Dr. Anthony D. Robichaud
Chiropractor, B.Sc., D.C.

George's Cerebrovascular functional test

Patient name: _____ **Case #:** _____ **Date:** _____

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

	Yes	No
1- High blood pressure (hypertension)	☐	☐
2- Hardening of the arteries	☐	☐
3- Diabetes	☐	☐
4- Heart or blood vessels disease	☐	☐
5- Bone spurs on the neck bones	☐	☐
6- Whiplash injury (flexion-extension injury/ cervical sprain)	☐	☐
7- Have any of your relatives ever suffered a stroke?	☐	☐
8- Were you ever a smoker?_____to_____	☐	☐
9- Do you take any medication?_____to_____	☐	☐
10- For women: have you ever taken oral contraceptives?_____to_____	☐	☐

Have you had any of the following, even short or temporary attacks, in the last year?

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

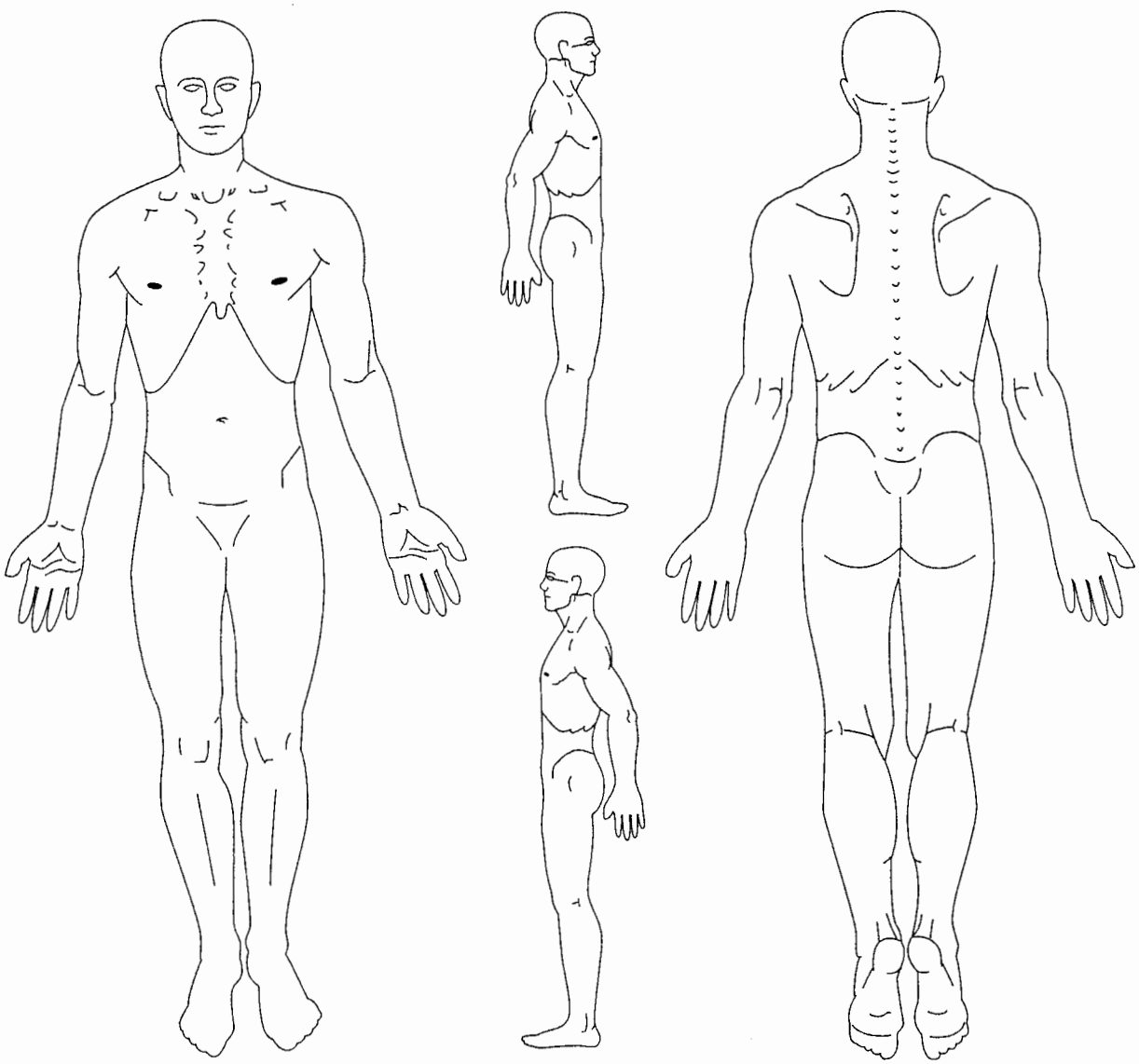
Patient's signature: _____ **Date:** _____

Patient Name(Print)_____ Date_____

Patient ID #_____

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain:

D = Dull
B = Burning
N = Numb
S = Stabbing/Cutting
T = Tingling (Pins & Needles)
C = Cramping



On the scales below, please draw a vertical line representing your pain or discomfort:

Rate the pain you have right **now:**

No Pain — Unbearable Pain

Rate your pain at its **best** in the past week:

No Pain — Unbearable Pain

Rate your **average** pain in the past week:

No Pain — Unbearable Pain

Rate your **worst** pain in the past week:

No Pain — Unbearable Pain