

ASSOCIATED NEUROLOGICAL SPECIALTIES
AUSTIN EMG CAPITOL EEG

Check In: _____
Patient Room Time: _____
Room #: _____

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Patient Name: _____ Date of Birth: _____ Date: _____

Chief complaints. *Please circle all that apply:*

- | | | |
|-------------------------------------|--------------------|------------|
| Multiple Sclerosis | Epilepsy/ Seizures | Headache |
| Attention Deficit Disorder | Dizziness/ Vertigo | Tremor |
| Numbness/ Tingling of hands or arms | Low Back Pain | Neck Pain |
| Numbness/Tingling of feet or legs | Memory Loss | Depression |
| Automobile Accident Injury | | |