

Please answer the questions to the best of your ability based on how you feel today. It may be necessary to observe certain precautions during your treatment if any of the following medical conditions exist.

Thank you for your cooperation.

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart condition      |
| <input type="checkbox"/> Pacemaker  | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Circulation problems |
| <input type="checkbox"/> Metal implants   | <input type="checkbox"/> Loss of sensation  | <input type="checkbox"/> Dizziness            |
| <input type="checkbox"/> History of seizures  | <input type="checkbox"/> Currently pregnant | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Drug Allergies   | Please list: _____                          |   |
| _____   |   |   |
| <input type="checkbox"/> Infectious diseases such as tuberculosis, hepatitis A, B, or C, HIV, etc |   |   |

Do you smoke?            YES            NO

What is the condition that brought you to therapy? \_\_\_\_\_

Have you ever been treated before for this condition? \_\_\_\_\_

What is your goal for therapy? \_\_\_\_\_

List dosage and frequency of medications including over-the-counter, herbals, vitamins/mineral/dietary or nutritional supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any surgeries you have had \_\_\_\_\_

\_\_\_\_\_

Please indicate your range of pain by circling the number when it is at its lowest level and when it is at its highest level  
(0=least pain, 10=most pain)

0      1      2      3      4      5      6      7      8      9      10

Circle the words that best describe your pain:

constant      frequent      occasional      aching      stabbing      burning      throbbing      shooting

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Therapist Signature