Patient Name: _____

Do you have any of the following (please circle yes or no):

High Blood Pressure	Yes	No	Numbness	Yes	No
Headache	Yes	No	Heart Problems	Yes	No
Fatigue	Yes	No	Pacemaker	Yes	No
Nausea	Yes	No	Circulation Problems	Yes	No
Dizziness	Yes	No	Diabetes	Yes	No
Tingling	Yes	No	Seizures	Yes	No
Swelling	Yes	No	Hernia	Yes	No
Heat Sensitivity	Yes	No	Metal implants	Yes	No
Ice Sensitivity	Yes	No	Pregnant (currently)	Yes	No

Previous Surgeries: Yes No

Please list dates and reason for surgery below (use backside if you need more room):

_____

_____

_____

_____

_____

_____

Are you presently taking Medications/Vitamins/Supplements?

Please enter the name, dosage and when you take them (use backside if you need more room):

Medication Name	Dosage	Times/Day/Hour
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Vista CA 92081
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Medication Name	Dosage	Times/Day/Hour

How many falls have you had in the past year? _____

The undersigned acknowledges and agrees that the information set forth is true and correct.

Signature _____ Date _____

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