



NEOCONTROL EVALUATION

DATE: _____

PT NAME: _____ PT #: _____

PHONE #: _____

First evaluation:

1. I currently have a Pacemaker Yes No
Artificial Hip Yes No

2. Is there any possibility that you may be pregnant? Yes No

3. How many times do you wake at night to urinate? _____

4. During the day, how frequently do you have to urinate every:
 <30 minutes 1 hour to 1.5 hours
 30-45 minutes 1.5 to 2 hours
 45-60 minutes >2 hours

5. On a scale of 1-10 (with 10 being the worst) how much pain do you experience in the urinary tract and during urination? _____

6. Urination accidents occur daily: Yes No

7. I commonly use pads to protect clothing: Yes No

If yes, how many pads per day?

1-2/day
 3-5/day
 > 5/day

8. Do you take any medications for frequent urination? Yes No

If yes, which medications: _____

9. What problems do you hope to resolve with the NeoControl chair? _____

10. What other treatment methods have you tried for this problem? _____

11. Which doctors assisted you with #7? _____

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