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: ________________________ PRIMARY CARE PHYSICIAN: __________________

ALLERGIES: List any medication(s) you are allergic to: ____________________________________

Are you latex sensitive? Yes No List any other allergies we should know about ____________________

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check (✓) any of the following whose care you're under

____ Medical Doctor (MD)
____ Osteopath
____ Dentist
____ Psychiatrist/Psychologist
____ Physical Therapist
____ Chiropractor
____ Other ____________________
____

Date of last physical examination ______________________

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

____

____

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

YES NO Cancer. If YES what kind: ____________________
YES NO Heart Problems. If YES what kind ________________
YES NO High Blood Pressure
YES NO Circulation Problems
YES NO Asthma
YES NO Stomach Ulcers
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. If YES what kind ________________
YES NO Blood Clots
YES NO Osteoporosis
YES NO Other ______________________________

For Office Use

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 or tried to injure you in any way? YES NO

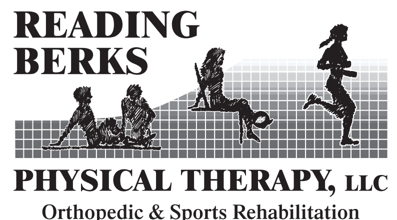
Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

SURGERIES/HOSPITALIZATIONS INCLUDE DATE AND REASON

1. ________ ______________________________

2. ________ ______________________________

3. ________ ______________________________



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

DATE	INJURY	DATE	INJURY
________	______________________________	________	______________________________
________	______________________________	________	______________________________

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

YES NO Diabetes
YES NO Heart Disease
YES NO High Blood Pressure
YES NO Stroke
YES NO Inflammatory Arthritis (Rheumatoid, Ankylosing)
YES NO Cancer
YES NO Alcoholism (Chemical Dependency)
YES NO Depression
YES NO Kidney Disease

Which of the following medications have you taken to the last week?

	Prescribed by a Physician	**Or Taking on Your Own**
Aspirin	YES/NO	YES/NO
Tylenol	YES/NO	YES/NO
Anti-inflammatories (Advil/Motrin/Ibuprofen etc.)	YES/NO	YES/NO
Vitamins/Mineral Supplements	YES/NO	YES/NO
Herbals/Remedies	YES/NO	YES/NO

Other medications/supplements **Taking on Your Own** ______________________________

Please list any other 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? ______________

Tobacco use: How many packs do you smoke per day ______ for how many years _______. If quit when? ___________

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? _______

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

______________________________ ______________________________

Therapist Signature Date Patient Signature Date