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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