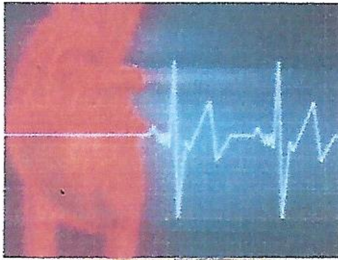
NEUROLOGIC RELIEF CENTER SURVEY

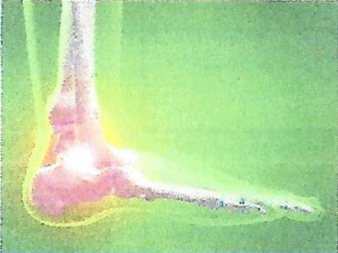
PURPOSE: To raise your awareness of any health problems you may be having and possible solutions.

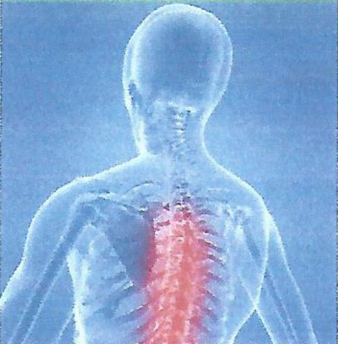
Name______________________________ Age__________ Phone ______________

Address______________________________ City________________ State____ Zip________

Email______________________________ Occupation ______________________







Check the boxes for any of the following symptoms you may have experienced in the past few months:

- ☐ Headaches/Migraines
- ☐ Fatigue, Tired
- ☐ Fibromyalgia
- ☐ Digestive Disturbance
- ☐ Difficulty Sleeping
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Multiple Sclerosis
- ☐ Low Back Pain
- ☐ Neck Pain
- ☐ Wrist/Hand Pain
- ☐ Elbow Pain
- ☐ Shoulder Pain
- ☐ Hip Pain
- ☐ Knee Pain
- ☐ Dizziness
- ☐ Parkinson's Disease
- ☐ Failed Surgeries
- ☐ Ankle/Foot Pain
- ☐ Ringing in the Ears
- ☐ Nervous
- ☐ Numbing/Tingling in Legs or Feet
- ☐ Numbing/Tingling in Arms or Hands
- ☐ Other ____________________

Which of the above bothers you the most?____________________

How long have you been bothered by this condition?____________________

What is your current pain/symptom level on a scale 1-10 (10 being the worst)?_____

What have you tried to correct the problem?____________________

Check the boxes of how this affects your life:

- ☐ Moody
- ☐ Irritable
- ☐ Interrupt Sleep
- ☐ Restricted on Daily Activities
- ☐ Slower in Movement
- ☐ Decision Making
- ☐ Poor Attitude
- ☐ Unable to Work Long Hours
- ☐ Lose Patience with Spouse or Children
- ☐ Restricted Household Duties
- ☐ Decreased Productivity
- ☐ Exhausted at the End of the Day
- ☐ Interferes with Ability to Participate in Hobbies or Other Desired Activities
- ☐ Hinders Ability to Exercise or Participate in Sports

NRCT™ (Neurologic Relief Centers Technique) may be able to HELP YOU.
In many cases people experience a relief of the majority of their symptoms at the time of testing that can last minutes, hours or even days.

Would you like to get relief? ☐ Yes ☐ No

If your answer is Yes, please check the item most appropriate for you.

☐ I would like to come to the office for a complimentary non-invasive Relief Test with the Doctor. This will allow me to find out if I can be helped by the Neurologic Relief Centers Technique without any obligation.

☐ I would like the Doctor to call me to discuss my health problems before making an appointment.

Are you a member of an HMO or Health Care Network? ☐ Yes ☐ No Name of HMO ____________

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