

Patient Name: _____

Date: _____ **DOB:** _____

HEALTH INFORMATION: Do you suffer from any of the following?

- | | | | |
|--|---|------------------------------------|--|
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Joint Swelling | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Communicable Diseases |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Numbness | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Metal Implants | <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Seizures | |

Allergies _____

Past Surgeries _____

Medications _____

NEXT SCHEDULED APPOINTMENT WITH REFERRING DOCTOR _____