



**BRACHIAL PLEXUS EVALUATION**

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

1. What was your chief complaint when you visited your doctor?  
\_\_\_\_\_
2. How long have you had this pain?  
\_\_\_\_\_
3. Does the pain go down your arm?  
\_\_\_\_\_
4. Does the pain go down your leg? YES NO  
-If yes, is it in the back or in the front?      BACK    FRONT    BOTH  
-Which side?                                              LEFT    RIGHT    BOTH
5. Do you have any numbness?                      LEFT    RIGHT              YES NO
6. Do you have any weakness?                      LEFT    RIGHT              YES NO
7. Have you ever broken any bones in the area being scanned today?      YES NO
8. Have you had surgery or arthroscopy to the area being scanned today? YES NO  
If yes, what was done? \_\_\_\_\_  
When? \_\_\_\_\_
9. Do you have any bowel or bladder changes? YES NO
10. Do you have any other medical conditions? YES NO
11. Do you have a history of cancer? YES NO
12. Describe your general health: \_\_\_\_\_  
\_\_\_\_\_