

Gotham Wellness
Electro-Equiscope Services

CLIENT INFORMATION

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____
Age: _____ Birthdate: _____ Sex: M / F Occupation: _____
Referred by: _____ Spouse/Partner: _____

MEDICAL HISTORY AND SYMPTOM / PAIN INFORMATION

Do you have Demand or other pacemaker? Y / N Are you or could you be pregnant? Y / N

Do you have a magnetic shunt or other surgically implanted pain stimulator? Y / N

Reason for today's visit:

☐ New injury ☐ Old injury ☐ Chronic Pain ☐ Wellness

Duration of current Condition: _____

Are you in pain? Y / N

Rate your pain with the following scale:

none 1 2 3 4 5 6 7 8 9 intense

Symptoms you have experienced in the past 6 months:

- ☐ Low back pain
- ☐ Pain between shoulder blades
- ☐ Neck pain
- ☐ Tension headaches, migraines
- ☐ Tired/fatigued
- ☐ Numbness/Tingling in arms or hands
- ☐ Numbness/Tingling in legs or feet
- ☐ Dizziness
- ☐ Ringing of Ears
- ☐ Nervous or anxiety/stress
- ☐ Difficulty sleeping
- ☐ Allergies
- ☐ Digestive problems
- ☐ Other: _____

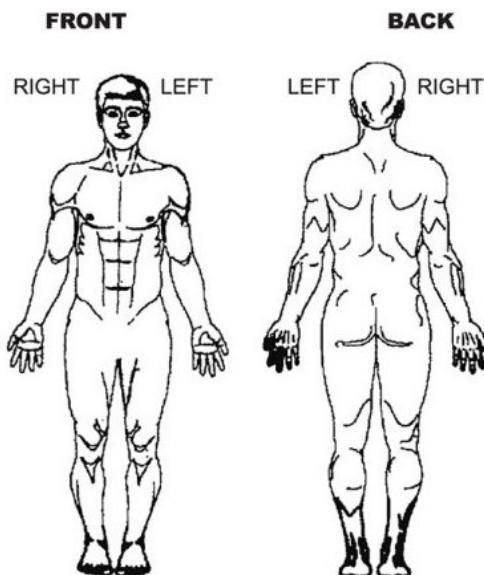
Previous surgeries: _____

Health Conditions/Medications:

PAIN DIAGRAM

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

P. PAIN
T. TINGLING
N. NUMBNESS
B. BURNING
S. STIFFNESS



Initial Here _____