PEMF EVALUATION

DATE: _____

PT NAME: _____ PT #: _____

PHONE #: _____

First evaluation:

1. I currently have a ….. Pacemaker ____Yes ____No
   Other Electronic Implant ____Yes ____No

2. Is there any possibility that you may be pregnant? ____Yes ____No

3. Are you currently receiving chemotherapy? ____Yes ____No

4. What problems do you hope to resolve with PEMF therapy?

   1.
   2.
   3.
   4.

6. On a scale of 1-10 (with 10 being the worst), how much pain is associated with the above symptoms?

   Symptom #1 _____ Symptom #3 _____

   Symptom #2 _____ Symptom #4 _____

7. Do you take any medications for the above symptoms? ____Yes ____No

   If yes, which medications: _____

   _____.

8. What other treatment methods have you tried for this problem? _____

_____.

9. Which doctors assisted you with #7? _____

_____.

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