐ Stable

When did it start: ____

Symptoms are triggered by: ____

____

Symptoms are relieved by: ____

____

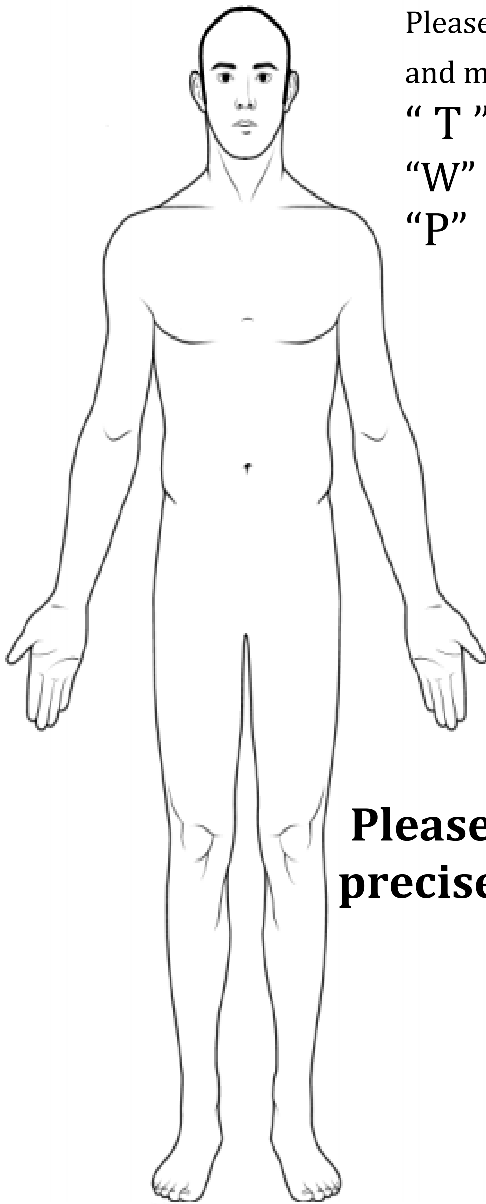
Have you tried any of these for your **CURRENT** symptoms?

☐ Physiotherapy/occupational therapy ☐ Acupuncture ☐ Massage therapy

☐ Chiropractor ☐ Pain medications ☐ Ice therapy

☐ Heat therapy ☐ Cupping ☐ Injections

Please shade the affected areas as it relates to your CURRENT (new) symptoms



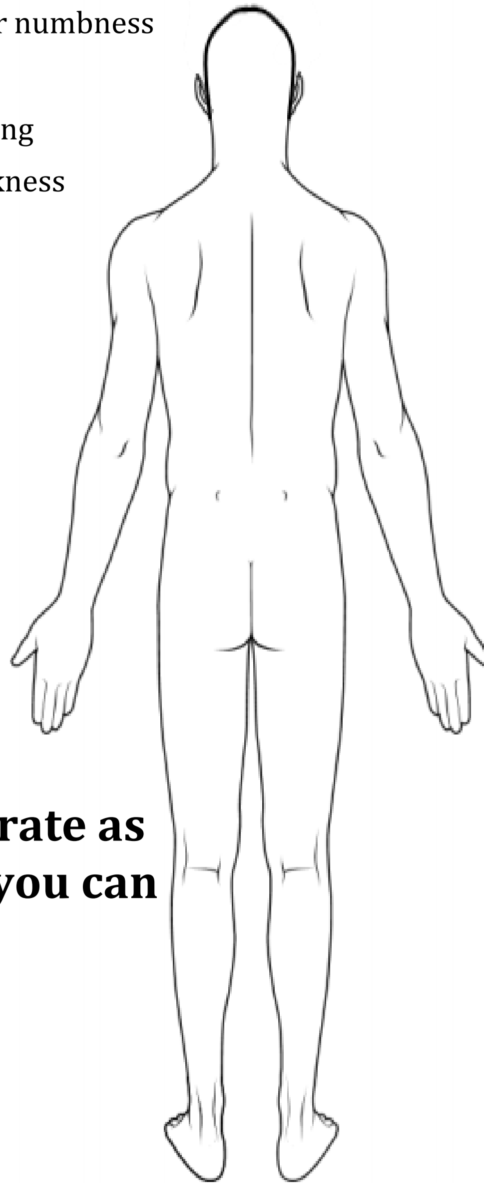
Please shade for numbness and mark:

