Patient Information Form

Date:____/____ /_____

Name: _____

Date of Birth: _____/_____/_____

Contact Phone: Day time (____)_____ Night time (____)_____

Address: _____Zip Code_____

Email address: _____

Main Complaint:_____

_____

_____

_____

_____

Any other problems you are concerned:_____

_____

_____

_____

_____

Medical history related to your complaints:_____

_____

_____

_____

For Female: Are you a pregnant? □ Yes □ No

Do you have a pacemaker? □ Yes □ No

Assessment and Plan:_____

_____

_____

_____

_____