

Mind Body WORKS

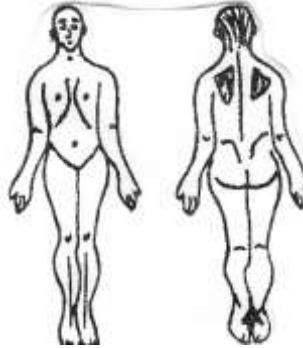
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MEDICAL INFORMATION

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/give dates:

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__

Other conditions not listed: _____

Pregnant Now: ___ Number of Pregnancies: ___ Type of Delivery: _____

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: _____

****In case of emergency, who should be notified?** _____

Phone: _____ **Relationship to Patient:** _____