

*** PLEASE PRINT ***

PREVIOUS TREATMENTS FOR PAIN

TENS Unit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Physical/Occupational Therapy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biofeedback?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychological Evaluations?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypnosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chiropractic Treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nerve Blocks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Helpful?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

MEDICAL HISTORY

Height _____ Weight _____

Which of the following conditions have you had, or do you presently have? Please note when diagnosed.

CONDITION	WHEN DIAGNOSED	CONDITION	WHEN DIAGNOSED
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Ulcer(s)	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Heart Problems	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Bleeding Problems	
<input type="checkbox"/> Chemo/Radiation		<input type="checkbox"/> Liver	
<input type="checkbox"/> Emphysema		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Thyroid Problems		<input type="checkbox"/> Other	

List any surgeries you have had:

SURGERY	WHERE	WHEN