Patient History

To ensure you receive a complete & thorough evaluation, please provide us with important background information by answering the following questions.

Name: _____ Age: _____

Do you <u>currently</u> have any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Dizziness			Diabetes			Scoliosis		
Rheumatoid Arthritis			Open Wounds			Fatigue		
Arthritis			Current Infection(s)			Headaches		
Osteoporosis			Anxiety			Nausea / vomiting		
High Blood Pressure			Fever/chills/sweats			Asthma		
Hypothyroidism			Visual Changes			Pacemaker		
Change in weight in past month for no reason?						Latex allergy		
Change in bladder or bowel functions?						Are you pregnant?		
Does pain wake you up when you sleep?						Surgical Implant?		
Other:								

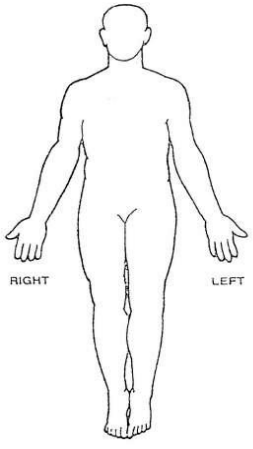
Did you ever have any of the following?

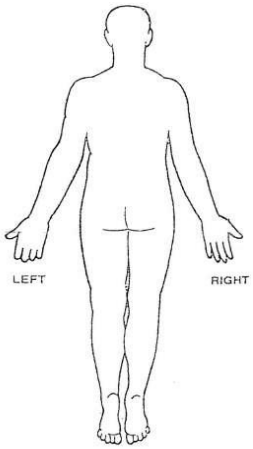
Heart Disease			Vascular Disease			CVA / Stroke		
Ehlers-Danlos (EDS)			Rheumatic Fever			Seizures		
Cancer / Tumor								
Any prior injuries:								
Family history of cancer:								
Surgeries:								

Please tell us more about your present symptoms / condition:

1. The reason for this visit is a result of: ☐work ☐sports ☐auto accident ☐other:_____
   Please explain what happened: _____
2. What is the exact location of your symptoms? _____
3. When did you first notice this condition (date)? _____
4. Have you had physical therapy at all this year? If yes, how many visits? _____
5. Have you ever been hospitalized for this condition? ☐ No ☐ Yes, How long? _____
6. Are you taking any medications? ☐ No ☐ Yes, which ones: _____
7. How much of your daily activities are you able to do now on a scale from 0 to 100%? _____
8. When is your next doctor's appointment? _____

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.





Ache ^^^
Numbness ===
Pins & Needles ooo
Burning xxx
Stabbing ///

PAIN RATING SCALE

Please rate the severity of your pain at its worst and at its best by circling a number between 0 and 10.

0	1	2	3	4	5	6	7	8	9	10
no pain		mild, annoying		nagging, uncomfortable		increasing, miserable		intense, dreadful		worst possible