DATE:_____

MEDICAL HISTORY

Patient Name: **Date of Birth:**

Area of Pain: **Date of Onset of the Pain:**

Primary Care Physician: **PCP Phone Number:**

Your E-mail

Medical conditons:

Anxiety	**yes**	**no**	**Hearing Loss**	**yes**	**no**
Arthritis	**yes**	**no**	**Heart Disease**	**yes**	**no**
Asthma	**yes**	**no**	**Hepatitis**	**yes**	**no**
Cancer	**yes**	**no**	**HIV/AIDS**	**yes**	**no**
CHF	**yes**	**no**	**Hypertension**	**yes**	**no**
Clotting Disorders	**yes**	**no**	**Heart Attack**	**yes**	**no**
COPD	**yes**	**no**	**Nerve/Muscles Disorder**	**yes**	**no**
Depression	**yes**	**no**	**Osteoperosis**	**yes**	**no**
Diabetes	**yes**	**no**	**Pneumonia**	**yes**	**no**
Dizziness	**yes**	**no**	**Seizures**	**yes**	**no**
DVT/PE	**yes**	**no**	**Skin Problems**	**yes**	**no**
Fibromyalgia	**yes**	**no**	**Stroke**	**yes**	**no**
GERD	**yes**	**no**	**Thyroid Disease**	**yes**	**no**
Headaches	**yes**	**no**	**Vision Problems**	**yes**	**no**

Allergies/how does it effect you?

Broken bones/Surgeries:

Other Medical Conditions:

Medications:

Current Pain Level 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Pain at its Worst (past 72 hrs) **/10**

Pain at its Best (past 72 hrs) **/10**

0 = no pain, 10= worst imaginable pain