

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. **If you do not understand a question leave it blank and your therapist will assist you.**

NAME: _____ LEISURE ACTIVITIES: _____

OCCUPATION: _____

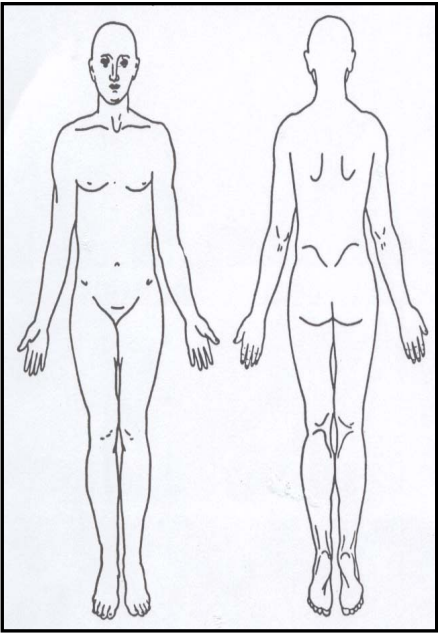
ALLERGIES: List any medication(s) you are allergic to: _____
 Are you latex sensitive? Yes No List any other allergies we should know about _____

Please check (√) any of the following whose care you're under
 ___ Medical doctor (MD) ___ Psychiatrist/Psychologist Other _____
 ___ Osteopath ___ Physical Therapist _____
 ___ Dentist ___ Chiropractor

On the diagram below, please indicate the location of your symptoms

Have you EVER been diagnosed as having any of the following conditions?

- YES NO Cancer. If YES, describe what kind: _____
- YES NO Heart Problems
- YES NO High blood pressure
- YES NO Circulation problems
- YES NO Asthma
- YES NO Emphysema/Bronchitis
- YES NO Chemical dependency (i.e., alcoholism)
- YES NO Thyroid problems
- YES NO Diabetes
- YES NO Multiple sclerosis
- YES NO Rheumatoid arthritis
- YES NO Other arthritic conditions
- YES NO Depression
- YES NO Hepatitis
- YES NO Tuberculosis
- YES NO Stroke
- YES NO Kidney disease
- YES NO Anemia
- YES NO Epilepsy
- YES NO Other



During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Have you recently noted:

- | | | |
|----------------------------------|---|-------------------------------|
| YES NO weight loss/gain | YES NO joint/muscle swelling | YES NO blood in the urine |
| YES NO nausea/vomiting | YES NO easy bruising | YES NO night sweats |
| YES NO dizziness/lightheadedness | YES NO excessive bleeding | YES NO hearing problems |
| YES NO fatigue | YES NO difficulty breathing | YES NO stress at home or work |
| YES NO weakness | YES NO regular cough | YES NO post menopause |
| YES NO fever/chills/sweats | YES NO arm/leg swelling | YES NO sexual difficulties |
| YES NO numbness or tingling | YES NO heart racing in your chest | |
| YES NO tremors | YES NO difficulty swelling | |
| YES NO seizures | YES NO heartburn/indigestion | |
| YES NO double vision | YES NO constipation/diarrhea | |
| YES NO loss of vision | YES NO blood in stools | |
| YES NO eye redness | YES NO pregnant or think you might be pregnant | |
| YES NO skin rash | YES NO problems urinating (difficulty starting, painful etc.) | |
| YES NO problems sleeping | YES NO urinary incontinence | |

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Please list any **surgeries** or other conditions for which you **have been hospitalized**, including the approximate date and reason for the surgery or hospitalization:

<u>DATE</u>	<u>REASON FOR SURGERY/HOSPITALIZATION</u>	<u>DATE</u>	<u>REASON FOR SURGERY/HOSPITALIZATION</u>
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

Please describe any **significant injuries** for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Tuberculosis	YES	NO	Arthritis
YES	NO	Heart disease	YES	NO	Anemia
YES	NO	High blood pressure	YES	NO	Headaches
YES	NO	Stroke	YES	NO	Epilepsy
YES	NO	Kidney disease	YES	NO	Mental illness
YES	NO	Alcoholism (chemical dependency)			

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

YES	NO	Aspirin
YES	NO	Tylenol
YES	NO	Advil/Motrin/Ibuprofen
YES	NO	Laxatives
YES	NO	Decongestants
YES	NO	Antihistamines
YES	NO	Antacid
YES	NO	Vitamins/mineral supplements
YES	NO	Other _____

Please list any **PRESCRIPTION** medication you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____	2. _____	3. _____
4. _____	5. _____	6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

How many days/ week do you exercise? _____

Patient signature

Date

Therapist signature

Date

OVER →