Performance Over Pain
Medical History Form

Area of Symptoms:____Age:_________

Date of onset/injury/surgery:____

Any known results of recent X-rays or tests:_______________________________________

____

Chronic Conditions: Yes ☐ No ☐ If yes, please list:________________

____

Allergies: Yes ☐ No ☐ If yes, please list:______________________

____

List surgeries and dates:____

Medications: Yes ☐ No ☐ If yes, please list:______________________

____

Do you have or have you had any of the following:

Cancer	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Metal Implants	Yes ☐	No ☐
Epilepsy/Seizures	Yes ☐	No ☐	Respiratory Problems	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Are you pregnant?	Yes ☐	No ☐

1. How would you rate your ability to perform your routine daily activities?

   Unimpaired (no problems) 0 1 2 3 4 5 6 7 8 9 10 Unable to perform

2. How would you rate your ability to perform the activities associated with your job?

   Unimpaired (no problems) 0 1 2 3 4 5 6 7 8 9 10 Unable to perform

3. How would you rate your current pain?

   No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

4. How did you select our service?

☐ Doctor Recommended	☐ Previous Patient	☐ Other _____________
☐ Insurance provider directory	☐ Family/Friend Recommended Name:__________________	May we notify them? Y N

____

Patient Signature **Date**