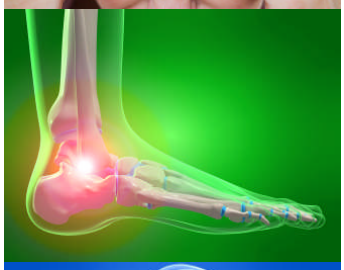
NEUROLOGIC RELIEF CENTER SURVEY

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	☐ Low Back Pain	☐ Parkinson's Disease
☐ Fatigue, Tired	☐ Neck Pain	☐ Failed Surgeries
☐ Fibromyalgia	☐ Wrist/Hand Pain	☐ Ankle/Foot Pain
☐ Digestive Disturbance	☐ Elbow Pain	☐ Ringing in the Ears
☐ Difficulty Sleeping	☐ Shoulder Pain	☐ Nervous
☐ High Blood Pressure	☐ Hip Pain	☐ Numbing/Tingling in Legs or Feet
☐ Arthritis	☐ Knee Pain	☐ Numbing/Tingling in Arms or Hands
☐ Multiple Sclerosis	☐ Dizziness	☐ 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	☐ Lose Patience with Spouse or Children
☐ Irritable	☐ Restricted Household Duties
☐ Interrupt Sleep	☐ Decreased Productivity
☐ Restricted on Daily Activities	☐ Exhausted at the End of the Day
☐ Slower in Movement	☐ Interferes with Ability to Participate in Hobbies or Other Desired Activities
☐ Decision Making	☐ Hinders Ability to Exercise or Participate in Sports
☐ Poor Attitude	
☐ Unable to Work Long Hours	

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 _____

The Redwood Clinic (510) 849-1176 www.TheRedwoodClinic.com
Neurologic Relief Center, LLC (866) 287-5465 www.stopfibro.net

Authorization

I hereby authorize _____ to perform the free test using the innovative NRCT™ (Neurologic Relief Centers Technique), a non-invasive orthopedic test. Our test usually relieves a percentage of your symptoms that may last minutes, hours, or even days. Although we have never had an issue with this test in the past, there is always a possibility for complications. I release _____of any liability for any complications that might arise. I also agree to let Neurologic Relief Centers, LLC use any video or photographic material I may appear in, in any way they see fit to further research and awareness.

Sign
Name:_____ Date:_____
Print
Name:_____

Internal Use Only	Level 1-10 (10 Worst)
Symptoms Before Test	
Symptoms After Test	
Other Misc. Notes	
	Seminar
	Date
	Coordinator