

**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:

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| <input type="checkbox"/> Recent fractures            | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Headaches          |
| <input type="checkbox"/> Metal Implants              | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> Rheumatoid Arthritis        | <input type="checkbox"/> Liver/Gallbladder problem   | <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> Heart Problems              | <input type="checkbox"/> Kidney problems             | <input type="checkbox"/> Ringing in Ears    |
| <input type="checkbox"/> Chest Pain/Angina           | <input type="checkbox"/> Bowel or Bladder problem    | <input type="checkbox"/> Nausea/Vomiting    |
| <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Hernia                      | <input type="checkbox"/> Surgeries          |
| <input type="checkbox"/> Allergy/Intolerance to Cold | <input type="checkbox"/> Allergies to Heat           | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Asthma/Breathing Difficulty | <input type="checkbox"/> Visual Problems    |
| <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Skin Abnormalities          | <input type="checkbox"/> 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:

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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

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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. Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying NeuroTherapy Specialists, Inc. at any time.

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Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_