Medical History Form

Dear Patient,

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and for your safety. Thank you.

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

Cancer	**Yes ___**	**No ___**	
Diabetes	**Yes ___**	**No ___**	
Epilepsy or Seizures	**Yes ___**	**No ___**	
Heart Disease	**Yes ___**	**No ___**	
High Blood Pressure	**Yes ___**	**No ___**	
Metal Implants	**Yes ___**	**No ___**	
Respiratory Problems	**Yes ___**	**No ___**	
Surgeries	**Yes ___**	**No ___**	**If yes, please explain_____**

_____

Allergies **Yes ___** **No ___** **If yes, please explain**

Chronic Conditions **Yes ___** **No ___** **If yes, please explain**

_____

Are you pregnant now? **Yes ___** **No ___**

_____

Patient Signature **Date**

_____

Therapist Signature **Date**