The Inner Connection
Medical History

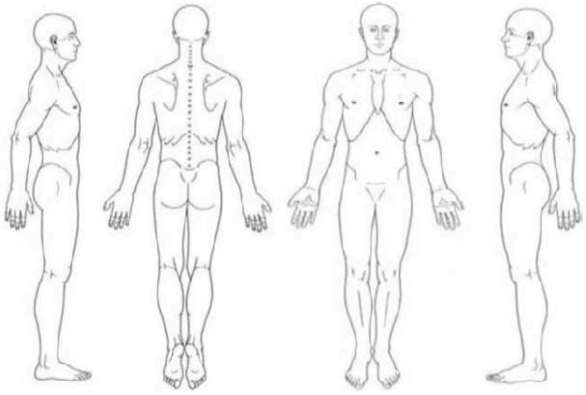
Patient Name_____
_____ **Date**_____
Primary Physician_____
Weight_____
Height_____
□ **Heart Disease** □ **Depression**
□ **Respiratory Disease** □ **Alcohol abuse history**
□ **Diabetes** – *Taking insulin? Yes / No* □ **Drug abuse history**
□ **Seizure Disorder** – *Date of last seizure* _____
□ **Smoker** *How much?*_____ *How many years?*____
□ **CVA** *(Cerebrovascular accident or stroke) Date*_____
□**Cancer** *What Type?*_____

Allergies_____
_____
_____
Current Medications:
_____
_____
_____
_____
_____
Check those conditions that apply to you:

□ **High Blood Pressure** □ **Infectious Disease**
*Explain*_____

□ **Dizziness / Fainting / Nausea** *(please circle)*
□ **Recent Surgeries**
*Type/Date*_____
_____
_____

Please Describe Your Current Symptoms
Indicate where you have pain or other symptoms.



How often do you experience your symptoms?

□ Constantly (76-100% of the day)
□ Frequently (51-75% of the day)
□ Occasionally (26-50 % of the day)
□ Intermittently (0-25% of the day)

What describes the nature of your symptoms?
□ Sharp □ Shooting
□ Dull ache □ Burning
□ Numb □ Tingling

How are your symptoms changing?
□ Getting better-
□ Not changing
□ Getting worse

During the past 4 weeks
• How much has pain interfered with your normal work activities?
Not at all A little bit Moderately Quite a bit Extremely
• How much has pain interfered with your normal daily living activities?
Not at all A little bit Moderately Quite a bit Extremely

Patient Signature_____**Date**_____