NEO Therapy

Patient Information

Yes /

Patient Name: _____

Date: _____

Date of Injury/surgery: _____

Occupation: _____

Describe Your Problem:

_____

_____

_____

How did the pain start?

- ☐ Suddenly
- ☐ Pulling
- ☐ Gradually
- ☐ Injured at work
- ☐ Lifting
- ☐ Bending
- ☐ No apparent reason _____

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Bending forward
- ☐ Exercise (after)
- ☐ Bending back
- ☐ Sitting
- ☐ cough/Sneeze
- ☐ Walking
- ☐ _____

What reduces the pain?

- ☐ Lying Down
- ☐ Pain Pills
- ☐ Sitting
- ☐ Cold Pack/Ice
- ☐ Standing
- ☐ Muscle relaxants
- ☐ Walking
- ☐ _____

How long have you had this pain?

_____ Years _____ Months _____ Weeks

How long have you had similar pain?

_____ Years _____ Months _____ Weeks

Have you had any of these diagnostic tests?

X-Rays	☐ Yes	Date:_____
CT Scan	☐ Yes	Date:_____
EMG/NVC	☐ Yes	Date:_____
MRI	☐ Yes	Date:_____
Arthrogram	☐ Yes	Date:_____
Injection	☐ Yes	Date:_____

Have you been hospitalized for your problem?

Yes / No Date: _____

Have you had surgery for your problem?

Yes / No Date: _____

What Other OTHOPEDIC Surgeries have you had?

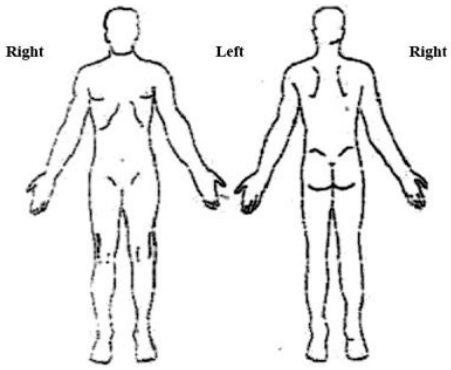
_____

Other treatments have you had for this issue?

Pain/Symptoms

Mark where you are having your issue:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning
Pain Level:
_____ (0-10)



Medical History

Check for those that apply

Allergies		Anemia	
Anxiety		Arthritis	
Asthma		Autoimmune Disorder	
Cancer		Cardiac Conditions	
Cardiac Pacemaker		Chemical Dependency	
Circulation Problems		Currently Pregnant	
Depression		Diabetes	
Dizzy Spells		Emphysema/ Bronchitis	
Fibromyalgia		Fractures	
Gallbladder Problems		Headaches	
Hearing Impairment		Hepatitis	
High Cholesterol		High/Low Blood Pressure	
HIV/AIDS		Incontinence	
Kidney Problems		Metal Implants	
MRSA		Multiple Sclerosis	
Muscular Disease		Osteoporosis	
Parkinson's		Rheumatoid Arthritis	
Seizures		Smoking	
Speech Problems		Strokes	
Thyroid Disease		Tuberculosis	
Vision Problems			

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