"GEORGE'S CEREBROVASCULAR CRANIOCERVICAL FUNCTIONAL TEST"

Patient's Name_____Date_____Age____Sex___Pt #_____
please print

Instructions: Please circle the correct response. Sign and date when completed.

1. HISTORICAL INFORMATION DOCTOR'S NOTES

Have you ever been diagnosed or told you had any of the following?

1. High Blood pressure (hypertension) Yes No
2. Hardening of the arteries (arteriosclerosis) Yes No
3. Diabetes Yes No
4. Heart or blood vessel diseases Yes No
5. Bone spurs on the neck bones (cervical spondylosis) Yes No
6. Whiplash injury (flexion-extension injury) (cervical sprain) Yes No
7. Have any of your relatives ever suffered a stroke? Yes No
8. Were you ever a smoker? From____To_____ Yes No
9. Do you take any medication on a regular basis? Yes No
10. (Women only) Have you ever taken oral contraceptives? From_____To_____ Yes No

Have you ever experienced any of the following even short temporary attacks?

11. Blurred vision? Yes No
12. Double vision? Yes No
13. Diminished or partial loss of vision in one or both eyes? Yes No
14. Complete loss of vision in one or both eyes? Yes No
15. Ringing, buzzing or any noise in the ear(s)? Yes No
16. Hearing loss in one or both ears? Yes No
17. Slurred speech or other speech problems? Yes No
18. Difficulty swallowing? Yes No
19. Dizziness? Yes No
20. Temporary lack of understanding? Yes No
21. Loss of consciousness, even momentary blackouts? Yes No
22. Numbness or loss of sensation in the face, fingers, hand, arms, legs or other parts of your body? Yes No
23. Any other abnormal sensation in any part of your body? Yes No
24. Weakness, clumsiness or loss of strength in the face, fingers, hands, arms or legs? Yes No
25. Sudden collapse without loss of consciousness Yes No

PATIENT SIGNATURE_____ DATE _____