**ADULT MEDICAL HISTORY**

**NeuroTherapy Specialists, Inc.**

 Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Injury/Onset:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

 Please describe your current problem(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have or have you ever had any of the following:

\_\_\_\_Recent fractures \_\_\_\_Diabetes \_\_\_\_Headaches \_\_\_\_Metal Implants \_\_\_\_Hepatitis \_\_\_\_ Seizures

\_\_\_\_Rheumatoid Arthritis \_\_\_\_Liver/Gallbladder problem \_\_\_\_Dizziness/Fainting

\_\_\_\_Heart Problems \_\_\_\_Kidney problems \_\_\_\_Ringing in Ears

\_\_\_\_Chest Pain/Angina \_\_\_\_Bowel or Bladder problem \_\_\_\_Nausea/Vomiting

\_\_\_\_Pacemaker \_\_\_\_Hernia \_\_\_\_\_Surgeries

\_\_\_\_Allergy/Intolerance to Cold \_\_\_\_Allergies to Heat \_\_\_\_\_Depression

\_\_\_\_High Blood Pressure \_\_\_\_ Asthma/Breathing Difficulty \_\_\_\_\_Visual Problems

\_\_\_\_Cancer \_\_\_\_Skin Abnormalities \_\_\_\_\_Hearing Problems

If you checked any of the above, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you taking any medications? \_\_\_\_\_Yes \_\_\_\_\_No If yes, please list the medication dosage and frequency:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Women Only: Are you pregnant? \_\_\_\_\_Yes \_\_\_\_\_No

Do you participate in any sports, exercise programs on a regular basis? \_\_\_\_\_Yes \_\_\_\_\_No

Rate the intensity of your pain on a scale of 1-10 (1=no pain, 10=the worst pain)\_\_\_\_\_

In the instance of emergency, who may we contact? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Name Date

Patient’s Signature Date

PRIVATE INFORMATION CONSENT

I have been given an opportunity to review NeuroTherapy Specialists, Inc. Notice of Information Practices. I understand that NeuroTherapy Specialists, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that NeuroTherapy Specialists, Inc. will consider requests for restriction on a case-by-case basis,but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes, as noted in the NeuroTherapy Specialists , Inc. Notive of Information Practices. I understand that I retain the right to revoke this consent by notifying NeuroTherapy Specialists, Inc. at any time.

Patient’s Signature Date