Results.
Neck & Back Therapy

HEALTH HISTORY FORM

Name: DOB: Age: Today's Date:

Who referred you to us? Your occupation/Job:

Site of Problem: Which Side: Left Right

Date of Injury: Height: Weight:

How were you injured: (Please circle one) No injury-just started hurting Sports (list sport):

Motor Vehicle accident Work/Job (Is there a work comp claim: Yes/No)

Please briefly describe the injury:

Previous treatments (other than surgery)

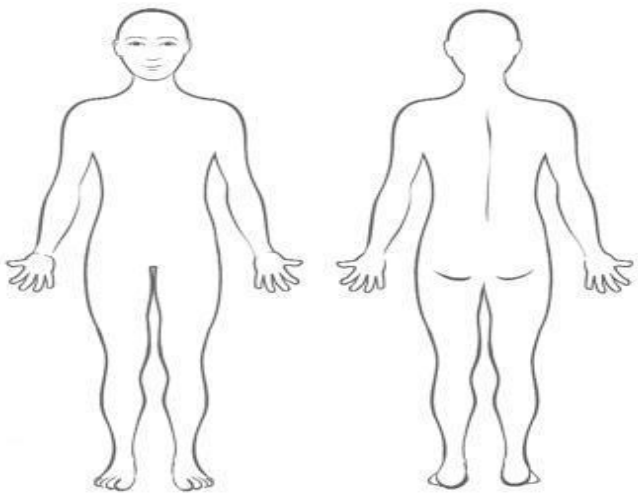
Previous surgeries for the injury:

List any medications you are currently taking:

Medical History

Please Circle any you have experienced

Arthritis
Asthma
Cancer
Cardiac Conditions
Diabetes
Epilepsy
Hepatitis
High Blood Pressure
Osteoporosis
Pace Maker
Stroke/TIA



Please indicate injured areas and rate pain on scale of 0-10 (0 being no pain and 10 being unbearable pain