

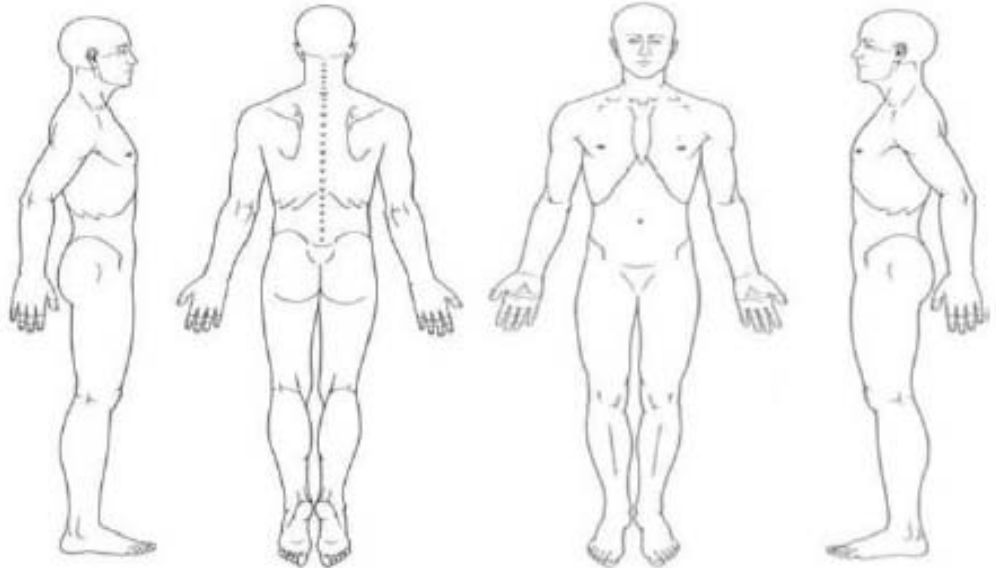
Patient's Name : \_\_\_\_\_ Date : \_\_\_\_\_

Draw on the figure to indicate where your symptoms are

Please use the following key to help us understand your symptoms

Shade = pain  
 Circle = numbness  
 /// = burning

Indicate a number from 1-10 with 1 = minimal symptoms and 10 = severe symptoms next to each area you indicated on the figure.



Are you currently taking any medications (prescription or over-the-counter)? Please list. \_\_\_\_\_

Have you had any surgeries? If yes, please explain \_\_\_\_\_

**Medical History:**

Have you ever had:	Yes	No		Yes	No
Anemia			Emphysema		
Epilepsy /Seizures			GERD		
Fibromyalgia/Myofascial Pain Syndrome			Gout		
Hepatitis/Jaundice			Guillan-Barre Syndrome		
Joint Replacement			Parkinson's Disease		
Polio/Postpolio			Peripheral Vascular Disease		
Shortness of Breath			Pneumonia		
Skin Problems			Prostate Problems		
Rheumatic/Scarlet Fever			Thyroid Problems		
Urinary Incontinence (dribbling, leaking)			Ulcer/Stomach Problems		
Varicose Veins			Diabetes		
Chronic Bronchitis					

**Cardiac History:**

**Medical History for Women:**

	Yes	No		Yes	No
MI/ Heart Attack			History of Endometriosis		
Cardiac Arrhythmia			History of Pelvic Inflammatory Disease		
CHF			Are you/could you be pregnant?		
Have you ever had heart surgery?			Any trouble with leaking or dribbling urine?		
Do you have a pacemaker?			Have you ever had a miscarriage/abortion?		

Number of Pregnancies \_\_\_\_\_ Number of live births \_\_\_\_\_

**General Health:**

- I would rate my health as (circle one):    Excellent    Good    Fair    Poor
- Are you taking any nutritional supplements? (any kind including vitamins) \_\_\_\_\_
- Have you had any illness in the last 3 weeks (e.g. colds, influenza, infections) \_\_\_\_\_  
 If yes, have you had this before in the last 3 months? \_\_\_\_\_
- Have you noticed any lumps or thickening of skin or muscle anywhere on your body? \_\_\_\_\_
- Do you have any sores that have not healed or any changes in size shape or color of a wart or mole? \_\_\_\_\_
- Have you had any unexplained weight gain or loss in the last month? \_\_\_\_\_
- Do you smoke or chew tobacco? (if yes, how many packs/pipes/pouches/sticks a day?) \_\_\_\_\_

Patients please sign and date: \_\_\_\_\_ Date: \_\_\_\_\_

Therapist's signature after reviewing form with patient \_\_\_\_\_