ADULT MEDICAL HISTORY
NeuroTherapy Specialists, Inc.

Patient Name: _____
Date of Injury/Onset:_____ __
Please describe your current problem(s):

_____

_____

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:

_____

_____

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