

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.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

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

- High blood pressure       Cancer       Currently pregnant       Dizziness
- Pacemaker       Diabetes       Heart condition       Stroke
- Metal implants       Loss of sensation       Circulation problems
- History of seizures       Drug allergies Please list: \_\_\_\_\_
- Infectious diseases such as tuberculosis, hepatitis A,B or C, HIV, etc.

Please list: \_\_\_\_\_

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: \_\_\_\_\_