" T " for tingling

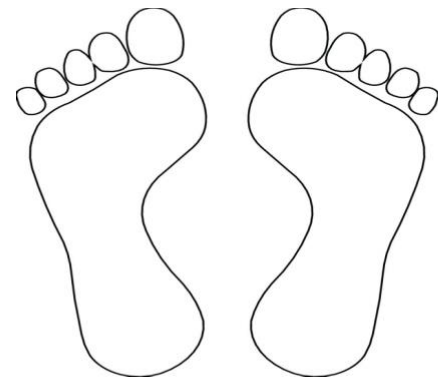
"W" for weakness

"P" for pain

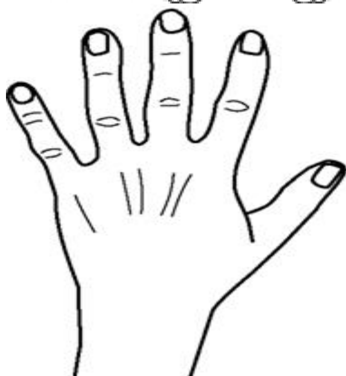
Please illustrate as precisely as you can



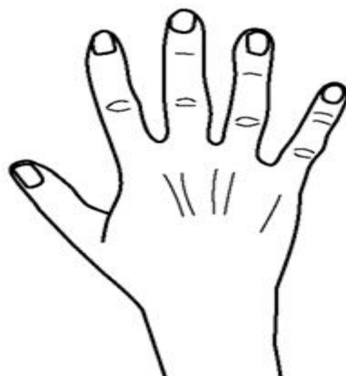
soles of your feet



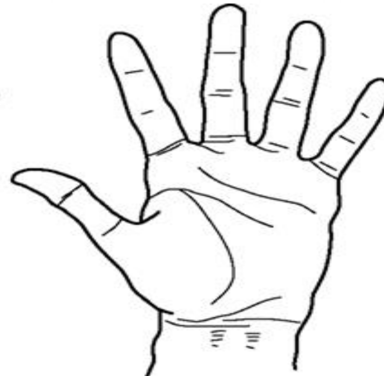
Right **Left**



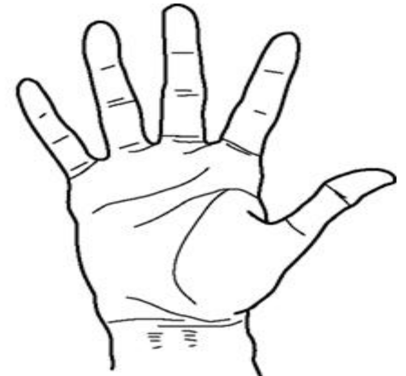
Left



Right



Left



Right

IF YOUR SYMPTOMS INVOLVE ONE OR BOTH HANDS ONLY-

Was trauma responsible for these symptoms? Y N

Do you experience any shooting pains from your neck along with these current symptoms? Y N

Is there a family history of similar symptoms? Y N

Do you ever wake up due to these symptoms? Y N

Have you had an MRI of your neck for these symptoms? Y N
If so, when? ________________________________

Have you had an EMG in the past for these symptoms? Y N
If so, when? ________________________________

Have you ever tried a hand/wrist splint or brace before? Y N
If yes, for how long? ______________________
Any benefit? Y N

Do you ever experience any of these? Please circle if yes.
Fatigue **Difficulty sleeping** **Difficulty concentrating** **Worsening of symptoms with stress**

Have you had difficulty performing your normal daily tasks? If so which ones?

____

____

____

____

____

____

____

____

IF YOUR SYMPTOMS INVOLVE ONE OR BOTH LEGS OR STARTED IN YOUR LEGS-

Was trauma responsible for these symptoms? Y N

Are these symptoms causing you imbalance? Y N

Do you experience any shooting pains from your back along with these current symptoms? Y N

Is there a family history of similar symptoms? Y N

Do you ever wake up due to these symptoms? Y N

Is there a change in urinary or bowel control arising from these symptoms? Y N

Have you had an MRI of your spine for these symptoms? Y N
If so, when? ___________________________________

Have you had an EMG in the past for these symptoms? Y N
If so, when? ___________________________________

Do you ever experience any of these? Please circle if yes.

Fatigue **Difficulty sleeping** **Difficulty concentrating** **Worsening of symptoms with stress**

Have you had difficulty performing your normal daily tasks? If so which ones?

____

____

____

____

____

____