Name: Date:

Birthdate: Age: Email:

Address: City:

State: Zip: Cellphone:

Occupation Referred By:

Emergency Contact Name & Number:

Primary Concern:

How long have you been experiencing these symptoms?

Is it getting worse? Does it bother your: □ Sleep □Work □Other (what?)

What seemed to be the initial cause:

Are you under additional care (chiropractic, PT, etc.…)

Current Medications:

Current Supplements/Vitamins:

Please mark YES or NO You have an implanted electrical device You are pregnant

 You have a seizure disorder You are actively bleeding, hemorrhaging or menstruating

MAJOR AREAS OF COMPLAINT, PAIN, TENSION:

Please mark all areas below:



|  |
| --- |
| What are you hoping to accomplish with PEMF? |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

Signature: Date: