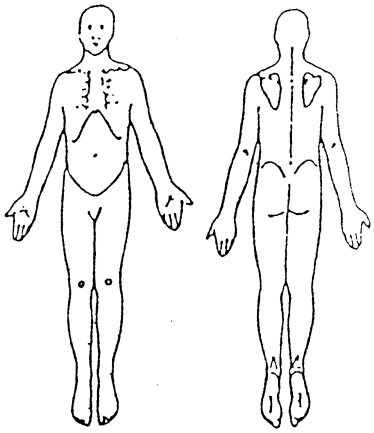
PATIENT HISTORY FORM

DATE _____ **NAME** _____ **AGE** _____

What are your symptoms? (circle) pain numbness tingling burning weakness other (please explain)

_____

(mark problem area below)



Have you had any of the following tests or treatments for your current symptoms? (circle) X-ray MRI Injection Physical Therapy

If you were hospitalized for your current symptoms, list dates

_____

Are you receiving Home Medical services in your home?

_____

Have you been treated for any of the following conditions? (circle) Cancer Cardiac Conditions Diabetes High Blood Pressure

Do you have a Pacemaker? _____

Are you Pregnant? _____

Why are you having Physical Therapy? _____

Past Medical History/Orthopedic Surgeries

_____

Return date to doctor (if known)? _____

Are you currently working? _____ **Occupation** _____

How long have you been doing this job? _____ **Employer** _____

Would you like information about our clinic's weight loss program Healthy Living Link _____