

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. Thank 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 _____

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) _____ Psychiatrist/Psychologist _____ Other
- _____ Osteopath _____ Physical Therapist
- _____ Dentist _____ Chiropractor

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? (Please circle yes or no)

- 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 Osteoporosis
- 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

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 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

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

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

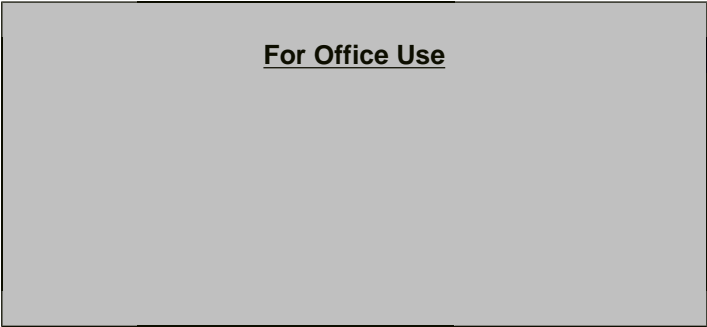
<u>DATE</u>	<u>INJURY</u>	<u>DATE</u>	<u>INJURY</u>
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

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. _____ | 3. _____ | 5. _____ |
| 2. _____ | 4. _____ | 6. _____ |

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

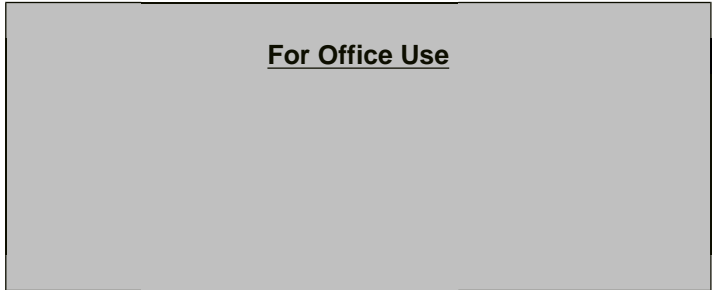
How many packs of cigarettes do you smoke a day? _____

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? _____

Have you recently noted:

- YES NO weight loss/gain
YES NO nausea/vomiting
YES NO dizziness/lightheadedness
YES NO fatigue
YES NO weakness
YES NO fever/chills/sweats
YES NO numbness or tingling
YES NO bowel/bladder irregularity



Therapist signature

Date

Patient signature

Date