



Patient History

Patient Name _____ Age _____ Today's Date _____

Occupation _____ Dominant hand(circle): R L

Currently Working? Y N Email Address: _____

History of injury / symptoms

Primary complaint _____

Date of injury or problem begin? ___/___/___ Date of Surgery? ___/___/___

What caused your problem to begin? Car accident ___ Work injury ___ Sports injury ___ Not sure ___

Other _____

Have you had any other treatment for this condition? _____

What tests have been done? X-ray ___ MRI ___ CAT scan ___ EMG ___

Bone Scan ___ Nerve Conduction ___

Current Medication(s)? _____

Check any other medical conditions you may have:

- | | | | |
|-----------------------------------------|--------------------------------------------|-------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Currently Pregnant |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |

Other : _____

Allergies (please list) _____

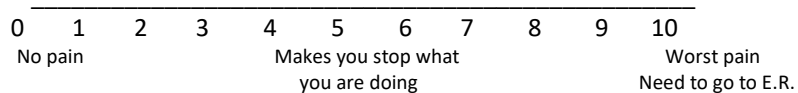
Recent surgeries (please list) _____

Do you have a pacemaker or any metal implants? _____

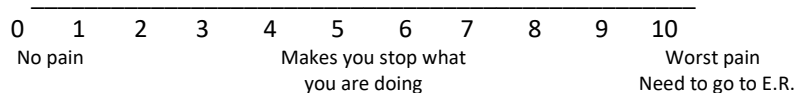
Pain Level

Mark on the scale what level your pain is:

At its **worst**:



At its **best**:



Where is your pain? Mark on the drawings below the areas where you feel your pain.

