SCENAR Care, LLC **HEALTH INFORMATION** **R #** _____

Patient Name _____ Date _____

Patient Information

Address _____

City _____ State _____ Zip _____

Phone: Home _____

Work _____ Cell_____

Date of Birth _____

Employer _____

Occupation _____

Emergency Contact _____

Phone: Home _____

Work _____ Cell_____

Recommended By _____

Health Care Provider

Name _____

Clinic _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Comments _____

Current Health Information

List Health/Concerns Check all that apply

Concern 1 _____

☐ mild ☐ moderate ☐ severe ☐ disabling

☐ constant ☐ intermittent

Symptoms ☐ ↑ w/activity ☐ ↓ w/activity

Treatment received _____

Concern 2 _____

☐ mild ☐ moderate ☐ severe ☐ disabling

☐ constant ☐ intermittent

Symptoms ☐ ↑ w/activity ☐ ↓ w/activity

Treatment received _____

Have you received SCENAR therapy before?

☐ Y ☐ N Comments _____

_____

List all conditions currently monitored by a Health Care Provider_____

_____

_____

List medications you took today including pain relievers & herbal remedies) _____

_____

_____

List all other medications taken in the last 3 months _____

_____

_____

List Activities that are affected by your condition

Work _____

_____

Home/family _____

_____

Social/Recreational _____

_____

How do you reduce pain?

_____

_____

Health History

Surgeries _____

_____

Accidents _____

_____

Major Illnesses _____

_____

Check All Current & Previous Conditions

General

Current	Past		Comments
☐	☐	Headaches	_____
☐	☐	Pain	_____
☐	☐	Sleep disturbances	_____
☐	☐	Fatigue	_____
☐	☐	Infections	_____
☐	☐	Fever	_____
☐	☐	Sinus	_____

Habits

Current	Past		Comments
☐	☐	Tobacco	_____
☐	☐	Alcohol	_____
☐	☐	Drugs	_____
☐	☐	Coffee, soda	_____

Allergies

Current	Past		Comments
☐	☐	Scents, oils, lotions	_____
☐	☐	Detergents	_____
☐	☐	Other	_____

Skin Conditions

Current	Past		Comments
☐	☐	Rashes	_____
☐	☐	Athlete's foot, warts	_____
☐	☐	Other	_____

Digestive/Elimination System

Current	Past		Comments
☐	☐	bowel dysfunction	_____
☐	☐	bladder/kidney dysfunction	_____
☐	☐	abdominal pain	_____

Endocrine System

Current	Past		Comments
☐	☐	Thyroid dysfunction	_____
☐	☐	Diabetes	_____

Cancer/Tumors

Current	Past		Comments
☐	☐	Benign	_____
☐	☐	Malignant	_____

Reproductive System

Current	Past		Comments
☐	☐	Pregnancy	_____
☐	☐	LMP	_____
☐	☐	Tubal ligation	_____
☐	☐	Painful menses	_____
☐	☐	Emotional menses	_____
☐	☐	Fibrotic cysts	_____

Muscles & Joints

Current	Past		Comments
☐	☐	Rheumatoid arthritis	_____
☐	☐	Osteoarthritis	_____
☐	☐	Osteoporosis	_____
☐	☐	Firbromyalgia	_____
☐	☐	Scoliosis	_____
☐	☐	Broken bones	_____
☐	☐	Spinal problems	_____
☐	☐	Disk problems	_____
☐	☐	Lupus	_____
☐	☐	TMJ, jaw pain	_____
☐	☐	Spasms, cramps	_____
☐	☐	Sprains, strains	_____
☐	☐	Tendonitis, bursitis	_____
☐	☐	Stiff or painful joints	_____
☐	☐	Weak or sore muscles	_____
☐	☐	Neck, shoulder, arm pain	_____
☐	☐	Low back, hip, leg pain	_____

Respiratory/Cardiovascular

Current	Past		Comments
☐	☐	Heart disease	_____
☐	☐	Blood clots	_____
☐	☐	Stroke	_____
☐	☐	Lymphedema	_____
☐	☐	High, low blood pressure	_____
☐	☐	Irregular heart beat	_____
☐	☐	Poor circulation	_____
☐	☐	Swollen ankles	_____
☐	☐	Varicose veins	_____
☐	☐	Chest pain, shortness of breath	
☐	☐	Asthma	_____

Nervous System

Current	Past		Comments
☐	☐	Head injuries, concussions	____
☐	☐	Dizziness, ringing ears	_____
☐	☐	Memory loss, confusion	_____
☐	☐	Numbness, tingling	_____
☐	☐	Sciatica, shooting pain	_____
☐	☐	Chronic pain	_____
☐	☐	Depression	_____

Other

Current	Past		Comments
☐	☐	Pacemaker	_____
☐	☐	Organ transplant	_____
☐	☐	Electrical intolerance?	_____
☐	☐	Do you use essential oils?	____

Patient Name _____ Date_____

Spirituality

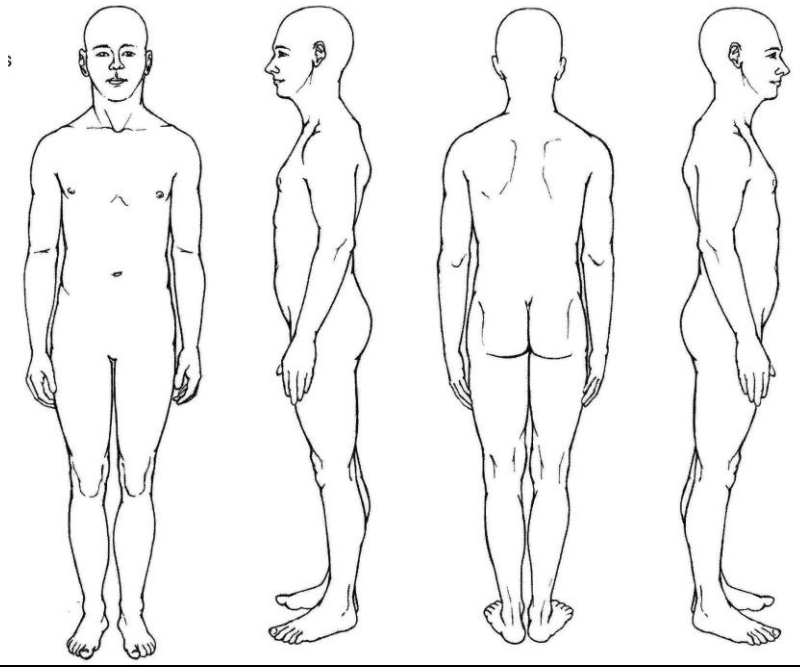
Yes No

☐ ☐ Would you like Christian prayer for healing or any other needs?

Diagram

Draw today's symptoms on the figures below using the letters in the key, then circle the letters.

Key **P** =pain or tenderness **S**=joint or muscle stiffness **N**=numbness or tingling



Comments

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PAIN ASSESSMENT

Patient currently experiencing pain? ☐ Y ☐ N Comments _____

Date of pain onset _____ Circumstances surrounding pain onset _____

_____

Pain-related medical condition(s) _____

Pain location(s) _____

Does pain radiate? ☐ Y ☐ N Where? _____

Pain Description

☐ Aching	☐ Dull	☐ Sharp	☐ Tender
☐ Burning	☐ Knot-like	☐ Shooting	☐ Throbbing
☐ Cramping	☐ Pressing	☐ Sore	☐ Tight
☐ Crushing	☐ Pounding	☐ Stabbing	☐ Other
☐ Deep	☐ Prickling	☐ Stretching	_____