PEMF EVALUATION

Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home: _____ Cell: _____

Email: _____

Whom may we thank for referring you to our office? _____

Sex: M F Birthdate: _____/_____/_____ ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Do you currently have any of the following?

Yes	No	
☐	☐	Currently receiving chemotherapy
☐	☐	Pacemaker
☐	☐	Cochlear implant
☐	☐	Other Electronic implant(s)

Please describe: _____

_____

_____

☐ ☐ I have had an organ transplant

Please describe: _____

_____

_____

☐	☐	Hip implant
☐	☐	Dental implants
☐	☐	Metal stents

Please describe: _____

_____

_____

Yes	No	
☐	☐	Other metal implant(s)

Please describe: _____

_____

_____

☐ ☐ I have other implants not safe for MRI

Please describe: _____

_____

_____

☐	☐	Breast implants
☐	☐	There is a possibility that I may be pregnant

Take 2 Healthcare
5777 Far Hills Ave, Dayton, Ohio 45429
Phone: (937) 433-3241 Fax (937) 496-5468

What problems do you hope to resolve with PEMF therapy?

1.
2.
3.
4.

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 _____

Please list all medication(s), dosage(s) and how long you've been taking them.

Medications	Dosage	How long have you taken this medication?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

_____

_____

_____

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