Initial Visit History — InterX Patient form 2

*To be completed by the **patient** prior first treatment*

Patient name: _____

Date: _____
day / month / year

Sex: ☐ M ☐ F Date of birth _____

Address:
Apt#
Street
City:
County:
Post Code:

Primary Phone No

Marketing consent ☐ Yes ☐ No

Treatment consent ☐ Yes ☐ No

1 **Referred by:** ☐ MD_____ ☐ Therapist_____ ☐ Other_____

How did you find out about the InterX? _____

2 Please describe **the Chief Complaint** and relevant details to your condition. Note **how long the pain** has been present.

_____

_____

_____

3 Diagnostic/surgical procedures related to cause of pain, within the last 12 months or (3 months for recent)

	Date Day /Mo / Year	Results Obtained	Comments
A) MRI	/ /	_____	_____
B) X-Ray/US	/ /	_____	_____
C) Blocks	/ /	_____	_____
D) Surgery	/ /	_____	_____
E) Other: _____	/ /	_____	_____

4 Inform the therapist if you currently have or have a history of the following:

- ☐ **Cardiac Pacemaker**
- ☐ **Implantable stimulator**
- ☐ **Epilepsy/Seizures**
- ☐ **Currently Pregnant**

5 Please record any ***medications*** used within the previous 2 month. ▪ here if none

	Dose/Freq	Efficacy	Improved	Worsened	No Effect
▪ 1 ▪ NSAID:	_____	_____	▪	▪	▪
▪ 2 ▪ Paracetamol	_____	_____	▪	▪	▪
▪ 3 ▪ Steroids*	_____	_____	▪	▪	▪
▪ 4 ▪ Pharmaceuticals*	_____	_____	▪	▪	▪
▪ ▪ Other:_____	_____	_____	▪	▪	▪

Please record any side effects from medications:

_____

6 Please tick the appropriate box for each of the following conditions and indicate whether the symptoms you currently experience are mild, moderate, or severe: ☐ ✓ here if none

Condition	Mild	Moderate	Severe
A) High/Low Blood-pressure	▪ 4	▪ 5	▪ 6
B) Heart Condition	▪ 4	▪ 5	▪ 6
C) Varicose Veins/Phlebitis	▪ 4	▪ 5	▪ 6
D) Slipped disc/back condition	▪ 4	▪ 5	▪ 6
E) Rheumatoid/Osteo-arthritis	▪ 4	▪ 5	▪ 6
F) Abdominal/Digestive complaint	▪ 4	▪ 5	▪ 6
G)Dysfunction of the nervous system	▪ 4	▪ 5	▪ 6
H) Fatal or terminal conditions	▪ 4	▪ 5	▪ 6
I) Kidney Infection	▪ 4	▪ 5	▪ 6
J) Thrombosis	▪ 4	▪ 5	▪ 6
K) Haemorrhage	▪ 4	▪ 5	▪ 6
L) Skin Diseases/disorders	▪ 4	▪ 5	▪ 6
M) Epilepsy/ Seizures	▪ 4	▪ 5	▪ 6
N) Diabetes	▪ 4	▪ 5	▪ 6
O) Asthma/Respiratory Conditions	▪ 4	▪ 5	▪ 6
P) Psychiatric disorders	▪ 4	▪ 5	▪ 6
Q) Traumatic Injury/Surgery Please describe: _____	▪ 4	▪ 5	▪ 6
R) Neuropathies_____	▪ 4	▪ 5	▪ 6
S) Auto-immune disorders (Lupus; Fibromyalgia ; CRPS, etc)	▪ 4	▪ 5	▪ 6
T) Other: _____	▪ 4	▪ 5	▪ 6

7 Please tick any therapeutic activities/interventions you have participated in to reduce your pain in the last 2 months: ▪ here if none

	Efficacy	**Improved**	**Worsened**	**No Effect**
▪ 1 ▪ Physical/Occupational Therapy:		▪	▪	▪
▪ 2 ▪ Acupuncture		▪	▪	▪
▪ 3 ▪ Electrical Stimulation		▪	▪	▪
▪ 4 ▪ Steroid Blocks		▪	▪	▪
▪ ▪ Other:_____		▪	▪	▪

Please record any side effects from treatment: _____
Comments:_____
_____

Patient Signature:_____ Date:_____