

Case# \_\_\_\_\_

“GEORGE’S CEREBROVASCULAR CRANIOCERVICAL FUNCTIONAL TEST”

Patient’s Name \_\_\_\_\_ Date \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
(Please Print)

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

I. 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? What?<br>(Coumadin, Heparin, Aspirin, Anti-hypertensive medicine, etc.) | Yes | No |
| <hr/>   |     |    |
| 10. (Women Only) Have you ever taken oral contraceptives?<br>From _____ to _____  | Yes | No |
| 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, hands, arms, legs or other<br>parts of your body?                 | Yes | No |
| 23. Any other abnormal sensations in any part of your body?   | Yes | No |
| 24. Weakness, clumsiness or loss of strength in the face, fingers, hands, arms, or<br>legs?                               | Yes | No |
| 25. Sudden collapse without loss of consciousness?  | Yes | No |

YOUR SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_