Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have preferred pronouns? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problem/Onset Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History: (Check all that apply)**

|  |  |  |
| --- | --- | --- |
| * Anxiety * Arthritis * Asthma/Difficulty Breathing * Autoimmune Disease   + Type: \_\_\_\_\_\_\_\_\_\_ * Cancer   + Type: \_\_\_\_\_\_\_\_\_\_ * Clotting Disorder * Concussions * Congestive Heart Failure * Depression * Diabetes | * Digestion Issues/Disease * Dropped Arches/Feet * Fainting Spells * Fibromyalgia * Hearing Impairment * Heart Attack (Date:\_\_\_\_\_\_\_) * Heart Disease * Hepatitis * High Blood Pressure * High Cholesterol * HIV * Kidney Disease * Lung Problems * Osteoporosis * Pacemaker | * Pelvic Pain * Pregnancies: \_\_\_\_\_ * Radiation Treatment * Scar Pain * Scoliosis * Seizures * Sickle Cell Disease * Smoker   + Current \_\_\_\_\_\_\_   + Past \_\_\_\_\_\_\_\_\_ * Stroke (Date: \_\_\_\_\_\_\_\_) * Swelling in Limbs * Urinary/Bowel Leakage * Visual Impairment * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

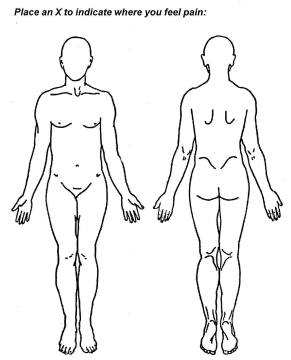
**Surgeries (What Kind and When):**

Please Mark (X) where you

feel the **MOST** pain:

**Please mark (X) where you**

**feel the MOST pain:**

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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R

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications (Include Dosage and Frequency):**

* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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