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: _____

Occupation: _____ **LEISURE ACTIVITIES:** _____

ALLERGIES: List any medication(s) you are allergic to: _____
Are you sensitive to latex products? Yes No
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please mark any of the following whose care you are under:

___ Medical Doctor (MD) ___ Psychiatrist/Psychologist ___ Dentist ___ Home Health
___ Osteopath ___ Physical Therapist ___ Chiropractor Other _____
If you have seen any of the above during the last three months, please describe for what reason (illness, medical condition, physical, etc): _____
_____

What is your main problem or concern? _____

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

YES NO Cancer – if yes, what kind and when were you diagnosed? _____
If yes, have you had chemo and/or radiation treatments? _____
If Breast Cancer- have you had any lymph nodes removed? _____
YES NO Heart problems – If yes, please give details _____
YES NO Kidney Disease – If yes, what kind? _____
YES NO Other Arthritic Conditions – if yes, please give details _____

YES NO	Rheumatoid Arthritis	YES NO	Stomach Ulcers
YES NO	Osteoarthritis	YES NO	Chemical Dependency (I.E. Alcoholism)
YES NO	High Blood Pressure Controlled? Y/N	YES NO	Diabetes Type 1___ Type 2___ A1C___
YES NO	Thyroid Problems	YES NO	Fibromyalgia
YES NO	Multiple Sclerosis	YES NO	Depression
YES NO	Hepatitis Type ___	YES NO	Tuberculosis
YES NO	Stroke	YES NO	Blood Clots
YES NO	Osteoporosis	YES NO	High Cholesterol
YES NO	Asthma	YES NO	Circulation Problems

Other _____

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

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

Have you ever had any surgical implants (e.g. pacemaker, joint replacement, metal plates/screws, mesh, cosmetic implants)? Yes _____ No _____ If yes, please describe: _____

_____

Have you recently noticed:

YES NO	Weight loss/gain	YES NO	Vision problems	YES NO	Pregnant or might be
YES NO	Nausea/Vomiting	YES NO	Urinary incontinence	YES NO	Headaches
YES NO	Dizziness/Lightheaded	YES NO	Problems sleeping	YES NO	Migraines
YES NO	Stress at home/work	YES NO	Easy bruising	YES NO	Anxiety
YES NO	Fevers/chills/sweats	YES NO	Excessive bleeding	YES NO	ADHD
YES NO	Numbness/tingling	YES NO	Difficulty breathing	YES NO	Skin Rash
YES NO	Hearing problems	YES NO	Heartburn/Indigestion	YES NO	Anemia
YES NO	Double vision	YES NO	Constipation/diarrhea	YES NO	Fatigue

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

YES NO	Aspirin	YES NO	Hormone Replacement Therapies
YES NO	Tylenol/Acetaminophen	YES NO	Water Pills
YES NO	Anti-inflammatories (Advil/Motrin/Ibuprofen)	YES NO	Heart Medication
YES NO	Stomach Ulcer Medications	YES NO	Blood Thinner/Recent INR?_____
YES NO	Vitamins/Mineral Supplements	YES NO	Antibiotics
YES NO	Herbal Remedies	YES NO	Thyroid Medications
YES NO	Muscle Relaxers	YES NO	Anti-Depressant Medication
YES NO	Prescribed Pain Relievers	YES NO	Insulin
YES NO	Steroids	YES NO	Seizure Medication

Please list any other prescribed or over the counter medications not listed above:

_____

_____

Lifestyle/Activity:

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

During the past month have you felt a lack of interest or enjoyment in activities? YES NO

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

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

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how many drinks do you have at an average sitting?

_____

Tobacco use: How many packs do you smoke per day and for how many years? _____

How many ounces of water do you drink on a daily basis? _____

What healthy habits do you have? _____

_____

What do you like to do for exercise activity? _____

_____

Patient Signature: _____ **Date:** _____