



Patient Medical History

Name _____ Date _____

Have you had or do you have any of the following?

Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Dizziness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hernia	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
High Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Metal Implants	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Seizures	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Chronic Headaches	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Previous Physical Therapy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Previous Surgery	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Currently Pregnant	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Pacemaker	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No					

If you answered yes to any of the above questions please explain and give the date of occurrence.

Do you have a latex allergy? Yes No

Are you taking any medications related to the problem you are here for today? Yes No

If yes, please list: _____

Have you had any injections? Yes No

If yes, where? _____

Have you had any X-Rays, MRI, etc? Yes No

If yes, what area? _____

Please circle on the scale below your level of pain today.

0 = no pain

10 = Pain that would make you go to the emergency room

0 1 2 3 4 5 6 7 8 9 10

Please mark an **X** on the diagram where your pain is located.

