

Patient Information Page 2

Name: _____ Date of Birth _____ Age: _____

In Emergency notify: _____ Relationship _____ Phone _____

Leisure Activities: _____ Job Description: _____

Medications : _____

Allergies: _____ Are You Pregnant? _____ **PACEMAKER** _____

Have you ever been diagnosed with any of the following? (Please circle those that apply)

Cancer	Diabetes	Hypoglycemia	Hypertension	Heart Disease	Stroke
Allergies	Asthma	Kidney Disease	Osteoarthritis	Rheumatoid Arthritis	
Hepatitis	Emphysema	Ulcers	Liver Disease	Chronic Bronchitis	Polio
Pneumonia	Reiter's syndrome	Osteoporosis	Rheumatic Fever	Other: _____	

Do you suffer from any of the following? (Please circle those that apply)

Chest Pain	Shortness of Breath	Kidney Problems	Urinary Problems	Dizziness
Headaches	Ringing in the Ears	Changes in Bowel/Bladder function if so	How _____	

Past Medical Problems, surgeries, and hospitalizations:

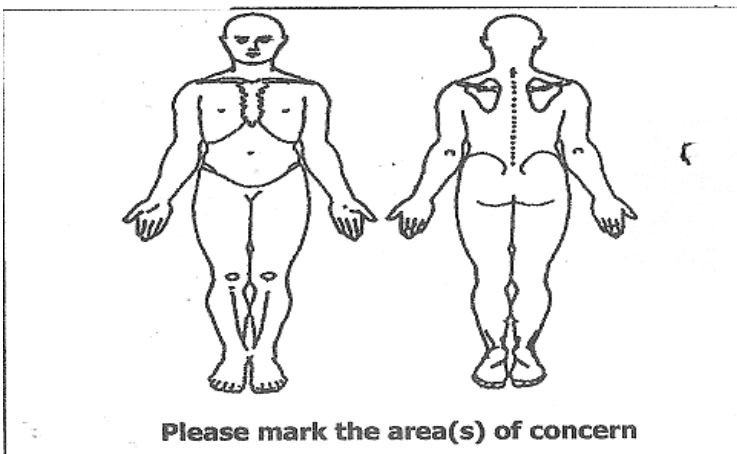
Please note any recent x-rays, CT Scans, MRI or other medical tests taken and their results. _____

What do you hope to achieve in therapy? _____

Date of Onset for this problem today: _____

Previous Therapy for this? Yes/No if yes when? _____

Please indicate on the diagram where your pain is located:



Average pain level _____
0= no pain 10= worst pain ever