Calmare Therapy Orlando.

Please complete this questionnaire. This confidential history will be part of your permanent record.
Name_____ Date of Birth _____

Sex M __ F __

Address
_____
City_____
___
U.S. State _____ U.S. Zip _____ Country
_____

Email Address
_____

Home Phone _____ Cell _____

Emergency Contact _____ Cell
_____

Are you: Not disabled ___Completely disabled ___Partially disabled Date of disability:
_____
Are you reliant on any devices for normal mobility (cane, wheelchair, etc.): Yes No
_____

EmergencyContact Name _____
Cell_____

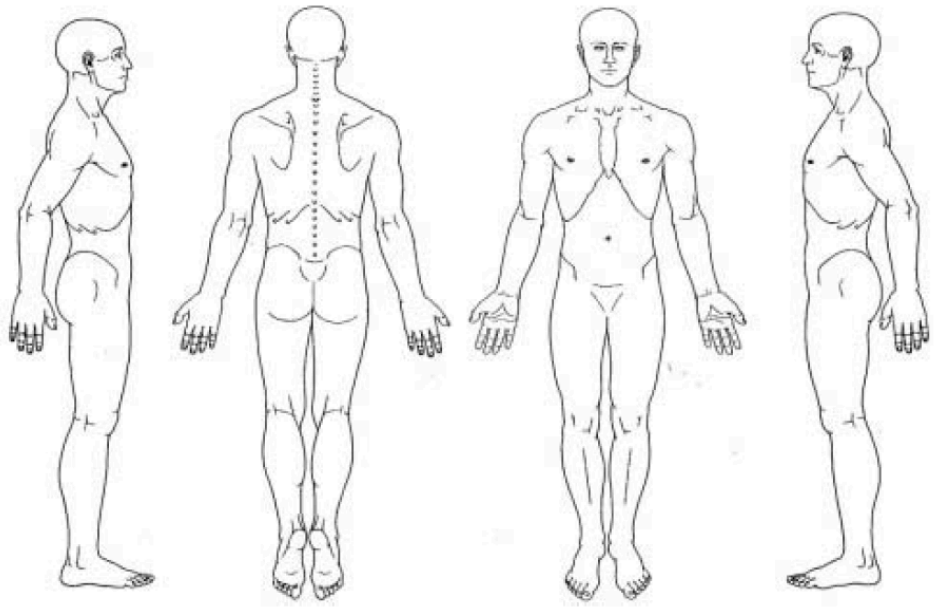
Name / city of your personal care physician:

NEUROPATHIC HISTORY

Name: _____ Date:_____
Please complete the following information as accurately as possible. All information will be held in strict confidence and will not be divulged to others without your prior authorization (or parent/guardian's authorization
in the case of a minor).

Below: Mark the type and location of pain on the body outlines below. Use code letters as indicated:
Pain Drawing Key
A= Ache P= Pins & Needles S= Stabbing
B= Burning X= Other N= Numbness

Please mark an X to indicate the areas where you feel pain, swelling, numbness or discomfort. Describe what you feel or observe in your own words. Write anywhere in this area.



CURRENT PAIN SCALE: (Mark your overall level or range of pain)

No Pain (0) |----------|----------| (10) Worst Pain

Please identify cause (diagnosis) of chronic pain:

_____
_____

Month/year pain condition began:

_____
_____

How did your condition start? Include approximate dates of injury or surgery.

_____
_____
_____
_____
_____
_____

What doctors have you seen for this condition?

Doctor Month/Year of Treatment Treatment Prescribed

1.
2.
3.
4.
5.

Any Contraindications to Calmare therapy?

Please read carefully for Specific Contraindications and Circle: Yes or No

Implanted Electronic Devices: Yes or No

Pacemakers, defibrillators, spinal cord stimulators, deep brain stimulators, and other implanted electronic or programmable devices can be affected by the electrical current used in Calmare Therapy.

History of Seizures or Epilepsy: Yes or No

Individuals with a history of seizures, epilepsy, or those currently taking antiseizure medications may not be suitable candidates for this therapy.

Pregnancy: Yes or No

Calmare Therapy is not recommended during pregnancy.

Recent Heart Problems: Yes or No

A history of heart attack or severe arrhythmia within the past six months is a contraindication.

Wounds or Skin Irritation: Yes or No

The presence of wounds or skin irritation in the treatment area can interfere with the placement of electrodes.

Active Withdrawal: Yes or No

Individuals in active withdrawal from drugs or alcohol are not recommended for this therapy.

Metal Implants or Orthopedic Repairs: Yes or No

Calmare Therapy may not be suitable for individuals with certain metal implants or orthopedic repairs.

Nerve Blocks: Yes or No

Nerve blocks within the four weeks prior to initial treatment can also be a contraindication.

Ketamine Use: Yes or No

Patients treated with Ketamine within the last 12 months may not experience relief from Calmare Scrambler Therapy.

Medications that Blunt Nerve Transmission: Yes or No

Medications like antiseizure drugs and anti-epileptic drugs (e.g., Neurontin, Lyrica) may reduce the effectiveness of Calmare Scrambler Therapy.

ANY OTHER MEDICAL CONDITIONS:

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS AND DAILY PRESCRIBED DOSAGE:

_____

_____

_____

_____

_____

_____

_____

_____

Any Allergies:

_____

_____

SYSTEMIC REVIEW:

Please tick Yes or No and circle the conditions if you suffer from the following conditions:

EYE Issues Yes / No
(blurred vision, eye pain, discharge, etc)

_____

_____

EARS, NOSE, THROAT, MOUTH Issues Yes / No

_____

_____

RESPIRATORY Yes / No
(asthma, emphysema, chronic bronchitis,

_____

_____

CARDIOVASCULAR Yes / No
(diabetes, hypertension, heart problems)

_____

_____

GASTROINTESTINAL Yes / No
(diarrhea, constipation, hernia, ulcers, etc.)

_____

_____

GENITOURINARY Yes / No
(painful urination, frequent urination, impotence, jaundice, etc.)

_____

_____

NEUROLOGY Yes / No
(Epilepsy, Stroke etc.)

_____
_____

LYMPHATIC Yes / No
(anemia, bleeding problems, problems with blood transfusions, etc.)

_____
_____

TOBACCO USE Yes / No (frequency)

_____

ALCOHOL USE Yes / No (frequency)

_____

WOMEN ONLY – GYNECOLOGICAL ISSUES Yes / No
(Describe)

_____
_____

By my signature below, I attest that the above information is true and accurate:

Signature:_____Date_____

TREATMENT AUTHORIZATION

I hereby acknowledge I am authorizing Dr. Faheem Khan of Calmare Therapy Orlando to perform Calmare therapy for me and I am fully aware of Calmare therapy for my condition and aware of the side effects of Calmare therapy, if any, which were discussed with me in detail by Dr Fahim Khan.

the parent/legal guardian).

Patient's Signature: _____

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Parent/Legal Guardian's Signature for Pediatric Patients Under age 18:

Date: _____