Legacy Pain and Spine Specialists

Joshua Meyer, M.D.

NCV Patient Questionnaire

Name: _____ Date: _____

Please check the boxes below:	Yes	No
1. Do you suffer from neck pain with pain in your arms or hands?	☐	☐
2. Do you have weakness, numbness or burning in either of your arms or hands?	☐	☐
3. Do your hands or arms fall asleep?	☐	☐
4. Do you have reduced feeling (sensation) in your hands or arms?	☐	☐
5. Do you suffer from a loss of hand grip strength?	☐	☐
6. Do you suffer from back pain with pain in your buttocks, legs or feet?	☐	☐
7. Do you have weakness, numbness or burning in your buttocks, legs or feet?	☐	☐
8. Do your legs or feet fall asleep?	☐	☐
9. Do you have reduced feeling (sensation) in your buttocks, legs or feet?	☐	☐

Patient Signature: _____

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