acousana®
Live Life - Pain Free

Patient Information:

Date: _____

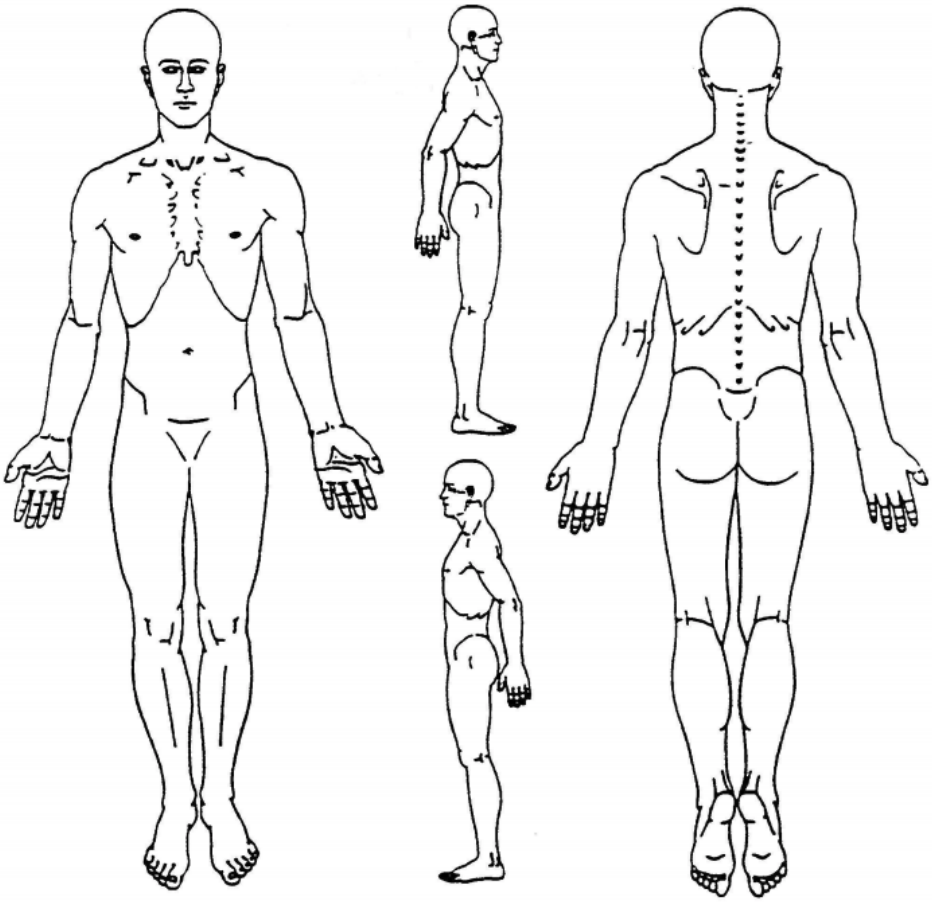
First Name:_____ Last Name:_____ Age: _____

Phone:_____ Email:_____

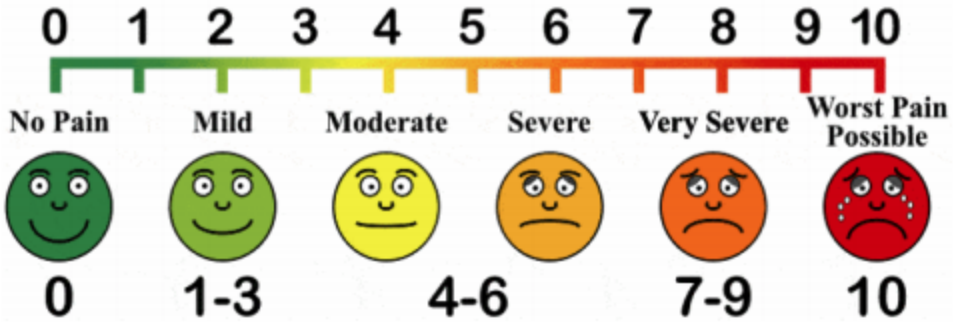
How Did You Hear About Us? _____

What Brings You In Today? _____

Place X's on the chart where you are feeling pain. If the pain is starting in one location and ending in another, draw a line showing how the pain travels.



Pain History:



Choose a number from the pain scale and describe the pain (i.e. aching, sharp, shooting, etc.) during the following activities:

Sitting

0 1 2 3 4 5 6 7 8 9 10

Aching Sharp Shooting Dull Numb Other:_____

Standing

0 1 2 3 4 5 6 7 8 9 10

Aching Sharp Shooting Dull Numb Other:_____

Walking

0 1 2 3 4 5 6 7 8 9 10

Aching Sharp Shooting Dull Numb Other:_____

Daily Activities

0 1 2 3 4 5 6 7 8 9 10

Aching Sharp Shooting Dull Numb Other:_____

Sleeping

0 1 2 3 4 5 6 7 8 9 10

Aching Sharp Shooting Dull Numb Other:_____

Is This Pain From an Injury? **Yes / No**

If yes, give a brief description of the injury and diagnosis: _____

_____

Has this pain been diagnosed by a doctor? **Yes / No**

If yes, please list the type of doctor and diagnosis given: _____

_____

Have you tried any other treatments or remedies? **Yes / No**

If yes, give a brief description of the treatment or remedy: _____

_____

Do you have an active hemorrhage? **YES / NO**

Do you have a Pacemaker or Implantable Defibrillators? **YES / NO**

Are you currently pregnant? **YES / NO**

Have you been diagnosed with cancer? **YES / NO**

Do you have a coagulation disorder? **YES / NO**

Have you been diagnosed with hemorrhagic diathesis? **YES / NO**

Have you been diagnosed with a serious infectious disease? **YES / NO**