Dakun Pain Relief Center

CONFIDENTIAL MEDICAL HISTORY FORM

Dakun Pain Relief

Name ………………………………………………………………………………… Today's Date ……/………/……………

Address ………………………………………………… Phone (Home) ……………… Phone (Cell) ………………………

City ………………………………………… State …………………… Zip …………… Gender M / F

Occupation………………………………… Date of Birth ………………… Email ………………………………………

How did you learn of Dakun Pain Relief Center? ………………………………………………………………………

SECTION 1: CURRENT / PAST MEDICAL CONDITIONS *(place an **X** in the box to the right)*

Head / neck	**X**	**Shoulder / arm**	**X**	**Back / pelvis / legs**	**X**	**General**	**X**
Headache/ migraine		Rotator cuff syndrome		Spinal deformity		Hypermobility	
Shooting pain in neck		Arthritis		Back pain / surgery		Skin diseases	
Jaw pain		Shoulder injury (surgery)		Night cramps		Fibromyalgia	
Bruxism, grinding		Frozen shoulder		Sciatic pain		Easy bruising	
Whiplash		Carpal tunnel syndrome		Foot pain / surgery		Blood clots	
Concussion		Tennis elbow		Hernia (repair)		Stress	
Broken neck		Golfer's elbow		Hip pain		Sports injuries	
Glasses/contact lens		***Male***		Knee trauma			
Eye strain		Testicular / groin pain		Ankle trauma			
Poor balance		***Female***					
Dizziness / vertigo		Pregnant					
Fainting		Recently post-partum					
Ringing in the ear		Mastectomy/lumpectomy					

Other not listed: ………………………………………………………………………………………………………

Current medical diagnoses: ………………………………………………………………………………………

Emergency contact: …………………………………………… Phone ……………………………………………

SECTION 2: RELEVANT MEDICAL PROCEDURES **(Accidents / Fractures / Surgeries / Scars / Dentistry)**

(list the most recent first, including date and outcome if possible)

Date………………Description…………………………………………………………………………………………

Date………………Description…………………………………………………………………………………………

Date………………Description…………………………………………………………………………………………

Date………………Description…………………………………………………………………………………………

Date………………Description…………………………………………………………………………………………

SECTION 3: SUPPLEMENTS

Taking …………………………for…………………… Taking …………………………for……………………

Taking …………………………for…………………… Taking …………………………for……………………

Taking …………………………for…………………… Taking …………………………for……………………

SECTION 4: CURRENT STATUS OF PAIN & DYSFUNCTION

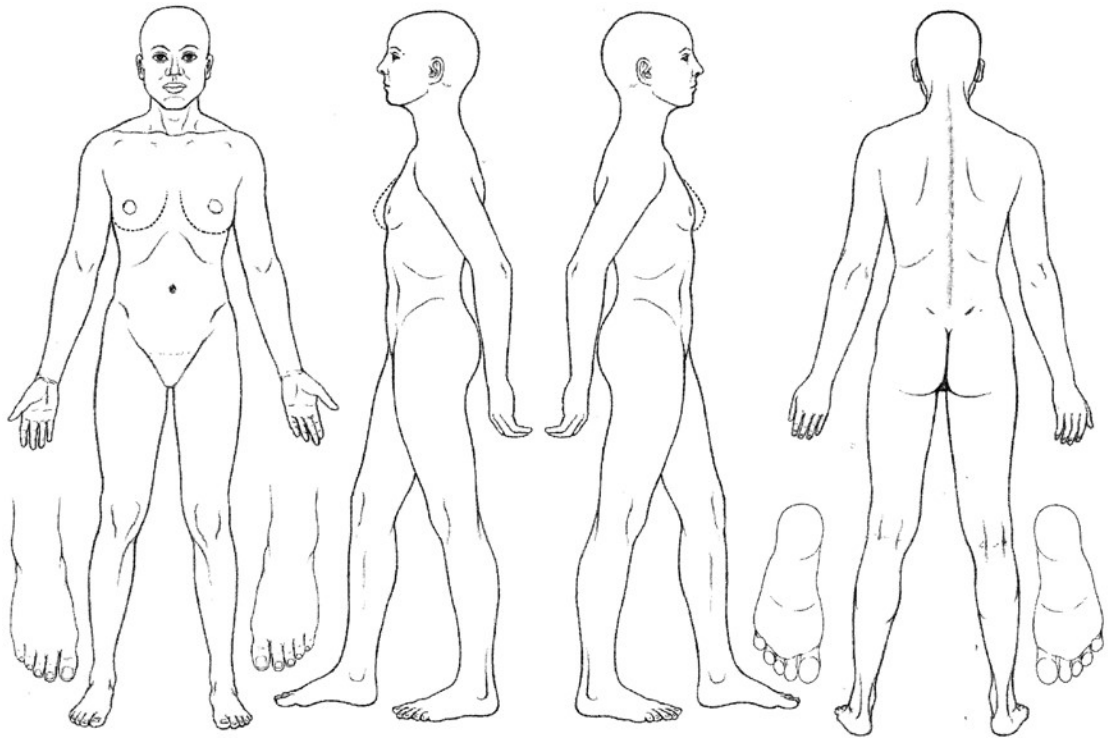
What is the main reason for your visit today? ……

When did the main problem begin? ……

What makes it worse? ……

What makes it better? ……

Please indicate below the locations of your pain **today.** Add pain numbers indicating your pain's severity. Use lines pointing to specific regions to separate pain levels and sensations in different areas and number accordingly. Add any descriptive words specific to any region. For example, your shoulder blades could be an 8/10 and "burning" while your front of shoulders are 3/10 and "nagging."



RATING 1: today's pain intensity rating: *(mark with a cross on the line)*

0 1 2 3 4 5 6 7 8 9 10

NO PAIN MODERATE PAIN WORST PAIN

RATING 2: today's function rating: (ability to shop, cook, clean, walk, climb stairs, drive, work, play, socialize)

(mark with a cross on the line)

0 1 2 3 4 5 6 7 8 9 10

FULLY ACTIVE MODERATE LIMITED FUNCTION FULL IMPAIRMENT

Signature_____ **Printed name** _____

Parent / Guardian's signature if under the age of 18 _____

Signees relationship_____ **Date:** ……. /……/ …….

SECTION 5: AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION (If needed)

I,_____, hereby authorize Dakun Pain Relief Center to discuss my treatment and disclose my massage therapy records to the following health providers:_____
_____

I understand that I may revoke this authorization at any time, but that I may not hold Dakun Pain Relief Center responsible for acting in a reasonable reliance on this statement prior to the time that it learns of my revocation. I understand that this authorization expires one year after the date signed below, unless I inform Dakun Pain Relief Center otherwise.

_____ _____
Signature of Client (or legal representative) **Relationship to Client**

_____
Client name (printed)