



Personal History

Name: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS AND SIGN THE BOTTOM PORTION UPON COMPLETION.

PERSON HISTORY – Have you ever had following:

	Yes	NO	IF Yes Specify
Osteoporosis/ Ostopenia	___	___	_____
Cancer	___	___	_____
Stroke	___	___	_____
Allergies	___	___	_____
Pace maker	___	___	_____
Broken Bones	___	___	_____
Arthritis	___	___	_____
Skin Disorders	___	___	_____
Mental Disorders	___	___	_____
Hepatitis	___	___	_____
TB/ Lung Disorder	___	___	_____
HIV/ AIDS	___	___	_____
Hypertention	___	___	_____
Diabetes	___	___	_____
Surgery	___	___	_____
Metal Implant in Body	___	___	_____
Other	___	___	_____
Are you currently in Pain?	___	___	_____

Specify body part: _____

Are you currently under medication? Yes No

If yes please specify type and for what condition: _____

TO THE BEST OF MY KNOWLEDGE, THE INFORMATION I PROVIDED IS TRUE AND CORRECT.

Patient Signature: _____ Date: _____

Note: This is a confidential record and will be kept in this facility or your doctor's office information supplied here will not be released to anyone without your written consent.