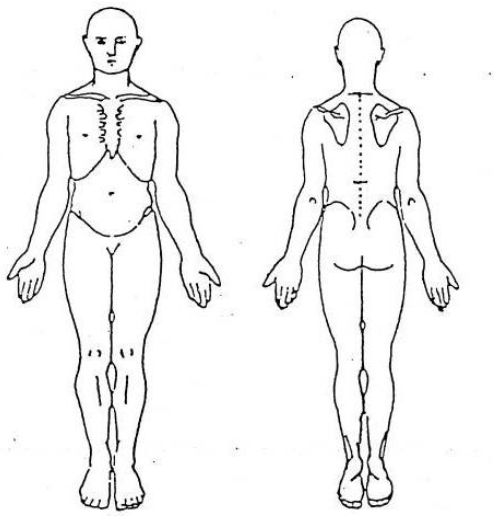
Mark on the body chart where your pain/symptoms are for THIS injury:



HEIGHT: _____

WEIGHT: _____

INJURY DATE/DATE OF ONSET: _____

REFERRED BY: _____

INJURY WAS/IS (CIRCLE ONE):

EMPLOYMENT AUTO OTHER _____

Please check if you have ever had any of the following:

_____ FRACTURES	_____ BACK INJURY	_____ NECK INJURY	_____ KNEE INJURY
_____ HEAD INJURY	_____ HEART DISEASE	_____ HYPERTENSION	_____ PACEMAKER
_____ STROKES	_____ SEIZURES	_____ LUNG DISEASE	_____ CIRCULATION PROBLEMS
_____ ASTHMA	_____ DIABETES	_____ HERNIA	_____ PNEUMONIA
_____ CATARACTS	_____ CANCER		

Have you recently noted:

Yes/No Weight loss/gain	Yes/No Numbness/ tingling	Yes/No Fatigue
Yes/No Fever/chills/sweats	Yes/No Nausea/Vomiting	Yes/No Weakness

Please list any other diagnosis that you have had _____

_____

Please list any surgeries you have had: _____

_____

Please list any medications you are currently taking: _____

_____

Allergic to: _____

Do you have any metal implanted in your body? If so, where? _____

If you are female, are you pregnant? _____

If you are over 65, have you fallen in the past year? _____Were you injured? _____

Do you:

Smoke? Yes/No __packs/day Drink Alcohol? Yes/No ___drinks/day Caffeinated beverages? ____/day

Other professionals you have seen, or are currently seeing for your present injury or illness._____

_____

_____ _____

Patient Name Date