

## MEDICAL HISTORY

Type of injury: \_\_\_\_\_ Date of onset \_\_\_\_\_

Please describe how injury occurred \_\_\_\_\_

List any medications you are presently taking (if any): \_\_\_\_\_

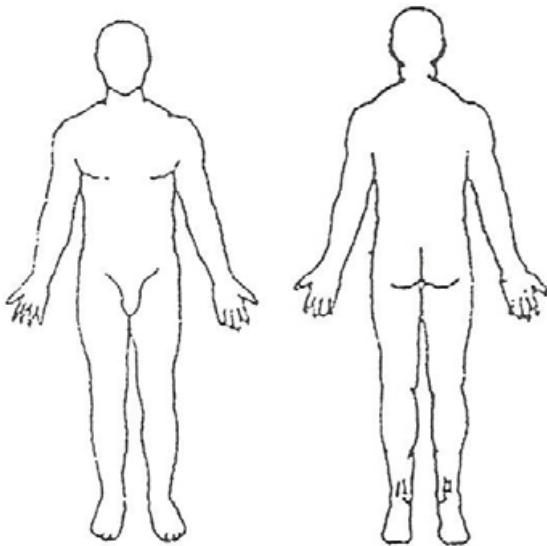
Have you had x-rays taken for this injury?      ( ) yes      ( ) no

circle what best describes your pain:      sharp      dull      aching      shooting

Circle what best describes your symptoms:      constant      intermitten      occasional

**PLEASE MARK ON THE DIAGRAM, THE LOCATION OF SYMPTOMS YOU ARE CURRENTLY FEELING:**

**X PAIN    ... NUMBNESS    --- TINGLING**



What makes you feel worse? (circle all that apply)

Sitting	Standing	Leaning	Climbing
Laying down	Stooping	Driving	Bending
Lifting	Stretching	Walking	Reaching

What makes your pain feel better?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Circle Yes or No

Do you have a history of Cancer?      Yes      No

Do you have Hypertension?      Yes      No

Are you Diabetic?      Yes      No

Do you have a pace maker?      Yes      No

Do you have Bowel/Bladder problems:      Yes      No

Are you Pregnant?      Yes      No

List any other medical or orthopedic history \_\_\_\_\_

\_\_\_\_\_