



PATIENT HEALTH INFORMATION

Name: _____ Occupation: _____

Age: _____

Date of Onset: Pain/Injury/Surgery: _____

Briefly state previous treatment, if any: _____

Do you have now, or have you ever had any of the following?

- | | | | |
|--|-----------|---------------------|-----------|
| DIABETES | YES__NO__ | ALLERGY TO COLD | YES__NO__ |
| HIGH BLOOD PRESSURE | YES__NO__ | OTHER ALLERGIES | YES__NO__ |
| PACEMAKER | YES__NO__ | PREVIOUS SURGERY | YES__NO__ |
| CHRONIC HEADACHES | YES__NO__ | SEIZURES | YES__NO__ |
| KIDNEY PROBLEMS | YES__NO__ | METAL IMPLANTS | YES__NO__ |
| NERVOUS DISORDERS | YES__NO__ | DIZZINESS | YES__NO__ |
| HERNIA | YES__NO__ | CANCER | YES__NO__ |
| ALLERGY TO HEAT | YES__NO__ | CURRENTLY PREGNANT | YES__NO__ |
| BONE DISEASE | YES__NO__ | OSTEOPOROSIS | YES__NO__ |
| FRACTURES | YES__NO__ | BOWEL PROBLEMS | YES__NO__ |
| BLADDER PROBLEMS | YES__NO__ | RECENT WEIGHT LOSS | YES__NO__ |
| PINS/NEEDLES FEELING | YES__NO__ | CIRCULATORY DISEASE | YES__NO__ |
| PROBLEM WITH BOTH ARMS OR BOTH LEGS AT THE SAME TIME | YES__NO__ | | |

If YES to any of the above, please explain and give appropriate details: _____

Are you presently taking any medications? YES__NO__

If YES, please list your medications and for what condition: _____

Have you had any x-rays, CAT scans, MRIs, or other diagnostic tests for your recent pain/injury/condition? YES__NO__ If YES, please explain the findings as you understand them:

Is there anything else you think I should know about your general health, or current condition? Please explain and, if necessary, we can talk about it: _____