NUW PEMF Intake Form Today's Date ____/___/____

Name: _____ __ Male __ Female

Birthdate: _____ Age: _____ Email:_____

FULL Address: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Emergency Contact Phone: _____

Referred by: _____

Reason for visit: _____

_____

How long have you had this condition? _____

Is it getting worse? _____ Does it bother your: ___ Sleep ___Work ___Other (what?)

What seemed to be the initial cause? _____

Pharmaceuticals taken in last two months:

_____

_____

_____

_____

Vitamins/ Supplements taken in last two months:

_____

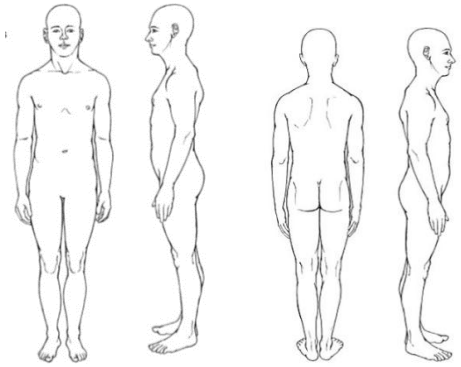
_____

_____

_____

MAJOR AREAS OF COMPLAINT, PAIN, TENSION_____

Please mark areas below:



What are you hoping to accomplish with PEMF?

_____ _____

signature date

Checking in on Facebook allows others to know that we are here to help! Thank you!