MEDICAL FORM

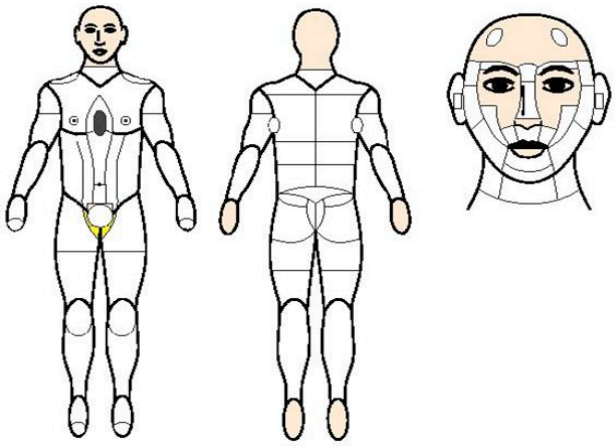
PATIENT NAME:_____ **DATE:**_____

1. BRIEFLY DESCRIBE THE HISTORY OF YOUR MAIN COMPLAINT:

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2. WHAT MEDICATIONS ARE YOU TAKING?_____

3. SENSITIVITIES OR ALLERGIES _____ **LOCATION OF METALS/TATTOOS** _____



4. Rate your pain on the scale below from 0–10 (0 = no pain) and 10 = worst pain)

Pain at rest:	0	1	2	3	4	5	6	7	8	9	10
Pain with Activity:	0	1	2	3	4	5	6	7	8	9	10

5. DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS:

- ❑ Hepatitis_____
- ❑ Diabetes (type, treatment etc) _____
- ❑ Seizure disorder (triggers, treatment etc) _____
- ❑ Blood thinning medications_____
- ❑ Cancer (year, location, treatment etc)_____
- ❑ Heart Problems_____
- ❑ Pacemaker _____
- ❑ Cortisone Therapy in target area) _____

Muscular / Joint / Visceral
- ❑ Earaches
- ❑ TMJ (Jaw Pain)
- ❑ Neck
- ❑ Shoulders
- ❑ Arm, Wrist, Hand
- ❑ Mid & Back
- ❑ Abdomen, Stomach
- ❑ Hips
- ❑ Leg Pain
- ❑ Ankle, Feet
- ❑ Arthritis _____
- ❑ Kidney
- ❑ Fibromyalgia
- ❑ Lupus
- ❑ Sprains, Strains
- ❑ Broken / Fractured Bones
- ❑ Tendonitis
- ❑ Rheumatoid Arthritis
- ❑ Bone / Joint Disease
- ❑ Closed head injury, concussion

Reproductive
- ❑ Pregnant (month) ___
- ❑ Hormonal imbalance
- ❑ Breastfeeding _____
- ❑ Other _____

Digestive
- ❑ Constipation / Diarrhea
- ❑ Irritable Bowel Syndrome

Cardiovascular
- ❑ Asthma
- ❑ Chronic Cough
- ❑ High or Low Blood Pressure
- ❑ Poor Circulation
- ❑ Varicose Veins
- ❑ Stroke History
- ❑ Sinus Problems
- ❑ Bruise Easily
- ❑ Blood Clots
- ❑ Heart Problem

Nervous System
- ❑ Numbness / Tingling
- ❑ Chronic Pain
- ❑ Fatigue
- ❑ Sleep Disorders
- ❑ Dizziness
- ❑ Emotional Changes

Neurological
- ❑ Headaches
- ❑ Migraines
- ❑ Seizures

Eyes
- ❑ Loss of Vision
- ❑ Blurred Vision
- ❑ Double Vision
- ❑ Dryness
- ❑ Redness

Endocrine
- ❑ Thyroid / Other Glands

Other
- ❑ Thyroid imbalance
- ❑ Active infection
- ❑ G6PD deficiency
- ❑ Anxiety
- ❑ PTSD
- ❑ Depression

Skin
- ❑ Herpes, Cold Sores
- ❑ Rash
- ❑ Warts or Athlete's Foot
- ❑ Other Skin Disorders
- ❑ Keloid Scarring
- ❑ Psoriasis / Vitiligo
- ❑ Skin disease /lesions
- ❑ Allergies _____

6. I certify these medical & personal statements to be true & correct. I am aware that it is my responsibility to inform the therapist of any updates to my current medical & health conditions.

Patient Signature: _____ **DATE:** _____