



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 _____

Do you take any medications for the above symptoms? Yes No

If yes, which medications: _____

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

8. Which doctors assisted you with #7? _____

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