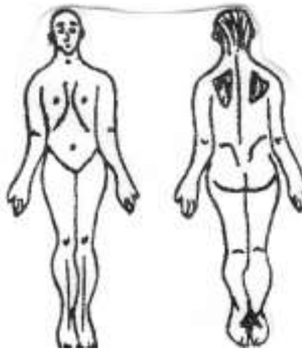
Mind Body WORKS

Village Commons, 620 Village Dr., Suite E
Virginia Beach, VA 23454
757-351-3332 | Fax: 757-351-2544

MEDICAL INFORMATION

Name: ____________________________ D/O/B _________________
Diagnosis or Complain: ______________________ Dominant Hand: L __ R __
Please mark and describe on these drawings the area(s) of your chief complaint.



Previous treatment for this condition (include dates): _____________________________

Check if you know you have or have had any of the following:

AIDS	YES__NO__	Heart or Circulatory Disease	YES__NO__
Allergies	YES__NO__	High Blood Pressure	YES__NO__
Arthritis	YES__NO__	Breathing Problems	YES__NO__
Cancer	YES__NO__	Seizures	YES__NO__
Pacemaker	YES__NO__	Recent Weight Loss	YES__NO__
Diabetes	YES__NO__	Dental Problems	YES__NO__
Dizziness	YES__NO__	TMJ	YES__NO__
Headaches	YES__NO__	Steroid Use	YES__NO__

If you checked YES to any of the above, explain and give dates: __________
____

Other conditions not listed: ____

Pregnant Now: __ Number of Pregnancies: __ Type of Delivery: ____________
What type of pillow do you use? __________ Position of comfort? ___________

Range of Pain (from 0-10; 0 is no pain and 10 is severe pain): __/10
When do you get pain?

Sitting	YES__NO__	Squatting	YES__NO__
Standing	YES__NO__	Kneeling	YES__NO__
Walking	YES__NO__	Bending Forward	YES__NO__
Running	YES__NO__	Heavy Lifting	YES__NO__
Sleeping	YES__NO__	Shaving	YES__NO__
Stairs	YES__NO__	Driving	YES__NO__

Other: ____