



9404 Genesee Ave., #310
 La Jolla, CA 92037
 (858)677-9700 • (858)455-7101

TODAY'S DATE _____

PATIENT'S NAME _____

REASON FOR THERAPY: _____

DATE OF INJURY/SURGERY: _____

CHECK IF YOU CURRENTLY HAVE ANY OF THE FOLLOWING:

- | | | | |
|---------------------|--------------------------|----------------------|--------------------------|
| PAIN | <input type="checkbox"/> | HERNIA | <input type="checkbox"/> |
| HEADACHES | <input type="checkbox"/> | CIRCULATORY PROBLEMS | <input type="checkbox"/> |
| FATIGUE | <input type="checkbox"/> | KIDNEY PROBLEMS | <input type="checkbox"/> |
| NAUSEA/DIZZINES | <input type="checkbox"/> | NERVOUS DISORDERS | <input type="checkbox"/> |
| TINGLING | <input type="checkbox"/> | ORTHOPEdic PROBLEMS | <input type="checkbox"/> |
| NUMBNESS | <input type="checkbox"/> | DIABETES | <input type="checkbox"/> |
| SWELLING | <input type="checkbox"/> | SEIZURES | <input type="checkbox"/> |
| LOSS OF MOVEMENT | <input type="checkbox"/> | ANY RECENT WEIGHT | |
| HIGH BLOOD PRESSURE | <input type="checkbox"/> | LOSS | <input type="checkbox"/> |
| HEART PROBLEMS | <input type="checkbox"/> | GAIN | <input type="checkbox"/> |
| PACEMAKER | <input type="checkbox"/> | METAL IMPLANTS | <input type="checkbox"/> |
| ALLERGIES | <input type="checkbox"/> | PREGNANCY | <input type="checkbox"/> |

ARE YOU PRESENTLY WORKING? YES NO

IS YOUR PROBLEM LIMITING YOUR DAILY FUNCTIONS? YES NO

IS YOUR PROBLEM CAUSING RECREATIONAL LIMITATIONS? YES NO

PLEASE EXPLAIN LIMITATION

PLEASE LIST MEDICATIONS YOU ARE CURRENTLY TAKING

THE UNDERSIGNED ACKNOWLEDGES AND AGREES THAT THE INFORMATION SET FORTH IS TRUE AND CORRECT.

NAME _____

DATE _____