PATIENT HISTORY & ELIGIBILITY

Patient's name:	Date of birth:
Phone:	

Please list your past & current medical issues:

Please list your past surgeries:

Current Medications (please include any over the counter and herbal supplements):

Please indicate whether you currently have or had any of the following in the past:

- Metal or electronic implants ☐ YES ☐ NO
- Cardiac pacemakers, implanted defibrillators, implanted neurostimulators ☐ YES ☐ NO
- Drug pumps ☐ YES ☐ NO
- Chronic pulmonary issues, COPD, emphysema or uncontrolled asthma ☐ YES ☐ NO
- Recent muscle injuries or torn muscles ☐ YES ☐ NO
- Malignant tumor(s) or cancer ☐ YES ☐ NO

- Cardiovascular diseases (heart or lung disease) ☐ YES ☐ NO
- Disturbance of temperature or pain perception ☐ YES ☐ NO
- Numbness or any type of nerve damage or neuropathies ☐ YES ☐ NO
- Bleeding / Hemorrhagic conditions ☐ YES ☐ NO
- Active or chronic infections ☐ YES ☐ NO
- Acute inflammatory or infectious diseases ☐ YES ☐ NO
- Systemic or local infection such as a cellulitis (skin infections), bone infection / osteomyelitis and tuberculosis ☐ YES ☐ NO
- Contagious skin disease(s) ☐ YES ☐ NO
- Do you have any thyroid conditions such as Grave's disease, Hashimoto's thyroiditis? ☐ YES ☐ NO
- Do you have any auto-immune skin diseases? (scleroderma, psoriasis, dermatomyositis, epidermolysis bullosa, bullous pemphigoid, Bechet's disease, dermatitis herpatiformis, linear IgA disease, lupus, morphea, Ocular cicatrical pemphigoid, phemphigoid or pemphigus, vasculitis, alopecia, or lichen sclerosis) ☐ YES ☐ NO
- Do you have any neuro-muscular diseases: amyotrophic lateral sclerosis (ALS), guillain-barre syndrome, carpal tunnel syndrome, polio, any type of spinal cord injury, or multiple sclerosis. ☐ YES ☐ NO
- Do you have and cervical or lumbar disc issues, or spinal stenosis? ☐ YES ☐ NO
- Do you have any congenital issues (medical issues you were born with)? ☐ YES ☐ NO

For female patients:

Do you currently have a metallic IUD, such as Paraguard®? ☐ YES ☐ No

Are you currently pregnant or within 2 months of your last pregnancy? ☐ YES ☐ No

Are you currently breast feeding? ☐ YES ☐ No

Have you ever had a cesarean section surgery previously (C-section)? ☐ YES ☐ No

Is there any chance you could be or become pregnant? ☐ YES ☐ No

Please check the reasons you can not become pregnant:

☐ Hysterectomy, ☐ Birth control pills, ☐ birth control patch, ☐ Diaphragm, ☐ Cervical cap, ☐ Cervical shield. ☐ Birth control uterine implant (Mirena®, Kyleena®, Skyla®, Liletta®, ☐ Depo-Provera® injection, ☐ Nexplanon® implant,
☐ Condoms ☐ Not active
☐ other birth control method please list: _____

If you answered YES to any of the above questions, please give additional details if needed:

_____
_____
_____
_____

Patient's signature: _____ Date**:** _____

Provider Signature: _____ Date: _____