**Medical Information Form**

**Please review the following questions and answer as applicable:**

1. Please list any medications (or provide us with a copy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you currently working and what are the activities involved for your job? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please indicate your expectations and goals for your treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which describes your pain (check all that apply):**

\_\_\_\_\_\_\_\_\_Constant

\_\_\_\_\_\_\_\_\_Comes and goes at regular times

\_\_\_\_\_\_\_\_\_Happens once in a while

\_\_\_\_\_\_\_\_\_Wakes from sleep

\_\_\_\_\_\_\_\_\_Prevents sleep

\_\_\_\_\_\_\_\_\_Better after sleep

\_\_\_\_\_\_\_\_\_Impairs ability to perform daily activities

**Please check any that apply to you:**

\_\_\_\_\_ Diabetes \_\_\_\_\_ Headaches

\_\_\_\_\_ Arthritis \_\_\_\_\_ Cancer

\_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Fainting/Dizzy Spells

\_\_\_\_\_ Heart Disease or Chest Pain \_\_\_\_\_ Night Sweats

\_\_\_\_\_ Blood Disease (anemia, AIDS, etc.) \_\_\_\_\_ Stroke/Head Injury

\_\_\_\_\_ Breathing Problems (asthma, emphysema, etc.) \_\_\_\_\_ Hernia

\_\_\_\_\_ Circulation Problems (varicose veins, phlebitis) \_\_\_\_\_ Pregnant/Possibly pregnant

\_\_\_\_\_ Digestive Problems (ulcers, hiatal hernia, etc.) \_\_\_\_\_ Thyroid Disorders

\_\_\_\_\_ Liver Problems (hepatitis, jaundice, etc.) \_\_\_\_\_ Exercise Restrictions

\_\_\_\_\_ Previous Surgery \_\_\_\_\_ Neurological Disorder

\_\_\_\_\_ Previous Fractured Bones \_\_\_\_\_ Bowel/Bladder Dysfunction

\_\_\_\_\_ Other

**Patient Name (please print)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_